

SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT PERTH

[2017] FAI 10

B141/15

DETERMINATION

BY

SHERIFF LINDSAY DAVID ROBERTSON FOULIS

**UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES (SCOTLAND)
ACT 1976**

into the death of

JOHN PERRY

**PERTH, 7th April 2017. The Sheriff, having considered all the evidence adduced,
determines:-**

1. In terms of Section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, that John Perry died at 12.28pm on 23rd January 2013 within Perth Royal Infirmary, Perth following his hanging himself in Cell B 1/4 within HMP Perth from the top of a bed by means of a ligature made from a shoe lace on 19th January 2013 between 2.26pm and 3.48pm.
2. In terms of Section 6(1)(b) of the said Act, that the cause of the death of John Perry was ligature pressure on his neck by a shoe lace.
3. In terms of Section 6(1)(b) of the said Act, that the cause of the said accident was the application of the ligature by Mr Perry round his neck.
4. In terms of Section 6(1)(c) of the said Act, that a reasonable precaution whereby the death of Mr Perry and the application of the ligature by him round his neck might

have been avoided was Prison Officer Roderick Thomson placing a copy of the letter from Mrs Gilmartin, Procurator Fiscal depute, Perth, dated 16th January 2013 addressed to the Governor, HMP Perth in the prison medical records of Mr Perry and attaching a copy of said letter to the ACT2care booklet relating to Mr Perry which was duly completed on his admission to HMP Perth on 16th January 2013.

5. In terms of Section 6(1)(e) of the said Act, that other facts which are relevant to the circumstances of the death of Mr Perry were that Prison Officer Lee and Nurse Ian Duncan should have been appraised of the terms of the said letter, which constituted additional information as defined in the ACT2care reception risk assessment form, by Prison Officer Roderick Thomson before they carried out the Reception Risk Assessment and Health Care Risk Assessments of Mr Perry respectively on 16th January 2013.
6. In terms of Section 6(1)(e) of the said Act, that other facts which are relevant to the circumstances of the death of Mr Perry were that the Personal Escort Record relating to Mr Perry made no mention of his having been subject to constant observations during part of the period he was held in police custody on 15th and 16th January 2013 and there was no specific provision on the said form to note that he was subject to constant observations at certain times whilst in police custody.
7. In terms of Section 6(1)(e) of the said Act, that other facts which are relevant to the circumstances of the death of Mr Perry was that Doctor Mark Wallace was not provided with a copy of the Personal Escort Record relating to Mr Perry when he carried out his assessment of Mr Perry on 17th January 2013.

NOTE

[1] This Fatal Accident Inquiry into the death of John Perry following events at H M Prison Perth on 19th January 2013 took place on 29th and 30th October 2015, 1st and 2nd February, 29th and 30th March, 16th 18th and 19th May, and 10th October 2016. Thereafter the parties were allowed time to lodge and intimate written submissions and I heard oral submissions on 21st December 2016. The parties' written submissions are appended to this note. Their oral submissions are recorded at the end of the appendix. Mr Quither, Procurator Fiscal depute, presented the case for the Crown. The other parties represented were the deceased's family, Tayside Health Board, the Prison Officers' Association, Prison Officer Ian Duncan, the Scottish Prison Service, Doctor David Sadler, and the Chief Constable of Tayside Police, now Police Scotland. These parties were represented by Mr Williams, solicitor, Glasgow, Mr Stuart, advocate, Edinburgh, Mr Cahill, solicitor, Glasgow, Miss Docherty, solicitor, Glasgow, Miss Phillips, solicitor, Edinburgh, Miss Railton, solicitor, Glasgow, and Mr Reid, solicitor, Glasgow respectively.

[2] Evidence was led by the Crown from M/s Pauline McLaughlin, Police Sergeants James Aitken, and Michael Assenti, Detective Constables Aitken Coupar and Lesley Murray, Police Constable Alan Boyd, Reliance and G4S officers Mark Cooper and Catherine Lindsay, Mrs Charmaine Gilmartin, Procurator Fiscal depute, Prison Officers Graeme Appleby, Peter Lee, Roderick Thomson, David Langlands, Kevin Sclater, Derek Pirie, and Peter Ward, Social Worker Richard Geddes, Doctor David Sadler, Prison

Nurses Ian Duncan, Catriona Baxter, and Gail Livingstone, Doctor Mark Wallace, Prisoners Jamie Morrison, Darren Byrne, and David Davidson, paramedic Amanda Storer, and M/s Lesley McDowall. M/s Dawn Wigley was called as a witness for Tayside Health Board and Chief Inspector Gordon Milne was called as a witness by the Chief Constable.

[3] The parties also produced a lengthy joint minute of agreement covering a number of issues. It dealt with the nature of the charges on petition upon which Mr Perry appeared on 16th January 2013 and documentation associated with the petition. It covered his appearance in court and his remand to HMP Perth. It covered his prison accommodation and prison routine. It covered his care in Perth Royal Infirmary after he was discovered in his cell on 19th January 2013, including details of the medical examination carried out and treatment administered. Finally, the joint minute covered the content of a handwritten note in his cell recovered on 19th January 2013, various photographs, the results of his post mortem, various documentary productions, recordings, DVDs of digital CCTV recordings, and the conclusions of a review carried out by the Scottish Prison Service after Mr Perry's death. Copies were also agreed to be the equivalent of principals.

[4] Before I move to consider the evidence, submissions, and my determination, I would wish to make certain observations. It cannot be anything other than regrettable that Mr Perry died in January 2013 but evidence only commenced in this inquiry almost three years after he passed away. The matters which required to be determined in terms of section 6(1)(a) and (b) of the 1976 Act were straightforward. Whilst I appreciate

evidence was led over ten days, there was no apparent difficulty in obtaining evidence from most of the witnesses. It accordingly was not immediately apparent why this inquiry could not have commenced earlier. Once started, I fully appreciate that a combination of court and representatives' diaries can cause problems in a lengthy inquiry, nonetheless it is again regrettable that evidence was led over twelve months as opposed to being concentrated over a shorter period. In making these remarks I am also fully aware that I have taken some time to issue my determination. I regret this.

Unfortunately the demands on shrieval time to produce reports in relation to criminal appeals and a judgement in a permanence proof have resulted in a delay on my part. Pressure upon court resources also results in dedicated writing days becoming something of a rarity nowadays.

[5] In considering my determination, the principal source of criticism is Mr Perry's family. In Mr Williams' written submissions, he focuses on three separate stages of the last few days of Mr Perry's life. I consider that this approach is helpful. Accordingly, I am going to cover matters under three headings, events within the police station, events at court, and thereafter events at HMP Perth. In looking at the last stage, I consider that it is also appropriate to separate matters further. It seems to me logical that I consider events surrounding Mr Perry's admission, his examination by Doctor Wallace, and events in B Hall separately. I also consider it appropriate that I examine the ACT2care procedure briefly as this procedure is relevant, apart from anything else, in considering the relationship between any acts and omissions which may have occurred at various stages and the death of Mr Perry. In all these events the presentation and demeanour of

the deceased is significant and I consider that this is the first matter which requires to be considered.

[6] Mr Perry was clearly a person who had a number of issues. He had been an abuser of controlled drugs, particularly cannabis. His mother also described him as a binge drinker. She described him as being significantly under the influence of drugs when she saw him in Greenock in 2012. She described displays of paranoia in 2012 involving such as the fidelity of his girlfriend. Before he was remanded in January 2013, he commented to his mother that he was fearful. He had written on his right groin 'I did not commit suicide.' He was described as ranting. During Christmas 2012 he made comments to his mother such as inquiring how to knot a noose. He was convicted in 2004 *inter alia* of assault to severe injury and permanent disfigurement and was sentenced to three years detention. He was convicted of an analogous offence in 2010 and received a further sentence of imprisonment, this time for two years. He was convicted of other matters between 2004 and 2010 and was sentenced to imprisonment on another five occasions. One of these convictions in 2008 was a contravention of section 4(3)(a) of the Misuse of Drugs Act 1971. His brother suffered from mental health problems. His father had died in 2008. According to the information M/s McLaughlin gave to Mr Geddes, his father had committed suicide. When the deceased was apprehended and the police contacted her, she made no mention of any concerns she had about her son to the officers. It cannot be overlooked that his mother had significant knowledge regarding his behaviour in the year prior to his death. The authorities who dealt with Mr Perry from 15th to 19th January 2013 were unaware of the great majority of

these matters, the only disclosure by M/s McLaughlin being her telephone call with Mr Geddes.

[7] On 18th January 2013 there were five telephone calls from Mr Perry to his mother over a period of approximately seven hours. He made a further two calls to his mother on 19th January 2013 over a two hour period and then called his partner at 2.24pm that day. During the calls between the deceased and his mother, she clearly was concerned for his welfare and expressed this to him, telling him to get help. She considered that he was displaying symptoms of psychosis and paranoia. He was making comments which did not make sense. M/s McLaughlin was sufficiently concerned that she contacted a social worker in HMP Perth, Mr Geddes, to advise that the deceased needed help. She, however, was told by Mr Perry that he would not self harm.

[8] Mr Perry had been apprehended on 15th January 2013. He appeared at Police Headquarters in Barrack Street, Perth around 5pm and said that he wished to speak to CID officers. He was described as appearing agitated. He was not prepared to discuss matters with the desk sergeant, Police Sergeant Aitken. He was described as coherent and talking sensibly. He did not appear under the influence albeit he was pale and sweaty. The officer thought he might be in trouble with a local criminal. CID officers then spoke with him. Detective Constable Coupar described him as appearing troubled. His account was all over the place. He described people in the west thinking him a grass and people were after him. Mr Perry failed to provide specific information. He then produced a knife as protection. He also had a hold all containing clothes. The officer had suspicions that Mr Perry was possibly banking drugs and seeking a remand to take

them into HMP Perth. Later, when he was taken to the observation cell, he struggled with officers. Detective Constable Coupar considered that the deceased appeared to be paranoid and he had concerns about his health. His colleague confirmed his account.

[9] Once Mr Perry was arrested, Police Sergeant Aitken went through the necessary procedures. He remarked that some of Mr Perry's responses verged on the paranoid. He was placed on thirty minute observations in his cell as the officer considered him a very vulnerable person. He was not quite right. Police Sergeant Assenti took over as custody sergeant around 7am on 16th January 2013. He described Mr Perry's behaviour as erratic. Mr Perry was lucid and coherent but was agitated at the suggestion that he go to Dundee for a medical assessment. Force had to be used to transport him from his cell to the escort vehicle for court. Police Sergeant Assenti had considered that his behaviour justified his being medically examined as he considered that there might be issues about fitness to plead. He did recall Mr Perry becoming calmer during the morning.

[10] At court Mrs Gilmartin was the Procurator Fiscal depute who dealt with the deceased's appearance on petition. His defence solicitor had no concerns about Mr Perry's ability to provide instructions. Although this appearance took place in the cells, he had been prepared to leave his cell and appear in court. However, the concern about his banking drugs meant that G4S staff requested the appearance take place in the cells. His reaction to being remanded in custody was no different from many persons. Mrs Gilmartin had no concerns about his self harming. Once remanded, Mr Perry was transferred to HMP Perth by G4S. He neither caused problems nor acted strangely.

[11] On admittance to HMP Perth, the prison officers on reception considered that Mr Perry acted normally. He was described as being calm and very quiet. Prison Officer Appleby disputed that Mr Perry had been remanded as a cry for help. He did not give that impression. Other officers on reception similarly had no concerns about him. Nurse Ian Duncan likewise had no concerns. He described Mr Perry as making good eye contact and giving no indications which might raise concerns. He conversed well. Doctor Mark Wallace saw Mr Perry on 17th January 2013. There was no suggestion that anything was amiss.

[12] Once Mr Perry was transferred to B Hall, three inmates spoke as to his presentation. Mr Jamie Morrison had been his cell mate for the first night. He spoke of him being fine overnight but acting in a weird manner the next day. He said that the television was talking to him. Mr Perry asked him for a pen to note things coming from the television. As a consequence of this behaviour Mr Morrison sought and was granted permission to move cells. Mr Darren Byrne confirmed that Mr Perry was behaving in an abnormal manner. On 19th January he talked with Mr Perry, who advised him that the television had told him to phone a number. His mood could change. Mr David Davidson said that Mr Perry seemed anxious and paranoid. He was quiet and did not appear happy.

[13] The Prison officers on duty in the hall in which Mr Perry was accommodated had no concerns about him. Prison officer Sclater saw him on 18th January and said that his presentation was no different to other inmates. He was clear and engaged sensibly. He recalled receiving the message from Richard Geddes, the social worker, and going to

check on Mr Perry in his cell. He told him that a family member was concerned for him. Mr Perry responded that he was fine. He chatted with Mr Perry for a little, while asking why he was remanded and whether he had taken any medication. His impression of Mr Perry was that he was more relaxed. He arranged for Nurse Baxter to speak to Mr Perry. She did so later that afternoon. She entered his cell and he acknowledged her, sitting up on his bunk. He made eye contact with her and in conversation denied that there was anything wrong. His interaction with her caused her no concern.

[14] In addition to the evidence from these witnesses, recordings of a number of telephone calls made by Mr Perry to his mother were played during the course of the inquiry. During these he not only spoke to her but also to his brother, his aunt, and girlfriend. There were nine played in full. These calls gave some indication of how he presented. The clear impression I gained from these calls was that until the call made around 8.36am on 19th January 2013, Mr Perry was able to engage in a perfectly intelligible conversation, responding appropriately to inquiries and comments made by his mother and others. His conversation appeared to have the differences in tone, volume, and expression one would expect. He was aware of what had happened. He made reference to refusing to go to Dundee to see Doctor Sadler, the court process, and his cell mate moving, for example. It is clear that his mother was concerned about him from an early stage. Further certain strange references start to feature in his conversations from the call at 11.30am on 18th January. These related to his owing money, that he was responsible for an armed robbery, that the television was making him say certain things, and that he was suspected on informing. There was a marked

change with the call on 19th January at 8.36am. His responses to his mother appear mainly monosyllabic and flat. He made a remark along the lines of 'I know what I have to do' and then told his mother 'I'll let you go.' When she questioned this, he repeated that he'd let her go. The last call recorded at 2.24pm on 19th January was with his girlfriend. Whilst there was more life in his conversation, he had forgotten that his mother told him she would be out in the afternoon and he did not appear to be really concentrating on what his girlfriend was saying. The call ended abruptly after a minute. The DVD recording, Crown production 23, showed the deceased slamming the telephone down before he went to his cell.

[15] Having considered the evidence to which I have referred, I am quite satisfied that Mr Perry was able to engage and present in a normal manner with persons he came into contact with during the period from his apprehension on 15th January. On other occasions, however, he did make odd remarks. Without any clear diagnosis from the appropriately qualified individual, it does appear to me that he was displaying certain signs of paranoia. Accordingly, the differing evidence given by the various witnesses fitted with the way Mr Perry could behave. It fitted with the way he presented in most of the telephone conversations he had with his family. Further, it fitted with his presentation to the various members of the prison staff. Again, during his conversations with his mother, he expressed clear reluctance about her contacting the prison social worker. He kept reassuring her that he was alright. He would sort out any problems he had. He had refused to see Doctor Sadler. His mother did not express surprise that he would deny he had any concerns to a prison nurse. This fitted with his responses to the

various persons who questioned him about his well being. Equally, when engaging with fellow prisoners, it fitted with his making remarks which indicated that all was not necessarily well, with him. In short, I am satisfied that there was no obvious indication given by Mr Perry to G4S staff, prison medical staff, or prison officers that there was something amiss. There was nothing these persons missed from his demeanour or in his interaction with them that should have alerted them that something was not right.

[16] Having reached this conclusion as to Mr Perry's presentation, I now wish to cover the ACT2care procedure briefly before going on to consider his care whilst in custody at various stages.

[17] The ACT2care assessment is engaged when a prisoner arrives at the prison and proceeds through the reception process. All prison officers are trained in the process. The process involves the prisoner being interviewed initially by a prison officer and thereafter by a nurse at reception. The nurse is normally a general practice nurse. I shall comment further on this later. The assessment form, an example appears between pages 76 to 81 of Crown production number 6 and related to Mr Perry's admission, provides numerous guidance notes and instructions. The officer carrying out the assessment should be in possession of the relevant Prisoner Escort Record and any other additional information. This can be anything at all according to the form, verbal or written from whatever source. The officer is given various instructions as to how to assess the prisoner. The officer is directed to check the prisoner records for the person being assessed to ascertain whether the person has been placed on ACT2care at any time in the past. Questions are to be asked of the prisoner and attention is drawn to various aspects

of the prisoner's presentation. The officer then completes a summary and risk assessment. The next section of the form is completed by the nurse at reception. The main difference in this section is that the questions to be asked are directed at mental health/self harm. If either person assesses the prisoner as being 'at risk' the prisoner is placed on ACT2care. This has various consequences from frequent observations by staff to being placed in a suicide cell. If the prisoner is placed on ACT2care, a case conference takes place the next day. This will determine whether the prisoner remains on ACT2care or comes off it. If the prisoner is not placed on ACT2care, he is subject to an examination by a doctor the following day. In short, the initial assessment from officer and nurse is to ensure there are no apparent risks relating to the prisoner during the first night.

Generally prisoners, if placed on ACT2care, wish to come off it as soon as possible. By its nature, the procedures are, at least to a degree, intrusive. Even after the admission process, if any member of staff has any concerns about a prisoner, they can initiate the ACT2care procedure.

[18] Turning firstly to his time in police custody, clearly Mr Perry was not the normal suspect that officers dealt with. I am satisfied of the following facts regarding this period. He presented himself at police headquarters in Perth and expressed a wish to speak to members of the CID. Whilst coherent, he was agitated. Once he was conversing with Detective Constable Coupar, the officer had doubts as to his account, albeit he was coherent. The officer had discovered through checks that Mr Perry had a significant criminal record. He then produced a knife. The holdall he carried contained clothes and the officer considered the possibility of Mr Perry deliberately engineering his arrest and

remand whilst he had banked drugs on his person. Everything did not add up. At one point he expressed the view that he might be killed in a manner which would look like suicide. Mr Perry also engaged in a struggle with officers at some point for no apparent reason. In his report to the Procurator Fiscal, the officer mentioned his behaviour. He had concerns regarding his health. He assessed Mr Perry as irrational, paranoid, and frequently aggressive.

[19] Initially Mr Perry was assessed as being high risk and subject to observation every thirty minutes. Following the decision to keep Mr Perry in custody and in light of his struggle with officers, he was moved to constant observations. In response to one question regarding self harm, Mr Perry denied he had ever attempted self harm. He was assessed as being high risk because of his violent behaviour in custody, the production of a knife, his admission to have taken drugs, and being known as having drug/alcohol issues. The Personal Escort Record recorded these matters. It also raised the possibility of his banking drugs for prison. Risks identified also included 'psychiatric condition.' Mr Perry was considered appropriate for a 'fit to plead' assessment on the morning of 16th January due to his presentation and behaviour in police custody. Police Sergeant Aitken did not consider Mr Perry required an immediate psychiatric assessment. He was orientated in space and time and responded to normal questions. He considered that Mr Perry was fit to plead albeit his behaviour was variable.

[20] The custody sergeant had twenty four hour access to nursing advice and, if there were pressing health needs, an ambulance could be summoned or a doctor or nurse called. The normal process was that nursing advice was sought first.

[21] Police Sergeant Assenti took over at 7am on 16th January. He made arrangements to have Mr Perry assessed to ascertain whether he was 'fit to plead' by contacting the custody nurse. Arrangements were made to take Mr Perry to Dundee as the police surgeon was unable to see him in Perth. Police Sergeant Assenti had concerns because of Mr Perry's demeanour. He was also agitated at the prospect of going to Dundee. It was eventually decided that Mr Perry would not be assessed and would be processed through court after discussion with Doctor Sadler and Mrs Gilmartin, the Procurator Fiscal depute. Police Sergeant Assenti also spoke to Doctor Sadler for further advice. Mr Perry had calmed down over time. This was consistent with drugs coming out of his system. When moved for court, Mr Perry was uncooperative. Police Sergeant Assenti recorded his erratic behaviour and demeanour on the Prisoner Escort Record. The boxes referring to 'suicide/self harm' and 'vulnerability' were not ticked on that form.

[22] Doctor David Sadler explained that in carrying out his duties in assessing a prisoner's fitness to plead, the normal arrangement was for the prisoner to be brought to Dundee as his main duty was as a pathologist. This was onerous. In early 2013, as a consequence of staff leaving and not being replaced quickly enough, he had been the only person qualified to carry out these assessments. Since then, another doctor had been appointed to carry out medical examinations. Such examinations were the responsibility of the practitioner, Doctor Sadler only providing holiday cover. This colleague was able to travel, if necessary, for such examinations. The 'fitness to plead' examination was straightforward involving ascertaining whether the prisoner was orientated in place, person, and time and understood their situation. He had asked to

see Mr Perry in Dundee due to his commitments in the morgue. He indicated that in light of the information he had been provided it was reasonable to believe that Mr Perry's behaviour could have been attributable to drugs. Mr Perry's refusal to leave his cell was not out of the ordinary. There was no suggestion that there was any urgency in the request. It was simply for a 'fitness to plead' assessment. He confirmed that it was always possible to obtain a psychiatric opinion. His opinion was that it was better to carry out the examination in a medical room where a prisoner might be more compliant than in custody. In 2013 general practitioners performed out of hours forensic medical examinations. During the week such examinations were his responsibility.

[23] Doctor Sadler confirmed that the practice since 2009 had been that if the custody staff had any medical query they contacted nursing staff based in Dundee. They provided advice in response to the information provided. If necessary, the nurses sought advice from a doctor. Under this system, a doctor could attend to examine a prisoner. Chief Inspector Gordon Milne confirmed this practice. He advised that there were five options when advice was sought from the nurses. They could tender advice, refer the matter to a doctor, ask that the prisoner be brought to Dundee, the nurse could attend the prisoner, or the prisoner could be taken to hospital. The nurses had been recruited from the National Health Service and then trained. There were twelve nurses recruited. They provided round the clock cover. This arrangement was preferable to the previous set up, which was dependent on a general practitioner being available and willing to attend a prisoner. The new arrangement provided twenty four hour care with immediate access to the National Health Service. The nurses had access to the National

Health Service data base albeit in 2009 this tended to be restricted to Tayside. By 2013 access had improved to take in records from other regions.

[24] Procurator Fiscal depute Charmaine Gilmartin confirmed that Police Sergeant Assenti had contacted her regarding Mr Perry to discuss his fitness to plead. As she had had discussions with the officer, she decided to deal with Mr Perry on 16th January. She considered the circumstances of Mr Perry's apprehension to be unusual. She decided to have Mr Perry assessed. However, as a result of Doctor Sadler's unavailability and Mr Perry's refusal to leave his cell to be assessed, she decided to process Mr Perry through court. She had been advised by Police Sergeant Assenti of Mr Perry's demeanour significantly improving. She did write a letter to the Governor, Crown Production number 5. She prepared this prior to going to Perth Sheriff Court to deal with Mr Perry.

[25] Dealing with Mr Perry's time in police custody, I do not consider that any criticism can be directed at the manner in which he was dealt with. The condition of persons who are taken into police custody is much varied. He was initially placed on thirty minute observations. This was increased to constant observations after the struggle with officers. Police Sergeant Assenti decided it was worthwhile investigating the possibility of an examination being carried out by a police doctor. This would have been a 'fitness to plead' assessment and, as a matter of fact, would have been carried out if Mr Perry had been prepared to travel to Dundee, a journey of less than an hour. It is clear in the first telephone call he made to his mother, recorded on Crown production number 15, that it was his decision to refuse to go to Dundee. It should not be overlooked that the consistent picture presented of Mr Perry is that, sadly, he was not a

person who was prepared to divulge any issues which he might have. Even when he was speaking to his mother by telephone and she expressed concerns for him, he told her that he would deal with matters and there was nothing wrong with him. There can be no criticism directed at Doctor Sadler indicating that he could not attend Perth Police Headquarters immediately. He was undertaking numerous duties at the time and no issue can be taken with his prioritising his other duties that morning. Further, in any event, the possibility of Mr Perry being examined was not thereafter discounted. Doctor Sadler had indicated that he was available to travel to Perth by late morning/lunchtime. In addition, Mrs Gilmartin's position was that she was prepared to take the necessary steps for Mr Perry to appear in court whilst at the same time monitoring his condition. Meantime, there had been an improvement in his presentation. In any event, any assessment carried out by Doctor Sadler related to his fitness to plead. It was not a psychiatric assessment. I accept the evidence from Chief Inspector Milne that the system in place in January 2013 was an improvement on the previous arrangement. There was all round access to medical advice with responses dependent upon the scenario disclosed. Further, it should not be overlooked that no one dealing with Mr Perry at this point considered that there was any risk of self harm. Mr Perry was dealt with in a perfectly satisfactory manner whilst in police custody. The proof of that was that he passed from police custody safely to court. In my opinion, the system in place for care of the health of persons in police custody was and is now perfectly satisfactory. In conclusion there is nothing relevant to section 6(1)(c) or (d) arising from Mr Perry's time in police custody. Aside from anything else, once Mr Perry was remanded, on arrival at

HMP Perth, he was assessed under the ACT2care procedure. That, in my opinion, breaks any connection between anything which might or might not have occurred in police custody and Mr Perry's unfortunate demise. There are, however, two matters which I believe could be looked at which might improve the system. I shall deal with these later.

[26] Moving on to events at Perth Sheriff Court, I am satisfied that when he appeared in court G4S staff acted on the assessment in the Personal Escort Record that he represented a risk. He was subject to checks five times hourly as was noted on the 'Record of Events' section of the Personal Escort Record. It was open to G4S staff to have a prisoner on constant observations at court. If this was required, the practice was to keep the prisoner at the police station for as long as possible because Perth Sheriff Court cells were unsuitable. Mr Cooper was surprised there was no mention of Mr Perry being on constant observations in police custody.

[27] Mrs Gilmartin decided to deal with Mr Perry's appearance in court herself. She wished to ascertain how he was. She had concerns as to his mental state. She was principally concerned as to whether Mr Perry was fit to plead. The solicitor representing him had no concerns. G4S Staff had concerns regarding Mr Perry appearing in court so the first appearance on petition took place in the cells. These concerns related to the issue of banking drugs. The hearing took place through the hatch of the cell occupied by Mr Perry. She recalled his being unhappy about his application for bail being refused but his reaction was not out of the ordinary. She still had concerns regarding his behaviour, albeit these had reduced, and thus handed over the letter she had written.

This was a bespoke letter and was not the standard 'risk of suicide letter.' She had no concern for Mr Perry self harming and removed reference to that risk in her letter. She gave the letter to G4S staff.

[28] Following his appearance in Perth Sheriff Court, he was transferred to HMP Perth. The escort officer, M/s Lindsay, had concerns regarding Mr Perry. These related to a possible psychiatric condition, the issue of weapons, and violent and erratic behaviour. He, however, had caused no problems during his transfer to prison. If there had been any problems, these would have been recorded on the Prisoner Escort Record. She recalled Mr Perry was very quiet.

[29] Dealing with this aspect of Mr Perry's care I again do not consider there is anything which merits criticism. The suggestion made on behalf of the deceased's family that an arrangement could and should have been made to have Dr Sadler examine him is not well founded. No one, who had any dealings with Mr Perry whilst he was within Perth Sheriff Court, considered that any medical assessment required to be carried out then. It should not be lost sight of that Mr Perry was in the care of G4S for a period of four hours. The Crown had had notice of his behaviour in custody since around 8.30am and, in my opinion, had taken all appropriate steps in light of the information provided. Indeed, I consider that Mrs Gilmartin was very thorough in her dealings with Mr Perry. My understanding is that she was not the Procurator Fiscal depute dealing with custodies in court on 16th January 2013. However, because of her personal knowledge of his circumstances, she dealt with his case that day. She was on notice and made inquiry of his legal representative that day. He had no concerns about taking instructions. Albeit

the hearing was conducted through the hatch of a cell, a bail application was made and thus the hearing was not simply formal. Again, she would have been alive to anything untoward in light of her prior knowledge. There was nothing. Notwithstanding this, she wrote the letter to the Governor, Crown Production, number 5. This letter was not simply a style letter. It was a letter which had deleted reference to self harm. The letter made reference to the unusual circumstances surrounding Mr Perry's apprehension. It made reference to the possibility of his having banked drugs. It made reference to his bizarre demeanour and gave details as to the manner in which this was manifest. It also made mention of his improvement in presentation. The letter gave Mrs Gilmartin's contact details and suggested that a psychiatric assessment might be considered. The letter put the prison authorities on notice that Mr Perry might be worthy of an assessment and gave reasons for this view. Mr Perry passed through the court process safely. In conclusion there is nothing relevant to section 6(1)(c) or (d) arising from Mr Perry's time within the court process. Again, for reasons already noted, the ACT2care assessment undertaken at the reception of HMP Perth breaks any causal chain.

[30] On behalf of the family, Mr Williams submitted that a more detailed assessment of persons is required before they are admitted to prison. The behaviour of Mr Perry, from the moment he entered police custody, indicated that 'something was not quite right.' These signs were not picked up or acted upon. There was, however, no evidence led to support the introduction of any such assessment. There are a number of matters which immediately come to mind. It is not unknown for persons in custody in court cells to act in a manner which could be described as unusual. It is not uncommon that people

will shout loudly, bang walls and doors and can struggle at times. It is not unknown for the sheriff to deal with a custody appearance in the cells. What would prompt the requirement to arrange a 'more detailed assessment?' It could not relate to all held in custody. What would such an assessment involve? There is also the issue of where the custody court appearance falls in the process. Of necessity, a person appearing from custody will have already been in police custody. Accordingly, the arrangements regarding the provision of medical care in police custody will have covered the prisoner at that stage. If remanded, the prisoner is then subject to assessment in terms of the ACT2care process. Further the period of time a prisoner is actually held at the court is limited. Indeed, Mr Cooper said in evidence that if there were significant issues with a prisoner, that person would be kept in police custody for as long as possible as the cells at Perth Sheriff Court were not suitable. This was not investigated further in evidence. It does, however, suggest that if the circumstances dictate, contingency measures are adopted. To conclude, in the circumstances, I do not consider that the requirement sought on behalf of the family is justified without clear evidence to support it.

[31] Turning now to his period in HMP Perth, I consider that it is appropriate to deal with this in three stages, the initial admission and the ACT2care procedure at reception, the medical examination the following day carried out by Doctor Wallace, and finally his time in B hall. I am satisfied that he arrived there at 2.45pm on 16th January 2013. Prison Officer Appleby was on duty at the reception to HMP Perth. It was quiet when Mr Perry was admitted. He received the relevant Prisoner Escort Record when Mr Perry arrived. He also recalled a letter enclosed in an envelope attached to the record. This was

passed Prison Officer Roderick Thomson. Thirty minutes passed from his arrival until the ACT2care assessment was carried out. Although he did not carry out the assessment, Officer Appleby was ACT trained and carried out such assessments daily. He had served on reception for seven years. Mr Perry's behaviour did not raise any concern whatsoever. He was not under the influence of drugs and never mentioned any issues to him or other officers. He confirmed that they had been informed that Mr Perry may have banked drugs. He was accordingly kept separate from other prisoners. He was subject to a drugs search carried out by dogs. This was negative. He was aware that Mr Perry was said to have acted bizarrely since he was apprehended.

[32] Prison Officer Lee was on reception when Mr Perry was admitted. He recalled accessing Mr Perry's custody record with the Scottish Prison Service. He received his Prisoner Escort Record and passed that and Mrs Gilmartin's letter to Officer Thomson. The items ticked on the record resulted in Mr Perry being 'wanded' and asked to sit on the metal detection chair to search for weapons. The reference to drugs and alcohol would be covered during the ACT2care process. He also indicated that normally they received advance notification of the prisoners to be admitted. This enabled officers to check the relevant SPS custody record, which can give an indication whether a prisoner has previously been placed on ACT2care. It can also give details of a prisoner having been bullied or being placed on protection. In the case of Mr Perry, he had not previously been subject to ACT2 care. The property accompanying Mr Perry was consistent with his being remanded or possibly on his way home. He chatted to Mr Perry whilst he was checking his property. Mr Perry engaged in a normal manner.

Officer Lee carried out the first part of the ACT2care assessment. In carrying out this assessment, he checked on Mr Perry's general demeanour and his eye contact. He looked for recent signs of self harm. His part of the assessment lasted no more than ten minutes. His completion of the form was not simply based on the prisoner's responses. He did not necessarily accept the responses given by the prisoner. He observed any prisoner as he was admitted and took account of any information from other sources and the prisoner's presentation. There was nothing which supported Mr Perry being assessed as at risk. He was given no real details as to Mr Perry's behaviour prior to his admission to prison. He completed his section of the ACT2care assessment form by inserting 'John stated clearly that he had no concerns or issues following his admission to prison.' He assessed him as 'no apparent risk.'

[33] Prison Officer Thomson was the manager on duty at reception when Mr Perry was admitted. He was qualified in relation to the ACT2care procedure. He received the letter from Mrs Gilmartin from his colleague, Officer Appleby. As a result of the information in the letter, he assessed Mr Perry whilst he was in the holding area. His behaviour was normal. The letter was put in a tray for mail to the general office. It would be taken there over the next few days. He did not consider the letter should be copied to Mr Perry's medical records or to security. On balance I don't consider he shared the content of the letter with other reception staff. He had assessed Mr Perry in the holding area and noted nothing untoward. The letter was addressed to the Governor and was dealt with in accordance with normal procedure for such correspondence. Copies were not sent to other destinations in the prison. Why then, having acted in

accordance with normal procedure, would he take an unusual step of disclosing the contents of the letter to others? The evidence from the reception staff was that Mr Perry did not behave in an untoward manner. Officer Thomson had other tasks to perform. He had to keep Mr Perry separate as a result of the suspicions regarding drugs. He had to arrange a drug dog to attend. He may simply have overlooked mentioning the contents to others. Officer Lee also had no recollection of being advised of the contents. I would have thought he would recall its contents if he had been informed of them as it would have been out of the ordinary. Similarly Nurse Duncan said he subsequently became aware of the letter after Mr Perry's death and a similar conclusion is reached. There is also a suggestion from the evidence of Officer Pirie that the letter may not have been opened at reception. He certainly in cross examination recalled that the letter was sealed when he received it from Officer Thomson. He opened the letter. He did accept that he might be mistaken and the SIDCAAR review, Crown production 34, did state that the letter was viewed by reception and nursing staff. Officer Pirie had been in attendance at the review as had Nurse Duncan. He further confirmed that that the review had been sent out to those participating to confirm its terms were correct.

[34] Nurse Ian Duncan carried out the medical assessment for the ACT2care procedure at reception. He chatted with Mr Perry for around twenty minutes whilst the procedure was gone through. He gave no indication that there was anything amiss. He conversed well, with good eye contact. He asked Mr Perry about the matters highlighted in the Prisoner Escort Record. Mr Perry denied these issues were of any relevance. He denied that he had any psychiatric issues and laughed at the reference to violence. The

drug tests carried out by Nurse Duncan were negative. He did not see the letter from Mrs Gilmartin. If he had he would have challenged Mr Perry as to its contents.

Depending upon his responses, he may have been placed on ACT2care. The picture of Mr Perry referred to in the letter did not accord with his memory of him during the assessment. He completed his assessment by noting on the ACT2 care assessment form 'No thoughts of self harm' and assessed Mr Perry as 'no apparent risk.'

[35] In considering the reception process regarding Mr Perry on 16th January 2013, I have no criticism of the conduct of Officer Lee or Nurse Duncan in the ACT2care process carried out upon Mr Perry. There was no suggestion and indeed no evidence which suggested that either Officer Lee or Nurse Duncan failed to act appropriately in assessing him as 'no apparent risk' in light of their interaction with Mr Perry and their state of knowledge. In submission, Mr Williams suggested that he was a borderline case and they should have erred on the side of caution and made him the subject of ACT2care. The evidence from these individuals is not to that effect and there was no evidence to counter that. The evidence from Mr Perry's mother as to her concerns has no significance at this stage. The officer and nurse had no information concerning the basis for her concerns for obvious reasons. Similarly, Mr Perry's presentation at the police station was significantly different to his presentation at the prison reception. There is also the evidence of his general improvement as he was processed from police custody through the court process to his arrival at HMP Perth. Officer Lee said that subsequent knowledge of Mr Perry's suicide would not have caused him to change his opinion as to the risk he posed. Nurse Duncan expressed a similar view.

[36] In any event, when considering events at reception, even if there had been any criticism levelled at Officer Lee and/or Nurse Duncan, for reasons already expressed in relation to events in police custody and Perth Sheriff Court, subsequent events break any causal chain. In particular, the ACT2care process provided for Mr Perry to be medically examined by a doctor the following day as indeed he was. Doctor Wallace also had significant psychiatric training.

[37] At this point it is also appropriate to deal with the submission on behalf of the family that all prisoners should be assessed by qualified mental health nurses on admission. I am not prepared to make any finding to that effect in light of sections of evidence from M/s Wigley relating to the availability of mental health nurses generally. There is a national shortage. I accept this evidence. Further the nurses who gave evidence had some psychiatric training, albeit Doctor Wallace indicated that mental health nurses would go into such issues in more detail. Further, it would be perfectly open to the nurse carrying out the assessment to place a prisoner on ACT2care and at the same time make a referral to the mental health team. In any event, as I have already noted, Mr Perry was seen by Doctor Wallace the following day. He had significant psychiatric training and thought that there was nothing amiss in that regard. The evidence before me points to there being no different assessment of risk being made by any mental health nurse if such a nurse had carried out the assessment of Mr Perry at reception.

[38] Still dealing with the evidence from M/s Wigley it may indeed be the position that the medical aspect of the assessment at reception is not limited to mental health but

also covers physical issues. There may be matters such as drug testing carried out. However, that does not, of itself, justify the Health Care Risk Assessment in the ACT2care procedure being carried out by a general practice nurse. The whole tenor of the ACT2care paperwork is aimed at self harm/suicide. One only needs to read the five lines on the first page of the assessment booklet to ascertain the purpose behind the procedure, a conclusion supported by the content of the remaining pages of the booklet. In addition, the relevant ACT2care assessment form within Crown Production 6 at page 78, when referring to a first admission into custody and the Health Care Risk Assessment, does clearly state that this assessment must be carried out by a nurse (preferably Mental Health) who has the appropriate training. The authors of the form clearly had in mind that this assessment was better carried out by such a nurse. The impression given by the evidence and submissions is that this is not and cannot be given effect to. It appears there is a general acceptance that this inability to provide mental health nurses to carry out this assessment simply is the factual position. That may well be the case and the only evidence I heard supported that. That does not mean that every effort should not be made to take steps to satisfy that preference set out in any process rather than have that preference have a hollow ring. This remains relevant notwithstanding the modifications to the ACT2care process and 'preferably' being watered down to 'where possible.' I shall come to that later.

[39] The final issue in relation to Mr Perry's passage through the prison reception relates to Mrs Gilmartin's letter. This letter arrived with Mr Perry. It was placed in Officer Thomson's out tray to go to the prison general office where it would find its way

to Mr Perry's general records. This meant that the contents of the letter did not appear in his medical records and thus would not come to the attention of Doctor Wallace when he carried out his assessment the following day. In my opinion the content of this letter should have been disclosed to Officer Lee and Nurse Duncan who carried out the reception assessment of Mr Perry. It may not have altered their assessments but they should have had full knowledge of its contents. The relevant ACT2care assessment form within Crown Production 6 at page 78 refers to disclosure of any information relating to a prisoner. The page is headed up as follows:-

'Guidance Notes: Reception Risk Assessment Procedure

Sometimes prisoners give us clues that they are worried and sometimes there are 'clues' in their personal histories which can lead us to the view that they are especially vulnerable. We need to be sensitive to these 'clues & clues' and the use of this document can help us to ask sensible questions, exploring with Prisoners their needs and explaining the help available in your prison and how it can be obtained.'

Thereafter on the same page the guidance notes provide instruction as to the completion of the Reception Risk Assessment and Health Care Risk Assessment parts of the form.

Both these parts of the form have the following section:-

'Check PER and any additional info: Has there been any information received from PER or other source that has raised concerns with regards to 'At Risk' status: **Yes/No'**

In both instances, as I have already noted, Officer Lee and Nurse Duncan circled 'No'.

The guidance notes define 'any additional information in the following way:-

'This could be anything at all that has been disclosed (verbal/written) from whatever source e g (escort staff, court staff, Prisoner's family, another prisoner, etc).'

This letter, written as it was by a legally qualified member of the prosecution service, was, to borrow a phrase from another field, significant intelligence from a trustworthy source. It was not simply something from an 'untested source.' It was also headed 'Urgent.' This would tend to denote it was important. The letter contains the following passages:-

'The circumstances are somewhat unusual in that he is alleged to have gone into Perth Police Station with a knife concealed, got into a room with a police officer and then produced the knife stating that it was for protection.'

Reference then is made to Mr Perry coming from Greenock and having no apparent connection with Perth and the concerns that he may have deliberately sought remand to smuggle contraband, particularly drugs, into prison. The letter continues:-

'Mr Perry's demeanour was 'bizarre' when he was first at the police station. For example at times he was unable to be understood and he said that the police were going to kill him and make it look like suicide. Overnight his demeanour has improved but it was thought appropriate that he be seen by a doctor. He has refused to be examined.

The Doctor has expressed an opinion that a change from bizarre behaviour to appearing to be fine today could be because he was under the influence of drugs and the effects have worn off.

I advise you of this because if he displays any further 'bizarre' behaviour, it may be that a psychiatric assessment is necessary.'

She then gave her direct dial number and e mail address and indicated her willingness to discuss matters further.

[40] Officer Thomson was ACT2care trained and thus should have been familiar with the sections on the form I have quoted. He also accepted in evidence that identification of a prisoner who presents a risk of self harm depended on, *inter alia*, good intelligence.

In my opinion the failure to disclose the contents of this letter to Officer Lee and Nurse Duncan meant that they were ignorant of an important item of additional information. Accordingly, whilst they carried out their duties in terms of the ACT2care procedure in relation to the risk assessments, one significant piece of information anticipated in that procedure was not made available to them. Officer Lee was not asked directly if his assessment of risk would have changed if he had seen the letter or been given details of its content. The impression I gained from his evidence was that it would have not. Nurse Duncan said that the letter would not, of itself, have altered his assessment although he would have asked Mr Perry about its contents. Depending on the answers received, he might have placed Mr Perry on ACT2care. This evidence, in my opinion, does not support any findings in terms of section 6(1)(c) or (d) regarding failure to disclose this letter's contents to those persons. However, I think it is worth noting that the drugs test carried out at reception were negative. Accordingly this might mean the possible link between the bizarre behaviour and drugs was slight. This might have had a bearing on the decision as to whether Mr Perry was placed on ACT2care. However, there is, in any event, still the issue of causation to which I have already referred. To conclude, I consider that this failure to disclose falls within section 6(1)(e).

[41] The manner in which the letter was dealt with at this stage, however, has further consequences because Doctor Wallace did not have sight of that letter when he came to interview Mr Perry on 17th January 2013 and I now turn to his involvement with Mr Perry. He saw Mr Perry on the morning of 17th January 2013. He noted in the relevant section of the ACT2care assessment form 'No suicidal ideation/thoughts of self harm.'

He likewise assessed him as 'no apparent risk.' Doctor Wallace had significant professional psychiatric experience. He had the ACT2care booklet which had been completed the day before together with Mr Perry's previous medical records and the reception nurse notes. He would assess any prisoner from the moment he entered the examination taking account of his eye contact, speech, and mood. He asked prisoners about self harm ideation and looked for delusional ideas. There was nothing amiss with Mr Perry. He considered the content of Mrs Gilmartin's letter indicated that Mr Perry was suffering from delusional belief which fell within the category of psychosis. If he had had sight of that letter he would likely have placed Mr Perry on ACT2care or asked the mental health team to review him that day. He would certainly have asked more questions of Mr Perry and his decision would have taken account of these replies. He accepted that Mr Perry might have refused to undertake a mental health referral but if that had been the case, he would have likely placed him on ACT2care. He also advised that the mental health assessment was more detailed, investigating his past history and that of his family. The questioning regarding mood was more detailed. Doctor Wallace commented that the vast majority of episodes of self harm/suicide, were the result of a quick decision taken impulsively.

[42] The evidence from Doctor Wallace undoubtedly raises the issue of a finding in terms of section 6(1)(c). There is, in my opinion, no question that it was a perfectly reasonable precaution to bring the content of the letter to the attention of the doctor carrying out the assessment of Mr Perry the day following his admission. A copy could have been placed in his medical records in addition to his general records. Alternatively

or additionally, a copy could have been attached to the ACT2care document which Doctor Wallace had the following day. The reasons are obvious when regard is had to the letter's contents, its author, and the whole ethos behind ACT2care. It is essential that the most qualified medical personnel have as much information as is relevant for his assessment. The crucial issue is whether this action might have prevented Mr Perry taking his life. This does not require me to conclude that such action would have prevented his death, only that the action had some potential in preventing his death. Doctor Wallace's evidence supports the conclusion that it was likely that he would have taken further steps to look into Mr Perry's health and well being, more detailed questioning at very least, but also the prospect of his being placed on ACT2care or a mental health referral. He carried out his examination two days before Mr Perry took his own life. If placed on ACT2care, there would have been a case conference on 18th January. By that time, Mr Perry's cellmate had sought and been granted a move. There may have been no further information but this request for a move in itself may have raised a concern. By early afternoon on 18th January there had been the call from M/s McLaughlin to Mr Geddes and the events following that call. In particular, concerns were raised as to Mr Perry's mental health. In light of that, it seems to me a reasonable conclusion to reach that further investigation may well have been undertaken as to Mr Perry's mental health. If either Mr Perry had been made the subject of ACT2care or a referral to the mental health team, officers in B Hall would have been aware of that. It is true that I cannot definitely assert that Doctor Wallace would have placed him on ACT2care or referred him to the mental health team after questioning Mr Perry in

greater detail. Nor can I discount his removal from ACT2care at any subsequent case conference or second guess any outcome from a mental health referral but that is not necessary to support such a finding in terms of section 6(1)(c). Further, Doctor Wallace may have made reference to the letter or inquiries he made of Mr Perry in his entry in the encounter report on page 39 of Mr Perry's medical records, Crown production 6. Such additional recorded information may have been helpful to anyone subsequently encountering Mr Perry. In addition, the involvement of Nurse Baxter would have potentially taken place against that background. She was clear in her evidence that if she had been aware of the content of the letter, her approach with Mr Perry would probably have been different, resulting in her questioning him about the content of the letter and asking him different questions. To conclude, the fact that various medical staff, in particular, were unaware of the content of this letter resulted in their encounters with Mr Perry being to that extent uninformed. All the evidence points to the assertion that the more intelligence on a prisoner the greater the chance of identifying prisoners at risk. It is clear that the majority of prisoners tend to be reluctant to disclose issues with staff. For these reasons I consider a finding in terms of section 6(1)(c) is appropriate.

[43] I do not consider there is any finding to be made in respect of this matter under section 6(1)(d). Simply there is no evidence that if there was any defect, it contributed to Mr Perry's demise. Further, I do not consider there is any basis to criticise the conduct of the medical examination of Mr Perry by Doctor Wallace. There is, however, one matter which does arise from his examination. The evidence indicates that Doctor Wallace did not have sight of the Prisoner Escort Record when he carried out his examination. The

box marked 'psychiatric condition' was ticked as was the box relative to 'drugs/alcohol issues' and reference to 'erratic demeanour/behaviour' had been entered in the additional information section. In light of the tendency of prisoners to be reluctant to disclose information to staff, it might be helpful for the doctor carrying out the assessment to have a copy of this form. He might have questioned Mr Perry about these matters and, depending on the answers given, might have taken further steps or inquiries.

[44] Moving on to his time in B Hall, as I have already stated, I am satisfied that Mr Perry made remarks, which would be considered odd, to some of his fellow inmates. There was some chat amongst the inmates. The evidence of the inmates does, however, have to be treated with care. The way in which they gave evidence is one reason for such an approach. For example, Mr Byrne gave the clear impression of being an aggressive individual who had significant difficulty in refraining from using the 'f word' when answering the questions put to him. His opinion as to what steps should have been taken regarding Mr Perry, namely placed in a suicide cell, were not the result of careful consideration. Use of a suicide cell is a delicate decision to make. Its use is undoubtedly a precaution for someone who is genuinely suicidal. However, it can also result in someone not in that frame of mind deteriorating because of the minimalist nature of such a cell. Mr Davidson was clearly excitable. Mr Morrison volunteered his critical opinion of healthcare in prison. He could not recall the identity of prison officers to whom he advised Mr Perry should be seen by the mental health team. It begs the question, if the healthcare was poor and it took at least two weeks to see the mental

health team, why would he make the comment to a prison officer? Further the evidence from the inmates contradicted itself. Messrs Byrne and Morrison said that they had told prison officers that Mr Perry was delusional whereas Mr Davidson said it was not for inmates to tell prison officers they had concerns about a prisoner. They should know about Mr Perry. Mr Davidson then seemed to contradict this. It is, however, clear that Mr Morrison wished to move cell after sharing with Mr Perry for a night. He made his request to Prison Officer Langlands. From his arrival in B Hall on 17th January until the telephone call made by his mother to Richard Geddes, so far as the staff were concerned, Mr Perry's behaviour was of no concern. He attended induction and there were no issues arising from his attendance.

[45] Mr Geddes received a telephone call from M/s McLaughlin on 18th January 2013 about 1.30pm. She told him of her concerns arising from his recent behaviour and that he had deliberately got remanded. Mr Perry's telephone calls to her that day had been concerning. Her son had told her the television was talking to him. Mr Geddes raised the issue of suicide and self harm with her but she did not think that was an issue, albeit his father had committed suicide. He was, however, acting out of character. She was genuinely concerned. Mr Geddes spoke to Prison Officer Sclater passing on the message concerning the telephone call. He told him that M/s McLaughlin considered that her telephone conversations with Mr Perry did not make sense and that he told her that the television was talking to him. Mr Geddes overlooked to call M/s McLaughlin back and she did not call again.

[46] There was an issue as to the precise content of the message passed from Mr Geddes to Officer Sclater. I am satisfied that it was as recorded in the preceding paragraph. I have come to this conclusion for a number of reasons. It accords with Mr Geddes record on the contact duty sheet made three days later. It also accords with Nurse Baxter's recollection and record. She said that Officer Sclater asked her to see Mr Perry because of concerns about his mental health. This was consistent with her entry in Crown Production number 6 regarding her meeting with Mr Perry. It made no mention of drugs but rather referred to his mother having concerns and asking Mr Perry if he heard voices. If her concern had been drugs, she said the entry would have taken a different form. Whilst I appreciate Officer Sclater wrote to the Governor by letter dated 19th January 2013 making reference to Mr Perry taking something and that was his evidence, I prefer the evidence from the others. It also sits better with the content of the telephone calls between Mr Perry and his mother. Whilst I appreciate by late morning on 18th January he had told her he had taken drugs, her main concerns related to his mental state. It is highly unlikely that she would make no mention of these concerns to Mr Geddes.

[47] I am satisfied, however, that in his dealings with Mr Perry there was nothing untoward to be noted by Officer Sclater. On receiving the telephone call from Mr Geddes, he spoke to Mr Perry who caused him no concern. There was nothing in his demeanour or the way he engaged with the officer which gave cause for concern. Nonetheless he mentioned matters to his colleague, Prison Officer Agnew, and when Nurse Baxter appeared in the Hall he asked her to speak to Mr Perry. She did so and

asked him if he had any concerns or whether he heard voices which he denied. She spoke to him for five minutes and there was nothing untoward as to his behaviour or demeanour. He made good eye contact, had good body posture, and engaged in clear and concise conversation.

[48] Dealing with his time in B Hall, I do not consider any issue arises. In my view the decision by Mr Perry to take his own life was probably one taken on impulse after his telephone call in which he spoke to his girlfriend. I do not consider that Mr Perry suffered from existing thoughts of committing suicide. This would be inconsistent with the words 'I did not commit suicide' found in his right groin area. Similarly the words 'I NEVER STUCK anycunt IN' written on the paper which was found covering the eyehole in his cell are not consistent with the presence of such thoughts. It is reasonable to infer that this note was put in place shortly before he hanged himself. If it had been otherwise, officers on carrying out their duties would surely have noted its presence. I do not consider there was any basis for criticism of his care in B Hall. In many respects what may or may not have been communicated about Mr Perry to Officer Sclater is not really critical. Nurse Baxter was asked to speak to Mr Perry and she did so. She had no concerns. At the time she was nine years qualified with four years at HMP Perth. Doctor Wallace described her as a very good nurse.

[49] I commented earlier in this determination that there were some matters which I was to refer to and I turn to these now. The first relates to the Prisoner Escort Record and two matters arise in relation to that form. The first is that there was no reference to Mr Perry having been the subject of constant observations when in police custody. This

was not recorded anywhere. Mr Cooper, the G4S employee at Perth Sheriff Court, was surprised at this. He expected that reference would have been made to this. I consider that it would be helpful if that information was provided. It is clear from the evidence I heard during the inquiry that there can be a general reluctance on the part of prisoners to advise police, G4S, and prison staff of any problems they have. Accordingly, any information as to how a prisoner was looked after once in custody can be of assistance in any subsequent assessment. It might prompt the prison officer or nurse carrying out the ACT2care assessment to ask further questions of the prisoner or make contact with the custody police officer for more information. In a similar vein, I consider that it would be beneficial if the Doctor carrying out the assessment the day after admission had a copy of the Prisoner Escort Form. The evidence at the inquiry gave no suggestion that Doctor Wallace had such a form when he assessed Mr Perry on 17th January. Possession of the form would have enabled him to ask Mr Perry why there were entries recorded on the form indicating 'erratic demeanour/behaviour'. I consider both these matters fall with section 6(1)(e).

[50] The second matter relates to access to NHS records. Chief Inspector Milne indicated that the nurses available to take any inquiries from custody staff had access to the National Health Service database but this did not cover all Scotland although access was improving. It seems to me that if there are still issues with accessing that data base as a result of geography this should be addressed as soon as possible in order that nurses have as much information to hand as they can when dealing with such queries.

[51] Finally, I heard evidence concerning modifications which have been undertaken to the ACT2care process. I was taken through these modifications with M/s McDowall. One modification which I consider worthwhile is the 'Concern Form'. This covers a scenario such as the telephone call taken from M/s McLaughlin by Mr Geddes. It enables a record of such information to be placed in the prisoner's records and largely formalises the procedure which took place as a consequence of the telephone call. I do have concerns, however, as to the removal of the assessment by a prison doctor the day after the prisoner has been admitted. The justification for this is that on a review there was no instance of a prisoner, who had not been put on ACT2care at reception, subsequently being made subject of the procedure following the doctor's examination. However, this might have been such a case if Doctor Wallace had been provided with certain information which it was quite reasonable for him to have.

[52] The ACT2care procedure in operation in 2013 envisaged a situation in which the nursing assessment was preferably carried out by mental health nurses. The clear evidence led at the inquiry, as already noted, was that this was not practical. That seems to be recognised under the new process. The health care risk assessment at reception is simply to be undertaken by a health care professional. It is only if a case conference is arranged that there may be involvement with a mental health nurse. The procedure speaks of this being carried out by 'a health care professional, where possible a mental health nurse.' There is accordingly no guarantee whatsoever that a mental health nurse will make an assessment of a prisoner. Doctor Wallace spoke of such nurses being able to get more detail from a prisoner. He also expressed a view that if Mr Perry had been

seen by a mental health nurse as opposed to a primary care nurse, this might have resulted in Mr Perry not hanging himself. If there is no guarantee that a prisoner will be seen by a mental health nurse, then it seems to me desirable that a prisoner sees a doctor such as Doctor Wallace. He had significant psychiatric training and thus seems better qualified to consider fully any psychiatric issues which might present themselves. It should not be overlooked that a significant number of prisoners have a combination of addiction and psychiatric issues. Criminal Justice Social Work reports often, for example, record an accused suffering from depression. In a number of Fatal Accident Inquiries relating to suicides in HMP Perth over which I have presided, the deceased has regularly been a prisoner with a record and used to incarceration. Many, if not all, have passed through the ACT2care procedure without being assessed as constituting a risk of self harm. Unless there is a pressing reason for the removal of the doctor's assessment, I am not persuaded it should be done away with. It appears to me that it provides a further safeguard. It may be that the rate of suicide in custody is no higher than that in, what M/s McDowall described as, the most deprived areas. However, in prison, the state is tasked with the care of those incarcerated.

[53] Finally I would conclude by offering my sincere condolences to Mr Perry's family.

SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT PERTH
UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY
(SCOTLAND) ACT 1976
FATAL ACCIDENT INQUIRY INTO THE DEATH OF
JOHN PERRY

PERTH SHERIFF COURT,

29 & 30 OCTOBER, 2015, 1 & 2 FEBRUARY, 29 & 30 MARCH, 16, 18 & 19 MAY and 10
OCTOBER, all 2016

SUBMISSIONS ON BEHALF OF THE CROWN

INTRODUCTION

This was a death in lawful custody and accordingly was a mandatory Inquiry in terms of section 1(2)(a)(ii) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("The 1976 Act").

THE INQUIRY

The Inquiry took place 29 & 30 October, 2015, 1 & 2 February, 29 & 30 March, 16, 18 & 19 May and 10 October, all 2016 and heard evidence from numerous Crown witnesses, namely:--

1. PAULINE McLAUGHLIN
2. JAMES AITKEN
3. AITKEN COUPER
4. LESLEY MURRAY
5. MICHAEL ASSENTI
6. ALAN BOYD
7. MARK COOPER
8. CHARMAINE GILMARTIN
9. CATHERINE LINDSAY
10. GRAEME APPLEBY
11. PETER LEE
12. RODERICK THOMSON
15. JAMIE MORRISON
16. DARREN BYRNE
17. DAVID DAVIDSON
18. DAVID LANGLANDS
19. RICHARD GEDDES
- 14 DR. DAVID SADLER
13. IAN DUNCAN
14. DR. MARK WALLACE
20. KEVIN SCLATER
21. CATRIONA BAXTER

22. PETER WARD

22. GAIL LIVINGSTONE

22. AMANDA STORER

23. DEREK PIRIE

24. LESLEY McDOWALL

It also heard evidence from Chief Inspector Gordon Milne, called by Police Scotland and Dawn Wigley, called by the Health Board.

In addition a Joint Minute of Agreement was lodged.

No other parties led evidence.

SUBMISSIONS ON FINDINGS

Section 6 of the 1976 Act requires the presiding Sheriff to make a determination regarding various matters:-

In terms of that section I would respectfully invite the Court to consider making findings in the following terms, as part of its Determination:

Section 6(1)(a) – WHERE AND WHEN THE DEATH AND ANY ACCIDENT RESULTING IN THE DEATH TOOK PLACE

There is no dispute that that Mr Perry died in Perth Royal Infirmary on 23 January 2013 at 12-28 pm, as a direct result of his own actions in cell B1/4 at HMP Perth on Saturday 19 January 2013, sometime between about 2-25pm when he returned to his cell after using the phone in B Hall, and about 3-45pm when he was discovered by Prison Officer

Peter Ward, then engaged in locking up prisoners' cells at the conclusion of the afternoon post-lunch recreation period.

This is reflected in the Post Mortem Report and Registrar's Intimation, being Crown Productions 9 and 24 respectively and in addition, is a matter of agreement in terms of the Joint Minute previously referred to.

Since the *modus operandi* of Mr Perry's death was his own action, it is submitted that there is no need to consider that it was as a result of any accident. However, the court might wish to refer to the evidence regarding the afternoon of 19 January in its determination, by way of completeness, context and background in relation to the cause of death as established by post-mortem examination.

Section 6(1)(b) – CAUSE OF DEATH AND ANY ACCIDENT RESULTING IN THE DEATH

6.2 Again, under reference to the Post Mortem Report, the cause of death was certified as:--

1(a) Ligature Pressure on the Neck (Shoe Lace)

which is entirely consistent with the evidence as to Mr Perry's discovery in his cell on 19 January, spoken to by Prison Officer Peter Ward and which can be safely accepted by the court as the cause of death, especially where the court has had the benefit also of hearing evidence from one of the co-signing pathologists whose evidence as to cause of death was not challenged.

Section 6(1)(c) – THE REASONABLE PRECAUTIONS, IF ANY, WHEREBY THE DEATH AND THE ACCIDENT RESULTING IN THE DEATH MIGHT HAVE BEEN AVOIDED

No finding is sought by the Crown in terms of this provision.

Section 6(1)(d) – THE DEFECT IN ANY SYSTEM OF WORKING WHICH CONTRIBUTED TO THE DEATH OR ANY ACCIDENT RESULTING IN THE DEATH

No finding is sought by the Crown in terms of this provision.

4.6 Section 6(1)(e) – ANY OTHER FACTS WHICH ARE RELEVANT TO THE CIRCUMSTANCES OF THE DEATH

No finding is sought by the Crown in terms of this provision

SUMMARY OF EVIDENCE

Essentially, there were 3 *loci* where Mr Perry was dealt with as a custody and where decisions were taken regarding his status and welfare, namely:-

1. Perth Police Office;
2. Perth Sheriff Court; and
3. Perth Prison

Although he was still in custody at Perth Royal Infirmary, where he was taken from Perth Prison on 16 January, he was taken there for medical treatment to try to save his life. No issue is taken regarding the medical care he received there, which is the subject

of agreement in the Joint Minute now lodged and accordingly I am not treating it as a locus for the purposes of this inquiry

1. Perth Police Office

On 15 January 2013 Mr Perry attended at Perth Police Office at about 5 pm. He had a holdall with him containing clothes and personal documents, as well as £119-43 cash (documented as part of Crown Production 13 at pp206-216). Police suspected he had an intention to get into jail for some reason, possibly for the purpose of smuggling drugs but conceded the possibility he was simply seeking to go back to Greenock, where he was originally from, and had packed his bag with belongings and effects to do so. He was reticent about his exact reasons for attending there but was persistent in seeking to speak to CID and was afforded the opportunity to do so. During that discussion he continued to be somewhat vague but produced a knife, said something about needing “protection” and was, inevitably, arrested, subsequently appearing at Perth Sheriff Court the next day, charged with possession of the knife and 2 other charges.

Charge Bar footage showed Mr Perry to be compliant, albeit somewhat suspicious of the officers dealing with him. There was evidence that an accused behaving somewhat truculently at a charge bar would not ordinarily give cause for concern. That being so, there was nothing to alert officers to any major matters of concern, albeit that his prisoner self-risk assessment identified possible risk factors arising out of his admission of having taken drugs, carrying a weapon and possible violence.

His initial period of observation was every thirty minutes and he was searched and placed in a conventional cell just after 5-40pm but then moved to an observation cell just after 6pm, because some of his answers to questions suggested paranoia. Initially, in the observation cell, there was no difficulty but at about 7-25pm he made repeated requests to again speak to CID. They attended to speak with him at about 7-50pm. He had a somewhat unfocussed but spirited discussion with them, again showing some signs of paranoia, which discussion culminated in him forcing his way out of the cell, but being subsequently returned thereto in cuffs and leg restraints. At about 8-15pm he was placed under constant observation and then, right through to when he was to go to court the following day, he was compliant, although much of that interval he spent sleeping.

The following morning Sergeant Assenti took over his care & custody and was in discussion with the Force Medical Examiner (Dr Sadler) and PF regarding Mr. Perry's general fitness, as well as his fitness to go to court. For various reasons that could not be done during the morning at Perth Police Office and Mr Perry did not wish to go to Dundee to be medically examined. It was agreed that he would go to court, the view being that his irrational behaviour the previous evening had perhaps been drug induced and his improved demeanour was indicative of the effects wearing off. Nonetheless, the PF would prepare a letter to accompany him to prison if he was remanded.

Consistent with his earlier refusal to leave his cell to go to Dundee for examination, Mr Perry had to be restrained and forcibly removed from his police cell to be taken to court, where he duly appeared later that day on Petition from custody as described above.

2. Perth Sheriff Court

Charmaine Gilmartin, the Senior Procurator Fiscal Depute who had discussed the circumstances with Sergeant Assenti, marked Mr Perry's custody case. She had some information from the SPR as to Mr Perry's demeanour within Perth Police Office. She formed the view it was appropriate for Mr Perry's bail to be opposed and marked his case accordingly. Various factors were taken into account in reaching that decision. Due to her knowledge of the circumstances, she dealt with his appearance personally. No issues as to Mr Perry's fitness to plead or difficulty in obtaining instructions were raised by his solicitor.

G4S advised of concerns arising out the suggestion Mr Perry was banking drugs and accordingly the court was convened outside Mr Perry's cell, a situation which is unusual but certainly not unheard of. Mr Perry did not refuse, as such, to leave his cell and, apart from where the court was convened, his court appearance was uneventful and unremarkable. Nothing arose or was mentioned to Mrs Gilmartin such as would have suggested Mr Perry be dealt with under s52 of the 1995 Act relating to accused persons with possible mental health issues. Had such circumstances arisen, chances are Mr Perry would have gone to Perth Prison pending assessment anyway, *ergo* from a practical point of view his circumstances would have been the same. Thereafter, in view of her concerns about possible concealment of drugs and his earlier behaviour, Mrs Gilmartin wrote a bespoke letter (forming Crown Production 5), addressed to the Governor of Perth Prison reflecting these issues and suggesting that psychiatric assessment might be necessary if there was any further "bizarre" behaviour. The letter was adapted from a

style of suicide risk warning letter commonly used by the Crown. There was no suicide risk warning contained in it because there had been no threats of self-harm made by Mr Perry. The following morning Mrs Gilmartin had a voicemail message confirming the letter had reached the prison, apparently conveyed there by G4S along with Mr Perry. The (admittedly short) journey from Perth Sheriff Court to Perth Prison was uneventful and Mr Perry was duly received into Perth Prison at about 2-45pm.

3. Perth Prison

Upon arrival at Perth Prison, the letter was handed to Graeme Appleby who, in accordance with usual practice, passed it onto his supervisor Roderick Thomson. Mr Perry then went through the first 2 parts of his Reception Risk Assessment and was assessed as posing “No apparent risk” by both prison and nursing staff. The following day, a prison doctor assessed him similarly. All were trained in how to be alert for the “cues & clues” indicating the possibility of a prisoner not answering questions truthfully. All asked him, specifically, if he had any suicidal thoughts etc, which he denied. There is a conflict of evidence as to whether the prison officer who assessed Mr Perry saw the PF letter or was advised as to its content but said officer could not say with any certainty he would have proceeded any differently even if he had had sight of the letter before assessing Mr Perry. The nurse and doctor who assessed Mr Perry were also of the view that even if they had seen the PF’s letter, they would not necessarily have placed Mr Perry on ACT, although they might have made enquiry with him about its contents. At that time, such a letter would not routinely be placed with a prisoner’s

file for consideration by reception staff during the admission process. The system has now changed to address that *lacuna*. During the admission process Mr Perry was searched for drugs and a “sniffer” dog was also used for this purpose, all with negative results. Throughout all of these procedures Mr Perry was co-operative and compliant, shown and confirmed to some extent by cctv footage from the reception area. In essence, the risk assessment of a prisoner commences by observation of him immediately he enters the prison.

On 17 January, Mr Perry was allocated to share a double cell with a convicted prisoner, Jamie Morrison. He became concerned about Mr Perry’s behaviour that overnight and asked to be moved to a different cell on that account, a request which was granted. His concerns were that Mr Perry had sat up all night smoking and watching television which stopped his cell mate from sleeping, was giving an impression he felt the television was speaking to him and was generally acting strangely. His recollection was that he raised concerns with prison officers about Mr Perry’s mental health and he had a theory that perhaps Mr Perry’s behaviour could be attributed to coming off drugs. He also indicated that if he wasn’t moved he was concerned there would be conflict between him and Mr Perry, possibly in the form of a “rollaboot” ie a physical confrontation. A fellow prisoner felt that instead of seeking a change of cell, Mr Perry’s cell mate should have taken more interest in, and care of, Mr Perry’s welfare with, if necessary, assistance from other prisoners, rather than prison staff. He took steps to try to re-assure Mr Perry. At least one other prisoner also observed what appeared to be somewhat odd behaviour by Mr Perry. Some prisoners felt that prison staff should have

been aware of Mr Perry's difficulties by observation of him, rather than requiring to be told by prisoners. One of them felt there was no opportunity to stop Mr Perry committing suicide, so quickly and without any prior warning did it happen.

At no time did Mr Perry give any cause for concern to prison officers in B Hall. Had he done so, they would have considered placing him on ACT, which any of them would have been able to do. Generally, officers would err on the side of caution. If placed on ACT a multi-discipline case conference would be convened regarding the prisoner by no later than the next day.

On Friday 18 and Saturday 19 Mr Perry had various telephone conversations with his mother. He made reference to owing a substantial sum of money to someone he was not prepared to name, that he had been involved in criminality and that he had been using heroin, which information caused distress to his mother, who pleaded with him many times, and passionately, to seek assistance. On the Friday, at about 1-30pm, she spoke by telephone to Richard Geddes, a prison social worker to express her concerns about her son's mental health. She did not indicate concerns about self-harm or suicide. Mr Geddes arranged for hall prison staff to speak to Mr Perry. In turn, the prison officer who did so arranged for a prison nurse to speak to Mr Perry. Mr Perry assured both of them they need have no concerns about him. He appeared to regard their concern about him as misplaced. He was assured and encouraged to revert to them to discuss any matters of concern. There was nothing about his demeanour to justify him being placed on ACT.

On the Saturday, Mr Perry had a very brief, strained telephone conversation with his ex-partner at about 2-25pm. The conversation ended abruptly with Mr Perry returning the telephone receiver so forcibly into its cradle that it bounced back out again. He then returned to his cell nearby and forcibly closed the door, which was then locked. He was then found within his cell at about 3-50, by which time he had apparently attempted to kill himself by using shoelaces as a ligature to suspend himself from the top bunk. Medical treatment was administered and he was taken to Perth Royal Infirmary, where lifesaving treatment continued. From the outset, his prognosis was poor. He failed to respond to treatment and at 12-28pm on 23 January 2013 his life was pronounced extinct.

CROWN SUBMISSIONS ON EVIDENCE

It is submitted that there are no reasonable precautions which might have prevented Mr Perry's death.

It is similarly submitted that there was no defect in any system of working which caused or contributed to his death

In relation to Perth Police office, there was a system in place for assistance to be provided to police from health care professionals. In addition, the custody staff who gave evidence were very mindful of all aspects of prisoner welfare. Initially, Mr Perry's behaviour was unusual, rather than threatening or dangerous to himself or others. He left the police with no option but to take him into custody when he produced the knife during his meeting with DC Couper, but even then he appears to have simply produced

the knife, rather than brandish it. Thereafter, he was fairly compliant, if not desperately forthcoming with information, up until he insisted on meeting again with CID later on, when he effected an escape from his cell. However, that led to him being placed on constant observation, which was indicative of how seriously the police took concerns for his welfare and after which he settled down somewhat.

Not content with that, Sergeant Assenti made further checks the following morning and discussed the situation both with Dr Sadler and the PF dealing with Mr Perry's case.

There was careful consideration about possible causes of his behaviour and whether anything further required to be done. It was clear that Mr Perry's attendance in Dundee for examination as to fitness to plead could, and would, be enforced if necessary but, given the change in demeanour, he would go to court and the position could be reviewed there if necessary. In the event, Mr Perry declined to leave his cell to go to court but his attendance was enforced.

The custody sergeants who dealt with Mr Perry used the system in place, the introduction and development of which system was spoken to in detail by Chief Inspector Gordon Milne. He was confident the system was as robust as it could be, given that it affords 24/7 medical assistance to police for custodies, an improvement on the previous system, which depended a good deal on goodwill and availability of GPs. Even if Dr Sadler had been able to see Mr Perry before he went to court it would only have been for a fitness to plead assessment, not any sort of full psychological assessment, which Dr Sadler was not qualified, as a medical doctor/pathologist to carry out anyway.

In relation to Mr Perry's custody appearance at court, the PF concerned appears to have been very mindful of the issues in question. By that time, Mr Perry was compliant and the issue of his case being called in the cell passageway appears to have arisen more out of practical concerns on the part of G4S, rather than any particular concerns regarding Mr Perry at that time. She had no additional information to lead her to do anything other than follow usual procedure regarding an accused appearing on petition from custody. Significantly, no mental health concerns were raised about Mr Perry by his solicitor. Even if they had been, in all likelihood Mr Perry would still have been sent to Perth Prison pending assessment of his mental health in terms of s52 of the 1995 Act. In Paragraph 4 of his Determination into the death of **ALAN MICHAEL MULLIN** from Inverness Sheriff Court on 15 September 2008, Sheriff Principal Sir Stephen Young considers whether a remand into psychiatric care as opposed to a standard remand into custody might have avoided the death and decided it would not have. Here, of course, we do not know what any mental health assessment would have found but that alternative disposal of the court might well have still resulted in Mr Perry being sent to Perth Prison from his court appearance on 16 January.

Turning to his time in Perth Prison, the last agency responsible for his care, the Inquiry heard a great deal of evidence about the ACT 2 Care Reception Risk Assessment. The witnesses who carried out the various parts of same advised that there was nothing to justify placing him on "ACT", not even on any sort of "borderline" or "err on the side of caution" basis. These witnesses included Dr Mark Wallace, who had extensive mental health experience.

Mr Perry presented with no particular concerns which might have alerted the staff to the need to place him on ACT. He gave no “cues or clues” as to future intentions and upon being asked on several occasions whether he had any thoughts of suicide or self-harm, he said he didn’t. It is easy, with the benefit of hindsight, to view things differently but based on the applicable criteria, the various prison staff who formally assessed Mr Perry and then had day to day dealings with him had no basis to change his status. Even if it is accepted, and it was matter of dispute, that other prisoners raised concerns about Mr Perry’s mental health with B Hall prison officers, there is no reason to suppose that his status would have been re-assessed, neither Kevin Slater nor Catriona Baxter were sufficiently concerned about him following their dealings with him on Friday 18 January to re-assess his status and, indeed, the indication was that Mr Perry seemed to regard their concern about him on that day as being misplaced and even something of a slight inconvenience to him, as if they were disturbing him when he was in his cell, minding his own business, bothering no-one.

In addition, the Court heard detailed statistical evidence from Lesley McDowell of the number of prison suicides as against the total number of prison admissions for a number of years. The highest number of these for any single year since 2005 was 10, against generally speaking 26,000 admissions and 8,000 or so prisoners being in jail at any given time, an infinitesimally small percentage and a reasonable indication, at the very least, that the system of risk assessment was robust and achieving its goal of, generally, keeping prisoners safe.

Notwithstanding that, we heard also that the system is being reviewed to the “new” “Talk to Me” system, which will in due course be adopted by SPS in place of the Act to Care system. Furthermore, SPS monitors and takes cognisance of determinations in prison deaths to clarify if any lessons are there to be learned

Such statistics can also be prayed in aid against any suggestion that there should routinely be mental health assessment of prisoners. The system in place as at Mr Perry’s death did not prohibit referral of prisoners and Mrs McDowall advised that as part of the process involved in developing “Talk to Me” consideration was given to including mental health assessments of prisoners as the norm but the view was reached that that was not necessary. She very fairly conceded that there were practical issues involved too—in some jails there could be perhaps 70 admissions on the one evening and detailed mental health assessments for all admissions would simply not be practical. In any event, at present there is a referral process for prisoners to see mental health professionals.

Briefly, and in passing, we also heard evidence about the “Listener” scheme which operates in Perth Prison to afford prisoners the opportunity to discuss matters of concern on a confidential basis.

Having regard to all the foregoing, it appears clear that Mr Perry was a troubled, young man who did not avail himself of various opportunities open to him to seek help, despite being implored to do so by his mother. For whatever reason, the final phone call we heard between him and his ex-partner, although innocuous in itself, appears to have been the catalyst for him deciding to take his own life. It might well be that that was the

“final straw” when taken along with the other issues he told his mother about which led him to act as he did.

In these circumstances the Crown seeks only formal findings.

CONCLUSION

I simply wish to close by expressing my own personal thanks, as well as that of the Crown, to the witnesses who attended and gave evidence and to the Court and my friends and learned friend for their assistance, patience and understanding in dealing with the various issues which arose in this Inquiry. I hope I was able to reciprocate. Finally, I tender my own sincere condolences, as well as those of the Crown, to the family and friends of Mr Perry. His mother was present throughout most of the evidence, much of which must have been harrowing to hear. She conducted herself with courtesy, dignity and respect and could not have done any more to persuade her son to seek help for whatever was troubling him. As such, she was a credit to herself, her family and the memory of her son.

Steven R. Quither
Senior Procurator Fiscal Depute
Glasgow,
12 December 2016

UNDERNOTE

In case it is of assistance to the Court in reaching its determination, in addition to my submissions I submit the following for ease of reference :-

1. A Fatal Accident Inquiry is not a fault finding exercise.

The 1976 Act does not empower the sheriff at a fatal accident inquiry in making his determination to make any finding of fault or apportion blame between any persons who might have contributed to the fatality. In the case of

Black v Scott Lithgow Limited 1990 SC 322; 1990 SLT 612

Lord President Hope, said at p615, Paras G to J, under reference to s6(1) of the 1976 Act : -

"There is no power in this section to make a finding as to fault or to apportion blame between any persons who might have contributed to the accident. ... It is plain that the function of the sheriff at a fatal accident inquiry is different from that which he is required to perform at a proof in a civil action to recover damages. His examination and analysis of the evidence is conducted with a view only to setting out in his determination the circumstances to which the subsection refers, insofar as this can be done to his satisfaction. He has before him no record or other written pleading, there is no claim or damages by anyone and there are no grounds of fault upon which his decision is required. The inquiry is normally held within a relatively short time after the accident ...It provides the first opportunity to canvass matters relating to precautions which might have avoided the death or any defects in any system of working which contributed to it, at a stage when these issues have not been clearly focused by the parties to any future litigation which may arise. And it is not uncommon ... to find questions being asked about possible precautions or defects which are not the subject of averment in the subsequent action of damages."

2. A Fatal Accident Inquiry is not the proper forum for determining criminal or civil liability.

In his **Determination into the Death of Keiran Nichol**, dated 3 June 2010,

(<http://www.scotcourts.gov.uk/opinions/2010FAI25.html>), Sheriff Liddle, at Edinburgh

stated in Paragraphs 6 & 7:

"Entitlement to decide whether I am satisfied that it has been established that there exists a reasonable precaution whereby the death and any accident resulting in the death may have been avoided, in my opinion, only requires it to be demonstrated, with the benefit of hindsight, that the precaution might have prevented the death or accident and, that it was a reasonable precaution in the ordinary sense of that

word. In that regard I agree that the reference to reasonableness relates to the question of availability and suitability or practicability of the precautions concerned... A fatal accident inquiry is not the proper forum for determination of criminal or civil liability”.

3. It is proper to apply hindsight when identifying reasonable precautions.

In her **Determination into the Death of Sharman Weir**, dated 23 January 2003,

(http://www.scotcourts.gov.uk/opinions/2B1596_01.html), Sheriff Reith, then of this court stated in her Note:

“In my opinion 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. A 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 concerned with the existence of reasonable precautions at the time of death and are not concerned with where they could or should have been recognised. They do not relate to the question of foreseeability of risk at the time of death which would be a concept relevant to the context of our fault-finding exercise, which this is not. The statutory provisions are widely drawn and are intended to permit retrospective consideration of the 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. In my opinion, the reference to reasonableness relates to the question of availability and suitability or practicability of the precautions concerned... In my opinion, the purpose of a Fatal Accident Inquiry is to look back, as at the date of the Inquiry, to determine what can now be seen as the reasonable precautions, if any, whereby the death might have been avoided, and any other facts which are relevant to the circumstances of the death. The purpose of any conclusions drawn is to assist those legitimately interested in the circumstances of the death to look to the future. They, armed with the benefit of hindsight, the evidence led at the Inquiry, and the Determination of the Inquiry, may be persuaded to take steps to prevent any recurrence of such a death in the future.”

4. The test for identifying a reasonable precaution under s6(1)(c) and a defect in a system of work under 6(1)(d)

In Sheriff Kearney's determination of 17 January 1986, regarding the death of James McAlpine, referred to in paragraph 8-99 of the 3rd edition of *Sudden Deaths and Fatal Accident Inquiries* by Ian Carmichael, he stated:--

(a) "In deciding whether to make any determination (under section 6(1)(d)) as to the defects, if any, in any system of working which contributed to the death or any accident resulting in the death, the court must, as a precondition to making any such recommendation, be satisfied that the defect in question did in fact cause or contribute to the death. The standard of proof and the rules of evidence (apart from the consideration that evidence did not require to be corroborated) is that applicable in civil business (1976 Act section 4(7)) and accordingly the standard of proof is that of the balance of probabilities.

(b) "In relation to making a finding as to the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided (section 6(1)(c)) it is clearly not necessary for the court to be satisfied that the proposed precaution would in fact have avoided the accident or the death, only that it might have done, but the court must, as well as being satisfied that the precaution might have prevented the accident or death, be satisfied that the precaution was a reasonable one."

Sheriff Kearney went on to say:-

"The phrase 'might have been avoided' is a wide one which has not, so far as I am aware, been made the subject of judicial interpretation. It means less than 'would, on the probabilities have been avoided' and rather directs one's mind in the direction of the lively possibilities."

SHERIFFDOM OF TAYSIDE, CENTRAL and FIFE at PERTH

SUBMISSIONS

by

Gordon Williams, Solicitor

on behalf of the family

in respect of Fatal Accident Inquiry

into the death of

JOHN PERRY

PF Ref: PR13000373

Williams, Solicitor for the family of the late John Perry (and in particular, on behalf of Mrs Pauline McLaughlin, mother of Mr Perry) respectfully submits to the Court that having heard extensive and detailed evidence of the circumstances surrounding the death of Mr Perry, a number of conclusions and recommendations can properly be made. These include the formal elements around the death which are largely incorporated in the joint minute of agreement entered into by parties; and in addition, include other elements about which evidence was led.

1. Introduction

1.1 At the outset, I should like to place on record my thanks to the Crown for their sensitive and considerate approach to the whole conduct of the Inquiry.

1.2 It appeared generally to be accepted by parties that the Inquiry fell into three distinct sections, namely (a) the circumstances surrounding Mr Perry's attendance at

Perth Police Office on 15 January 2013; (b) his admission to prison on 16 January 2013 and (c) the various events - in particular relating to Mr Perry's wellbeing in prison – leading up to his attempting to take his own life on 19 January 2013.

1.3 The concerns of Mr Perry's mother ("the family") centre upon all these issues.

The first of these relates to the manner in which the Police dealt with him from the point he presented himself at Perth Police Office at around 5 pm on 15 January 2013 to the point he was transferred to the cells at the Sheriff Court the following day. This includes the manner in which he was treated whilst in custody in the police station overnight and the fact that he was not medically examined.

1.4 Thereafter, the family are concerned about the procedures followed by the Scottish Prison Service (SPS) in relation to Mr Perry's safety and wellbeing in HMP Perth; and why he was able to take his own life whilst in custody in prison.

2. The Inquiry – Evidence of the family

2.1 Whilst it is not appropriate to rehearse all the evidence of the family, Mr Perry's mother was the first witness to be called by the Crown. She spent the whole of the first day giving evidence. She did so with great dignity. She described how she had made considerable efforts to maintain contact with her son (by telephone) in the weeks leading up to his death; and it was clear that she felt he was deteriorating psychologically and exhibiting clear signs of what she believed to be psychosis. (Her other son has been hospitalised following diagnosis as paranoid schizophrenic). She also displayed a quiet determination to find out as much as possible about her son's involvement with the

authorities, in large part to ensure, so far as possible, that other young men in custody do not meet a similar fate.

2.2 Mr Perry's mother began her evidence by providing the Court with a fuller picture of her son. She described his formative years. He had suffered burns as a baby and had always been a nervous child and had difficulty controlling his nerves. She explained how he began smoking cannabis in around 2004 when aged 16. She felt he was not a drinker but used cannabis more frequently and heavily as the years progressed. She thought this adversely affected his mental health and he began showing signs of paranoia. She also described how he fell into crime and had been imprisoned on a number of occasions. In March 2012, he had moved to Perth to try to make a clean break, but at one point, had ended up in hospital following a seizure. He had claimed it was his first seizure, but his mother stated it was his second one. In July 2012, when he returned to Greenock to visit his mother, she recalled seeing him 'zonked' due to drugs (she thought it was a combination of excessive use of the painkiller Tramadol as well as heavy use of cannabis).

2.3 By this time, Mr Perry's girlfriend had also moved to Perth and the 2 of them got a flat and moved in together. His mother said she noticed him getting more paranoid; and when he returned to her house in Greenock for Christmas 2012, he was 'zonked out' once again due to excessive use of Tramadol and cannabis. He spent the whole of Christmas day in that state. She recalled him asking her how to tie a knot because he said he might hang himself. There was evidence that Mr Perry was behaving very oddly at this time. On reflection, Mr Perry's mother felt he was obviously suicidal then but she

did not fully appreciate or understand the situation. He made an appointment to see his GP at around this time. Generally, his mother felt that although he was quite well physically – he was being more active and eating healthily – he was clearly unwell mentally. She was very worried about him and feared that he would ‘go the same way as his brother’. Mrs McLaughlin came across as a very concerned and caring mother who had quite an insight into her son’s condition. She was a patently honest witness. She was conscious of his difficulties (and his faults) but was frustrated that the authorities did not necessarily take sufficient time to understand him.

2.4 Mr Perry’s mother also spoke of events leading up to her son’s decision – which she discussed with him on the telephone – to return to Greenock in January 2013 to see his girlfriend, who was then living there. There was no doubt in her mind that her son’s intention was to travel back to Greenock from Perth. (He was subsequently to be found in the police station with all his possessions in a holdall, as well as enough money to travel home). It was all the more surprising, therefore, that he had gone to the police station on 15 January 2013. On the evidence, it is submitted that there were clear signs that something was not quite right about Mr Perry, but the police seem to have focussed their attention more on what offence(s) he may have committed, rather than concentrating on his needs as a vulnerable person. His mother only learned of his arrest when the police contacted her and advised her he was being kept in custody for being in possession of a knife.

2.5 There is a separate body of evidence relating to Mr Perry’s time in custody at Perth Police Office. It is accepted that he was reported in custody to the Procurator

Fiscal and was subsequently appeared on petition on 16 January 2013 and was remanded in custody (bail having been sought and refused). The history of these proceedings is more fully set out in the joint minute.

2.6 The Court heard rather harrowing recordings of various telephone calls between Mr Perry (who was now on remand in prison) and his mother (at home in Greenock). In these calls, Mr Perry's mother could be heard pleading with her son to get help. She had been hoping that he would be psychiatrically examined and given treatment. She was very worried about him. He was rambling, often making no sense. He talked of owing someone '3 grand' which he was worried about. On being pressed further, he told his mother that this was something the TV had told him. He had also told her he was going to write on his leg 'I did not commit suicide' in case someone kills him and tries to make it look like suicide. She was also worried he might be taking heroin in jail because he told her he was 'dabbling with stuff'. She was sure his psychosis was settling in again.

2.7 The recordings of the calls revealed the extent of Mr Perry's mother's anguish. She was convinced of his psychosis and knew all about his irrational behaviour. She was at a loss to understand why he had gone into the police station with a knife, describing it as 'not normal'. She could only assume it was in furtherance of the notion that someone was out to get him.

2.8 She felt her son needed to see a psychologist. He needed medication. She told him he should be telling the authorities about his brother Graeme, who was psychotic. (He had been sectioned in December 2010). . Her main concern was her son's health.

She asked him if he had seen a doctor, and he told her he had not. She felt John did not get the help that her other son Graeme had been given (in the community) despite both suffering from similar conditions with similar symptoms, although she did concede that her son felt it was a weakness to ask for help. He was nonetheless wary and suspicious of everybody which is something she thought the experts would have picked up and acted upon.

2.9 Against this background, Mr Perry's mother accepted that he had taken his own life. However, she felt there were several missed opportunities where steps could have been taken to prevent the chain of events leading to his death.

3. The Inquiry – Events at the Police Station

3.1 It is a matter of agreement that on 15 January 2013 Mr Perry presented himself at Perth Police Office in the early evening at about 5 pm. He had a holdall with him which contained his clothes and toiletries and other personal items (including his passport) described by one police witness as being 'packed like a weekend bag'. This is entirely consistent with his mother's belief that he was intending to travel back to Greenock the following day. It is reasonable for the Court to conclude that it was indeed Mr Perry's intention to travel back to Greenock rather than deliberately engineer his arrest (as might be suggested from other evidence, including the suspicion – later shown to be unfounded – that he was concealing drugs in his person to take into prison).

3.2 In the police station, Mr Perry asked to speak to members of the CID but initially refused to say who he was. He was described as coherent, not under the influence, but

pale, sweaty and agitated. It is submitted that this initial presentation should immediately have put the police on their guard. He was described by one of the interviewing officers as 'kind of troubled' and said people from Greenock were after him. The officers were concerned about him. He said he had a knife with him for protection. He was asked about this and he produced a kitchen knife from his right hand trouser pocket. This led to his being arrested and charged with possession of the knife. (He also had a small quantity of cannabis in his possession, confirming other evidence that he was a regular heavy user of the drug). The officers described him not as difficult, but 'strange'. They were asked to interview him a second time when the information he gave them amounted to 'paranoid rambling' including that someone was going to murder him and make it look like suicide.

3.3 There was considerable evidence of Mr Perry's unusual and worrying irrational demeanour in the police office. It led to an experienced Duty Officer, Sergeant Assenti, making a call the following morning to the then Tayside Police Headquarters in Dundee for medical assistance. The system then in operation meant that there was no doctor available to travel to Perth to examine Mr Perry. The Duty Police Casualty Surgeon Dr Sadler was advised that Mr Perry was coherent, not under the influence of alcohol but was pale, sweating and agitated. Dr Sadler was not in a position to travel from Dundee to Perth and suggested the police bring him to Dundee to be examined. Mr Perry, however, was not prepared to leave his cell, so in the event he was not medically examined whilst in the police station.

3.4 There was detailed consideration of the custody records at Perth Police Office when it was noted that Mr Perry's initial period of observation every thirty minutes was upgraded to 'constant obs' overnight. There was evidence that Mr Perry's demeanour and appearance alone caused concern. The police formed the view that given the unusual circumstances, Mr Perry was possibly concealing drugs within his person with a view to taking them into prison.

3.5 Mr Perry's condition and behaviour were closely monitored by the Police overnight and a further discussion to place between Sergeant Assenti and the Police casualty doctor in the morning when the view was taken that Mr Perry had 'calmed down', having possibly been suffering from the after effects of drugs and would, in any event, be fit to go to Court later that day. A report was duly prepared by the Police and submitted that morning to the Procurator Fiscal's Office.

3.6 Although not the Reporting Officer, Sergeant Assenti took it upon himself to telephone the Procurator Fiscal's Office and spoke to Mrs Cole, a Depute Fiscal there and relayed his concerns about Mr Perry. The Sergeant was 'unhappy' with Mr Perry and wondered about the appropriateness of him being 'put straight to Court'. He had to be restrained and forcibly removed from his police cell. There was evidence from both Sergeant Assenti and Mrs Cole as to their detailed involvement. In due course, Mr Perry appeared on Petition from custody as described above.

4. Events at Court

4.1 After being detained in custody overnight at the police office, Mr Perry was

transferred to the Sheriff Court to await an appearance. He was seen by a local defence solicitor who took instructions from him to move for bail. When Mr Perry had been due to appear in Court, he refused to leave his cell and the hearing had to be convened in the passageway outside appeared in Court. Whilst this is unusual, it does happen from time to time. At the hearing, the Crown opposed bail and following the refusal of bail at the CFE stage, Mr Perry was remanded in custody and taken the short distance from Perth Sheriff Court to HMP Perth by G4S staff. Mrs Cole, the Depute who had marked the case and dealt with it in Court, was sufficiently concerned about the background that she prepared a letter (CP no.5) addressed to the Governor of Perth Prison setting out her concerns and, among other things, describing Mr Perry's demeanour when he was first at the Police Station as 'bizarre'. This letter also raised the possibility that he might have deliberately arranged his arrest in order to bring drugs into the prison. Unfortunately, this letter – which was placed in a sealed envelope and conveyed along with Mr Perry to the prison – was never seen by a number of those who were destined to have close involvement with him in prison.

4.2 The impression left by those with whom Mr Perry engaged at Court was that something did not quite fit with his behaviour. His demeanour had to be viewed in the light of his mother pleading with him to get help. It is respectfully submitted to the Court that a more detailed assessment of individuals is required – or at least a more in depth process – before they enter prison. Taken together with events in the police station the previous day, the situation with Mr Perry at Court offered a warning that

‘something wasn’t quite right’. These signs were for whatever reason not picked up or acted upon.

5. Events in the Prison

5.1 As the Joint Minute makes clear, Mr Perry was remanded in Perth Prison on 16 January 2013. He spent 3 nights on remand in a ground floor cell in B Hall. Although he had been in custody before – he served sentences at Greenock and Barlinnie – he had never been in Perth Prison. He was allocated a double cell, sharing with another convicted prisoner. It is a matter of some significance that the other prisoner asked to be moved out of the cell because he thought Mr Perry’s behaviour was very odd: he was claiming that the television was speaking to him and generally acting very irrationally. During one of the nights, he had spent the entire time smoking and watching television which meant his cell mate could not get to sleep.

5.2 The Crown led extensive evidence from experienced prison officers, nurse practitioners and mental health nurses, as well as from other prisoners about their involvement with Mr Perry. It was clear that he presented as someone with a certain history and there was close consideration of the question of suicide risk and/or assessment. There was evidence at the time of a shortage of suitably trained and qualified mental health nurses in the prison; as well as evidence of the operation of the Act to Care Strategy. In addition, the Court heard of the current strategy related to the prevention of suicide in prison (‘Talk to Me’) which revises and updates the approach

the prison authorities take in their efforts, among other things, to avoid anyone committing suicide in prison.

5.3 Reference has already been made to the telephone calls Mr Perry made to his mother from prison. In addition, the Court heard evidence about a call made by Mr Perry's mother to the prison social worker pointing out some of the family medical history and highlighting concerns about Mr Perry's behaviour in the weeks before. Unlike calls made by prisoners, this call was not recorded and it is submitted there is nothing to prevent such calls being routinely recorded and monitored. In particular, Mr Perry's mother took the trouble to advise the prison authorities that her son was demonstrating obvious signs of psychosis (probably drug induced) and that this was a condition from which her other son also suffers. It is submitted that this represented a further warning sign that could have permitted a different course of action to be followed.

5.4 However, no decision was made to put Mr Perry on Act to Care. He should have been. There was evidence from a number of prison officers and nursing staff to the effect that they felt he did not fully meet the criteria for such a placement, but it is significant that some of these assessments were made in ignorance of the letter from the Fiscal's office (from Mrs Cole) . Several witnesses saw the letter for the first time after Mr Perry died or shortly before giving evidence at the Inquiry and conceded its terms would (or might) have made them act differently (by placing Mr Perry on Act to Care). In the event, Mr Perry was apparently regarded as someone able to cope with a period on

remand as well as a person who did not require the level of close supervision which he should have received.

5.5 Whilst the management of prisoners – including their allocation to particular cells – is very much a matter for officers ‘on the ground’, it is significant that the prisoner who originally shared a cell with Mr Perry felt compelled to ask for a transfer to another cell. This request was immediately granted without any evidence of proper enquiry, leaving Mr Perry in a cell by himself. Any feelings of isolation he may have harboured on entering the prison are likely to have been heightened by being left alone. It also meant that there was no ‘experienced’ prisoner sharing his cell and able to keep an eye on him as practice seems to favour. As it turned out, Mr Perry had both the means and the opportunity to carry out all the actions described in evidence to take his own life.

5.6 There was some evidence of the attempts made by prison staff and paramedics to resuscitate Mr Perry when he was found unconscious in cell B-1/4 during the early afternoon of 19 January 2013. However, all the evidence clearly points to Mr Perry having taken his own life, although the true reason (or what was going through his mind) may never be known.

6. Submissions

Section 6(1)(a) - ‘where and when the death ... took place’

6.1 It is submitted that the evidence plainly demonstrates that Mr Perry’s death took place in Perth Royal Infirmary on 23 January 2013 at 12.28 pm. It occurred as a direct

result of an attempt he made to take his own life in cell B1/4 at HMP Perth during the afternoon of 19 January 2013.

Section 6(1)(b) – ‘the cause or causes ... of the death’

6.2 The cause of death was certified following post mortem examination as ‘1(a) Ligature Pressure on the Neck (Shoe Lace)’.

This is very much in keeping with suicide and it is submitted that the Court can determine accordingly.

The Other Subsections of the 1976

6.3 As in many Fatal Accident Inquiries, an element of overlap can exist between the following three subsections, but there are nonetheless a number of areas where the family feel that decisions made in relation to Mr Perry’s welfare between 15 and 19 January 2013 should have been exercised with greater caution:

Section 6(1)(c) – ‘the reasonable precautions, if any, whereby the death ... might have been avoided’

6.4 Under this subsection, the family have a number of concerns. For convenience, these are set out below in relation to the interests of each of the parties represented at the Inquiry. They are set against the general background that prison was not the only answer in relation to Mr Perry’s involvement with the criminal justice system in January 2013 and in particular following his decision to attend at the police station.

The Police

6.5 Mr Perry's death might have been avoided if the police at Perth had been able to secure the attendance of a medical practitioner at the police office when he presented himself on 15 January 2013. His mother expressed the view that the Police could have telephoned her in relation to their concerns about her son. No substantial reason was offered for not doing so. It is also submitted that there is no substitute for a personal, face to face examination of a person in custody if there are obvious concerns about that person's physical or mental welfare. In this case, Dr Sadler was unable to travel from Dundee (where he was based at the time) to Perth when the police contacted him. Further efforts could and should have been made to arrange for a proper examination of Mr Perry whose behaviour and demeanour caused sufficient concern that an experienced custody sergeant made contact with health care professionals in Dundee on more than one occasion during Mr Perry's period in custody at the police office.

6.6 On the morning of 16 January 2013, Dr Sadler was unable to attend at the police office until around 2 pm (by which time Mr Perry had been transferred to the Sheriff Court). In the event, Mr Perry was not seen or examined by a doctor. One possibility – which it is submitted was not ruled out on the evidence – is that he might have been declared unfit for Court and conveyed instead to hospital. The police had sufficient concerns that, unusually, the procurator fiscal was formally advised (see below).

COPFS

6.7 Apart from writing to the Governor of the prison, it appears that no further steps were taken by the Crown which might have altered the course of events. Mr Perry's

case was marked for petition proceedings and his bail was opposed. The family expressed concerns that, since Dr Sadler had been unable to attend upon Mr Perry at the police station, an arrangement could and should have been made for Dr Sadler to see him at Court. Either way, it is submitted that the absence of any face to face examination is a significant feature of the factual background and could well have altered the turn of events.

7. Scottish Prison Service

7.1 There was much evidence from various prison staff about the standard procedure routinely followed when a prisoner is being admitted. The precise procedure varies according to whether or not the prisoner has been in Perth Prison before (whether on remand or as a convicted prisoner). As mentioned earlier, Mr Perry had experience of Greenock Prison and Barlinnie but had never been in Perth Prison. In these circumstances, there were some prison records available on the SPS computer system containing useful information about him (but nothing which apparently caused anyone to consider that – taken together with all the circumstances then prevailing – he should receive any special attention).

7.2 The general tenor of the evidence is that Mr Perry presented with no particular concerns which might have alerted the staff to the need to place him on Act to Care. In broad terms (although this is not the language actually used by the witnesses) he might be described as a 'borderline case' for being placed on Act to Care. If that is the case, he should have placed on Act to Care. Erring on the side of caution in this respect seems to

be vital, for obvious reasons. As mentioned above, the staff agreed with the suggestion that had they been aware of the concerns expressed in the Fiscal's letter to the Governor, they would have viewed things differently. It is therefore a reasonable submission that this administrative failing meant that Mr Perry was denied the extra attention that Act to Care would have provided.

7.3 In light of the fact that many prisoners find themselves in custody as a result of drink or drugs problems and/or mental health issues, it is reasonable to suggest that all prisoners should be assessed by a qualified mental health nurse on entering prison. The evidence suggests that only those nurses who are fully trained and have experience in this specialist area are in a position to detect and act upon signs of mental illness which may not otherwise be detected. It is of very considerable importance that the prison staff are in a position to obtain the most accurate possible assessment of a prisoner's mental health. This in turn would allow prison staff to put proper procedures in place to deal with such mental health issues right from the start. In fairness to SPS, the new Talk to Me protocol helps to address some of these issues.

7.4 Still on the subject of a prisoner's mental health, the evidence reaffirmed that greater consideration ought to be given to information relayed by other criminal justice partners, such as the police, the social work department, COPFS and the courts (as well as family, friends and other prisoners). The picture painted by the evidence suggests that once he had been processed and allocated to a cell, the prison staff were not in a position to keep Mr Perry's welfare under close enough scrutiny, perhaps because of pressure on resources or perhaps because of what could be described as 'information

gaps'. (An example of the latter is the telephone call Mr Perry's mother made to Mr Geddes, the prison social worker, alerting him to her concerns – see below).

7.5 There was evidence that on Friday 18 January 2013 at around lunchtime Mr Perry's mother telephoned Mr Geddes, the social worker at the prison and expressed her concerns about her son's mental health. She thought he was presenting with symptoms of psychosis and told Mr Geddes about her other son suffering from paranoid schizophrenia. It seems this information was not adequately conveyed to those in the prison dealing with Mr Perry routinely.

7.6 In the course of these calls to Mr Geddes, Mr Perry's mother stated that she was convinced her son needed to see someone in the mental health team, but was informed that as it was a Friday and they finished early (at 4pm) it would not be possible for her son to see anyone until the Monday morning. This was despite Mr Perry's mother emphasising that she felt it was an emergency. Mr Geddes undertook to make the wardens in the hall aware of the situation. Against this background, consideration might be given to introducing a system which allows emergencies such as this to be dealt with out-with normal working hours.

7.7 The evidence clearly establishes that Mr Perry effectively decided to commit suicide the following day (Saturday 19 January 2013), possibly after making a telephone from the prison to his girlfriend (who did not give evidence). However, if his mother's genuinely held concerns, which were expressly conveyed to the prison authorities, had been acted upon promptly – and if, perhaps, things had not occurred over a week-end –

the opportunity to have Mr Perry examined by a doctor might not have been missed; and steps could have been taken to prevent his suicide.

Section 6(1)(d) – ‘the defects, if any, in any system of working which contributed ... to the death’.

8.1 In keeping with other government bodies, the SPS has many demands on its resources. Over the years, it has reviewed and revised its protocols in an effort to develop best practice. This is very much the case when dealing with efforts to prevent suicides in custody. Every such case results in a mandatory FAI which in many respects follows a similar pattern of events. On one view, the system of working within SPS (and in HMP Perth, in particular) did not ‘contribute’ to the death of Mr Perry. However, the system let him down, not because individuals working within it were necessarily unprofessional or uncaring, but because the demands placed upon them meant they could not devote the time and attention required by prisoners such as Mr Perry. One example of this relates to the provision of fully qualified mental health nurses. The Inquiry heard that there was a shortage of such nurses in January 2013, but – whether as a result of Mr Perry’s death or not – the present system has been improved and developed so that all nurses in prison have the requisite mental health professional qualifications; the same can also be said for police casualty surgeons, since the evidence at the Inquiry suggested that lack of resources on this front also played a part.

Conclusions

9.1 As described above, the evidence at the Inquiry discloses that there were a number of defects in the various systems of working which contributed to Mr Perry's death. The Court is invited to make a Determination that will reflect these deficiencies.

9.2 As with any Inquiry under the 1976 Act, this particular Inquiry offers an opportunity for soul-searching about the events leading up to Mr Perry's death. The Court is respectfully invited to place him at the centre. Although he had been 'in the system' before, he was a stranger to all the witnesses. Time and again, in one way or another, he displayed signs that 'something was not quite right'. From the moment he walked into the police station there was cause for concern. This situation continued, by and large, to the point where he was found hanged in his cell 4 days later. There were numerous opportunities to heed warnings which were obvious from dealing directly with Mr Perry. In addition, his mother made repeated efforts to alert the authorities to her son's psychotic behaviour. Many warning bells were sounding.

9.3 Specific suggestions as to particular recommendations the Court might make have not been made in these submissions. Rather, I have sought to highlight the family's various areas of concern about the whole circumstances from which the Court can make appropriate recommendations under s. 6(1)(c) to (e) of the Act.

SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT PERTH

SUBMISSIONS

for

TAYSIDE HEALTH BOARD

in the

FATAL ACCIDENT INQUIRY

into the death of

JOHN PERRY

It is respectfully submitted on behalf of Tayside Health Board that the learned Sheriff should, in making a determination under s.6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, set out the following circumstances of the death of the late Mr Perry:

1. Where and when the death and any accident resulting in the death took

place: (s.6(1)(a))

- (i) Mr Perry died at Perth Royal Infirmary at 12.28pm on 23rd January 2013: (Joint Minute, paras. 3 and 15);
- (ii) The accident which resulted in his death happened in Cell B1/04 of HM Prison Perth, on 19th January 2013 between about 2.30pm and 3.45pm.

2. The cause or causes of such death and any accident resulting in the death

(s.6(1)(b))

- (i) The cause of death was ligature pressure on the neck by a shoe lace: (post mortem report, Crown Production 9, pp.1 and 3);

(ii) The cause of the accident which resulted in Mr Perry's death was that he tied a shoe lace tightly around his own neck: (post mortem report, Crown Production 9, p.3).

3. The reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided: (s.6(1)(c));

(i) There are no reasonable precautions whereby the death might have been avoided;

(ii) There are no reasonable precautions whereby the accident which resulted in the death might have been avoided;

4. The defects, if any, in any system of working which contributed to the death or any accident resulting in the death: (s.6(1)(d));

(i) There were no defects in any system of working which contributed to the death;

(ii) There were no defects in any system of working which contributed to the accident which resulted in the death.

5. Any other facts which are relevant to the circumstances of the death:

(s.6(1)(e)).

There are no other facts which are relevant to the circumstances of the death.

Summary

1. It is submitted on behalf of Tayside Health Board:

(a) As to reasonable precautions: (s.6(1)(c)):

(i) That there are no reasonable precautions, insofar as relating to Tayside Health Board or its employees, whereby the death or the accident which resulted in the death might have been avoided.

(ii) In particular, that it would not have been a reasonable precaution to have all new admissions to HMP Perth examined on admission by either a psychiatrist or a mental health nurse.

(b) As to defects in systems of working: (s.6(1)(d):

(i) That there were no defects in any system of working, insofar as relating to Tayside Health Board or its employees, which contributed either to the death or to the accident which resulted in the death. In particular:

(ii) That there was no defect in the system for detainees in the custody of the police at Perth to be seen by a police surgeon;

(iii) That the Health Board staff who assessed the deceased in HMP Perth (Ian Duncan, Dr Mark Wallace and Catriona Baxter) had no reason to consider that he presented a suicide risk and therefore to place him on ACT.

Reasonable precautions

2. On the question of whether there are any reasonable precautions whereby the accident or the death might have been avoided, insofar as relating to Tayside Health Board or its employees, the issue that arose from the evidence was whether it would have been reasonable to have all new admissions to HMP Perth examined on admission by either a psychiatrist or a mental health nurse.

3. The inquiry heard evidence from Dawn Wigley, Head of Nursing for NHS Tayside Prisoner Healthcare. She said that it was not unusual in Scottish prisons for admission assessments to be performed by general nurses, as opposed to mental health nurses. Ms Wigley had made enquiries and had established that at Barlinnie and Inverness prisons

admission assessments were performed by general nurses. It was reasonable in her view to have the assessment carried out by general nurses, because the assessment was not only for the purposes of identifying any mental health issues. Rather, the nurse would also be assessing the prisoner's physical healthcare needs, issues arising from withdrawal from substances and so on. Further, Ms Wigley stated that it was not practical to have mental health nurses carry out admission assessments at HMP Perth. There were not enough mental health nurses to be able to undertake the task. There was a national shortage of mental health nurses. In 2015 the Health Board had provided more funding for nurses and they had had a recruiting exercise in the summer of 2016. However, they had difficulty in filling even the existing posts for mental health nurses.

4. In any event there was no evidence to suggest that if the deceased's Health Care Admission Assessment had been performed by a mental health nurse, as opposed to Ian Duncan, there is any real possibility that it would have made any difference to the outcome. Indeed the evidence suggested the contrary conclusion. Dr Wallace, whose background included significant psychiatric training and experience, had no concerns with the deceased's presentation. The deceased consistently presented in a positive light when dealing with prison and NHS staff within the prison: (see SIDCAAR report, Crown Production 34, p.664, para. 7). Even if the deceased had been put on ACT on 16th January 2013, it is submitted that he would probably have been taken off it by no later than 17th January 2013: (e.g. the evidence of Ian Duncan and Peter Lee).

5. It is therefore submitted that having the deceased's Health Care Risk Assessment on admission performed by a mental health nurse, as opposed to a general nurse, was not a reasonable precaution which might have prevented either the accident or the death.

6. As to the suggestion that all new prisoners undergo assessment by a psychiatrist upon admission, Lesley McDowall, suicide prevention adviser to the Scottish Prison Service, said in her evidence that that this was not practical. The 'Talk To Me' review, which resulted in the 'Prevention of Suicide in Prison Strategy 2016-2021' had consulted with the Mental Welfare Commission and with psychiatrists. The suggestion of universal psychiatric assessment was not seen as appropriate. It was not thought that it would significantly reduce the incidence of suicide in prisons. Indeed she explained that under the new Prevention of Suicide in Prison Strategy, which was due to launch on 5th November 2016, the role of doctors in the admission assessment was being removed. An audit had established that on no occasion had the doctor changed the decision of the prison officer and nurse on whether a prisoner was at risk.

7. Further, there was no evidence to indicate that there was a real possibility that having the deceased assessed by a psychiatrist upon admission would have made any difference to the outcome. The evidence tends to suggest that it would not. Reference is made to para. 4 above .

8. It is therefore submitted that having the deceased assessed by a psychiatrist upon admission to prison was not a reasonable precaution which might have prevented either the accident or the death.

Defects in systems of working.

9. On the question of whether there were any defects in any system of working which contributed either to the accident or to the death, two issues arose in relation to Tayside Health Board and their employees:

- (a) Whether there was a defect in the system for detainees in the custody of the police at Perth to be seen by a police surgeon;
- (b) Whether the Health Board staff who assessed the deceased in HMP Perth, (Ian Duncan, Dr Mark Wallace and Catriona Baxter) should have placed him on ACT.

Review of police detainees by police surgeon

10. Two issues arise:

- (a) Whether Dr Sadler's limited availability on 16th January 2013 amounted to a defect in a system of working;
- (b) Whether that limited availability contributed to the accident or the death.

11. It was the evidence of Sergeant Assenti (retired) that on 16th January 2016 he had been on early shift at Perth police station. He had taken over custody of the deceased from Sergeant Letham at about 0640 hours: (Crown Production 2, p.19, two entries at 0640 hours). A fitness to plead examination was to be arranged. The issues with the deceased were that it was suspected that he may be banking drugs and his strange, erratic behaviour.

12. Sergeant Assenti said in his evidence that the usual practice would be to contact the custody nurses in Dundee and to advise them of the concerns about the detainee. A

view would then be taken on whether to arrange for the police surgeon to see the detainee.

On this occasion it fell to him to contact the custody nurses. The nurse said that the deceased would have to go to Dundee if he was to have a fitness to plead examination, as the surgeon was not available to come to Perth until late morning or lunchtime.

Sergeant Assenti therefore had to tell the deceased that he needed to go to Dundee.

Sergeant Assenti was not happy with him going to Dundee, given his agitated demeanour. It would also be logistically difficult, as he would need transport with a police escort. His evidence was however that if the deceased had to go to Dundee it would be done. The deceased would have no say on whether he would go. However, Sergeant Assenti's evidence was that when the deceased refused to go to Dundee, he (Sergeant Assenti) left it at that. He felt that it would be prudent to discuss the matter with the Fiscal. He therefore contacted the Fiscal and discussed with her whether it was appropriate to send him to court without a fitness to plead examination. It was decided that that would be appropriate. Sergeant Assenti accepted in re-examination that he had also spoken with Dr Sadler. He remembered talking to him about drugs coming out of the individual's system and leading to a change in behaviour.

13. Dr Sadler gave evidence. He was a pleasant and straightforward witness. He was credible and reliable. His evidence was that at the material time, in early 2013, they would try, ideally, to get prisoners who needed to be examined by the police surgeon brought to Dundee. He had post mortem duties in Dundee and it was therefore onerous for him also to travel to Perth and Arbroath. Whenever possible therefore prisoners

would be brought to Dundee. He did however regularly go to Perth to see prisoners.

Before early 2013 there had been various other doctors filling in to perform the work of Force Medical Examiner.

For a few months around early 2013 however he was the only person covering the work.

The position changed in the summer of 2013, when a full time Force Medical Examiner was appointed. His role included travelling around police stations.

14. Dr Sadler remembered being contacted by the custody nurse in Dundee, Ms Rowe.

The nurse had had discussions with the custody sergeant in Perth. Although Dr Sadler did not know the deceased's name at that time he knew that he was a prisoner in Perth and that a fitness to plead examination had been requested. Dr Sadler had said to the nurse that he would prefer him to come to Dundee. Dr Sadler had mortuary commitments that morning. He understood that the prisoner refused to be transported to Dundee. He understood from the records that he had taken a telephone call from the sergeant. He told him that he could not go to Perth until late morning or lunchtime. His understanding was that if there was any concern about the prisoner, he would be kept in the cells for Dr Sadler to see him. Dr Sadler confirmed in his evidence that he would have made himself available to see the deceased on 16th January 2016 and that he would if necessary have gone to Perth to see him, though it would not have been until late morning or lunchtime.

He spoke to the printed nursing records, in particular the entry made on 29th January 2013 about the events of 16th January 2013: (Production 2 for Tayside Health Board). Dr Sadler confirmed that the contents of that entry were consistent with his recollection of

events. He said that if the deceased had been brought to Dundee, he would have seen him there.

15. Dr Sadler's evidence that he was not available to go to Perth to see the deceased until late morning or lunchtime; that he would if necessary have gone to Perth to see him; and that if the deceased had been brought to Dundee he would have seen him there was not challenged. While Sergeant Assenti agreed in cross-examination on behalf of the deceased's family that he had formed the impression that Dr Sadler had been available to travel to Perth but was simply refusing to do so, that was in response to a leading question and amounted to an unsupported assertion. He had made no such suggestion in his evidence in chief. Indeed, Sergeant Assenti only remembered in re-examination that he had spoken to Dr Sadler on the day in question. His recollection of events was therefore unclear. Given that Dr Sadler's evidence on the matter was not challenged, it is submitted that his evidence should be preferred.

16. Chief Inspector Gordon Milne said that in his view the arrangements in this case had worked as intended, in that Sergeant Assenti had contacted the custody nurse, had been given information about Dr Sadler's availability and had spoken to Dr Sadler direct about the deceased.

17. It is therefore submitted that Dr Sadler's limited availability to see the deceased on 16th January 2013 did not amount to a defect in a system of working. In particular, the evidence was that Dr Sadler would have seen the deceased by about lunchtime that day, if Sergeant Assenti had considered it necessary. In particular, Dr Sadler's unchallenged evidence was that he was available to see the deceased in Dundee or Perth, albeit that he

would not have been able to travel to Perth until late morning or lunchtime. It is therefore submitted that the system operated as it was intended to.

18. There was also discussion regarding the introduction of the system, current in 2013, whereby the police would contact the custody nurses in Dundee for help with detainees, including fitness to plead examinations. Chief Inspector Gordon Milne spoke of the introduction in 2009 of a pilot project, whereby Tayside Police would work with Tayside Health Board to create a nurse-led medical welfare services and forensics suite, based at Dundee. Initially the NHS was paid by Tayside Police to provide custody nurses at the suite in Dundee. The pilot was a success and the arrangements became permanent. The system provided (and still provides) the police with access to the custody nurses, 24 hours a day, 7 days a week.

19. The review which resulted in the new arrangements looked at the arrangements which were in place before 2009, whereby the forensic medical service was provided by local on call general practitioners. That service had been provided at considerable expense.

It was also dependent on local general practitioners being willing and able to come out. This was particularly difficult in rural areas, because of the lack of availability of general practitioners. There was also a reluctance on the part of general practitioners to become involved with the criminal justice system. Under that previous system the situation could arise whereby there were several police vans at Accident & Emergency with detainees, which was an inefficient use of police resources.

20. Compared to the previous arrangements, the new system was regarded as a godsend. Medical advice was on hand for the police. A bank of nurses was created. Nurses were specifically recruited and trained for the service. By 2013 most of the nurses would have been there since 2009. The custody sergeants became used to using the nurses' services. As well as giving the police instant access to the custody nurses, the new system also gave the police access to the wider NHS, such as to specialists. Although access to specialists had been available before, it was only available in extreme cases, whereas it was now available as a matter of routine. Nurses were therefore now seen as a gateway to further medical help. The nurses took over the prescription of medication to detainees. The custody sergeants were delighted to be relieved of that responsibility. Although Chief Inspector Milne acknowledged that doctors' reluctance to provide cover for the service can cause difficulty, to his knowledge cover was always provided. There were never gaps in the medical cover.

21. It was suggested to Chief Inspector Milne on behalf of the deceased's family that the deceased was served no better under the new system than he would have been under the old system, in that under the latter a local general practitioner could have been contacted to examine the deceased. It is submitted that there is no merit in the point. The new system was piloted and rolled out because the old system was inefficient. Under the old system there were difficulties with the availability of local general practitioners and their willingness to become involved. As Chief Inspector Milne acknowledged in cross-examination, in the present case the local general practitioner, even if willing to come out, may well not have been immediately available to visit the police station or to

speak to Sergeant Assenti. In that respect the position would have been no better than under the 'new' system, with Dr Sadler. Sergeant Assenti may well still have decided to let the deceased go to court without a medical assessment. In many other respects the new system is better, because of the many advantages identified by Chief Inspector Milne.

22. It is further submitted that Dr Sadler's limited availability to see the deceased on 16th January 2013 did not in any event contribute either to the accident or to the death. In particular, the decision on whether to have the deceased undergo an assessment of his fitness to plead was one for Sergeant Assenti to make. Sergeant Assenti's evidence was that when the deceased refused to go to Dundee, he (Sergeant Assenti) left it at that. Sergeant Assenti spoke to the Fiscal Depute, Mrs Cole or Gilmartin, at about 10.30am on 16th January 2013. He told her that there had been a vast improvement in the deceased's demeanour overnight: (Crown Production 35, p.669). He appeared to be fine that morning: (Crown Production 5, p.36). The evidence of both Sergeant Assenti and Mrs Gilmartin was that they agreed that the deceased would go to court without undergoing a fitness to plead assessment. In the circumstances therefore the matter was taken out of Dr Sadler's hands (and those of the custody nurse).

23. It is also submitted that even if Dr Sadler had performed a fitness to plead examination of the deceased on 16th January 2013, it would probably not made any difference to the outcome. Dr Sadler would probably not have found any cause for concern.

Dr Sadler's evidence was that a fitness to plead examination is a cursory, brief assessment of the individual's mental state. He would ask the individual such things as where they were, what the date and time were and whether they understood what the charges are and why they were going to court. The evidence was that by the morning of 16th January 2013 the deceased's demeanour had vastly improved. That was reflected in the discussion between Sergeant Assenti and Mrs Gilmartin: (Crown Production 35, p.669). Sergeant James Aitken's evidence was that, despite the events of 15th January 2013, his gut feeling was that the deceased was fit to plead. Sergeant Assenti and Mrs Gilmartin were content that he go to court without a fitness to plead examination. He was transferred to court and from there to prison, all without any record of either mental disturbance or risk of selfharm:

(Crown Production 3, pp.26-28). Mark Cooper, G4S custody officer at court, said that if the deceased had been behaving strangely at court, it would have been recorded in the Record of Events: (Crown Production 3, pp.27-28). In the event there was no record of such behaviour. Mrs Gilmartin said that the deceased's behaviour during the hearing at court was appropriate and that nothing happened at that time to suggest to her that he was unfit to plead. She was satisfied that he was fit to plead. She was not concerned that he was at risk of self-harm. His solicitor, who had met with him at court, had not raised any concerns regarding his mental state. When Mrs Gilmartin had composed the letter to the Governor at HM Prison Perth, (Crown Production 5) she had started with a standard letter regarding suicide risk and had removed the standard wording regarding the risk of suicide, as she had no concern that he was at risk. Mrs Gilmartin explained

that the hearing at court had been held in the cell area because of the concerns that G4S had about security and logistics, arising from the suspicion that the deceased was banking drugs. It was not because of the deceased's mental state or behaviour. Catherine Lindsay, the G4S custody officer who transferred the deceased from court to prison, said that the transfer was uneventful and that if the deceased had behaved strangely then that would have been recorded: (Crown Production 3, p.26). Graeme Appleby, who processed the deceased when he arrived at prison, said that the deceased was calm and relaxed, with no sign of anything untoward.

24. In the circumstances therefore it is submitted that even if Dr Sadler had performed a fitness to plead examination of the deceased on 16th January 2013, he would probably have concluded that he was fit to plead. He would not have found any cause for concern regarding the deceased's mental state. In any event another three days elapsed between the approximate time at which Dr Sadler would have examined the deceased and the time of the deceased's suicide attempt, during which period the deceased underwent three formal assessments of his level of risk, as well as many contacts with prison staff. Any causal connection between Dr Sadler's availability on 16th January 2013 and the suicide attempt three days later is therefore tenuous.

25. It is therefore submitted that Dr Sadler's limited availability on 16th January 2013 was not a defect in a system of working and that in any event it made no contribution either to the deceased's death or to the accident which resulted in his death.

Assessment of the deceased in prison

26. On the issue of whether the Tayside Health Board staff who assessed the deceased at

HMP Perth should have placed him on ACT, the position regarding each staff member will be discussed in turn.

27. Ian Duncan

(a) Ian Duncan gave his evidence in a straightforward manner. He was a credible and reliable witness. He was an extremely experienced nurse. He said that he had qualified as a nurse about 40 years ago and had been working in prisons on and off throughout that period. He had worked at HMP Perth for about 8 years.

(b) On 16th January 2013 Mr Duncan performed the Health Care Risk Assessment of the deceased, recorded in the ACT 2 Care booklet: (Crown Production 6, p.80). He saw the deceased at about 1630 hours: (clinical notes, Crown Production 6, p.70). He finished completing his section of the ACT 2 Care booklet at about 1645 hours: (Crown Production 6, p.80). His assessment had therefore lasted about 15 minutes. His evidence that he was on back shift at the time. It was quiet. He had never seen it so quiet. The deceased was the only admission that he had to deal with. He had therefore had time to test the deceased's urine, which would usually have been done at night, after admissions had been completed. The urine sample came up negative for drugs: (Crown Production 6, p.70). Mr Duncan said that he had access to the deceased's prison history, which he would have looked at while he was with the deceased. He confirmed that he had the Reception Risk Assessment: (Crown Production 6, p.79). He also had the Personal Escort Record: (Crown Production 3, p.25).

(c) Mr Duncan said that he remembered the deceased clearly. He had chatted with him for a considerable amount of time. There was nothing about him that indicated that he

felt that he would not be able to handle being in prison. Mr Duncan's impression was that the deceased was a fine young man. The deceased wasn't too bothered about being there.

He said that he had hated Barlinnie but did not mind Perth prison. Mr Duncan said that they didn't get many prisoners who were so pleasant.

(d) Mr Duncan spoke about the ACT 2 Care system. He said that any member of staff within the prison could put a prisoner on ACT. Some prisoners liked being on ACT, but not many did. Most couldn't get off it quickly enough. They wanted to get back to the hall. He said that a prisoner could be referred to the mental health team, to see a mental health nurse, if it was thought that there was a mental health issue. That could be done without putting the prisoner on ACT.

(e) Mr Duncan said that there was nothing in the deceased's Personal Escort Record (Crown Production 3, p.25) that caused him concern. He had scrutinised it. He had initialled the form, above the 'Prisoner Number', to record that he had seen it. He had discussed it with the deceased. He had noted that 'Psychiatric condition' and 'Drugs/alcohol issues' had been ticked and he had asked the deceased whether he had any issues with these. The deceased denied having any such issues. There were no 'red flags'.

He told Mr Duncan that there were no problems at all. Mr Duncan said that the 'Psychiatric condition' box on the Personal Escort Record is often ticked, for example if the prisoner has cancer or diabetes or just wants tea and sandwiches. Mr Duncan said

that the deceased laughed at the 'Violence' box being ticked. He was not indignant or perturbed about that entry.

(f) Mr Duncan's impression was that the deceased was 'perfect'. He was not on medication and he had had no psychiatric contact outside prison. He maintained good eye contact.

(g) As to the letter from the Procurator Fiscal's office to the Governor of the prison (Crown Production 5), Mr Duncan said that they got lots of communications from the court regarding prisoners, mainly by way of faxes and phone calls. These would be treated seriously if they indicated that there were worries at court about the prisoner. He would always look at such communications. On this occasion he had not seen any such documentation and there was no record that he had seen any. He had first heard about the letter from the Procurator Fiscal's office when he was being interviewed by the CID after the deceased's death. Mr Duncan confirmed that he had not seen that letter when he saw the deceased. His evidence to that effect was not challenged. He acknowledged that the letter recorded bizarre behaviour at the police station, though he agreed that such behaviour was in any event referred to in the Personal Escort Record. When he saw the deceased his behaviour was perfect. Reading the Fiscal's letter did not alter his assessment of the deceased with hindsight.

(h) Mr Duncan confirmed that when he saw the deceased he had in mind the 'Key Aims' of the ACT 2 Care process, (printed on the front page of the Reception Risk Assessment document: Crown Production 6, p.76). With the deceased he saw nothing like any of the 'cues and clues' discussed in the ACT document, (Crown Production 6, p.78) such as

'Does the prisoner appear: anxious ... angry ...'. He was conversing well. There was nothing at all untoward. He was completing the Health Care Risk Assessment (Crown Production 6, p.80) while he chatted to the deceased. He knew from speaking to the deceased that he understood the assessment. He would be watching the deceased's reactions to questions. Even when he went to collect the deceased for the assessment, he would be watching and assessing him as he was coming to the room. He went through the list of questions at Section 2 of the assessment and marked off the answers. At that stage if the prisoner wants to tell you something he will do so. By way of a cross-check of the first three questions in Section 2, he checked the deceased's history on the computer system but showed no problems at all in the past. He wrote 'No thoughts of self harm': that was his assessment. He also wrote in the medical notes: (Crown Production 6, p.70).

He wrote those notes while still talking with the deceased, after completing the assessment form.

(i) Mr Duncan said that he was quite shocked when he heard later what had happened to the deceased. He did not however think that there was anything that he could have done differently. There was nothing to give him reason to put the deceased on ACT. If he had been in doubt, he would have gone to speak to the reception officer after his assessment. If he had a concern, but he couldn't put his finger on it, he would put the prisoner on ACT.

(j) It is therefore submitted that there was no reason for Mr Duncan to consider that the deceased presented a suicide risk and that he should therefore be placed on ACT. He

was a highly experienced nurse. He carried out a full and careful assessment of the deceased, beginning before the deceased even entered the room. He had a lengthy conversation with the deceased, without pressure of time, and assessed him throughout. He duly went through the Health Care Risk Assessment form with the deceased and also made separate notes regarding his health: (Crown Production 6, p.70). He duly took into account the Reception Risk Assessment which had been carried out by Peter Lee, as well as the Personal Escort Record. It was his unchallenged evidence that he did not have the letter from the Procurator Fiscal when he assessed the deceased. Nothing in Mr Duncan's assessment of the deceased caused him to consider that he was at risk.

(k) It is also submitted that even if Mr Duncan had put the deceased on ACT, it would probably not have made any difference to the outcome. The deceased would have continued to present in a positive light. Reference is made to paragraph 4 above. He would not have been considered to be at risk. He would have been taken off ACT at the earliest opportunity.

28. Dr Mark Wallace

(a) Dr Wallace was an entirely credible and reliable witness. He was an experienced doctor. He had been a doctor for 16 years and a general practitioner for 12 years. He had worked as a medical officer in prisons since 2008 and at HMP Perth since 2009. He spoke to his CV: (Crown Production 32). He had received significant psychiatric training in the course of his medical training. Psychiatry was a particular interest of his. He had found his psychiatric training useful in his prison work.

(b) Dr Wallace had significant experience in performing prisoner risk assessments. He estimated that he had done 10-15 a day since 2008. He had therefore done several thousand. The ACT medical risk assessment would start as soon as the prisoner came into the room. He would be looking for such things as eye contact, speech, mood and affect. He would always ask about suicidal thinking. He would be looking for psychotic signs. He would look for 'cues and clues', including non-verbal cues, such as whether the prisoner appeared dishevelled. Dr Wallace considered that he was well placed to look for such signs, given his professional experience and interest. He considered that a lot could be gleaned through casual conversation.

(c) Dr Wallace performed the Doctor Risk Assessment of the deceased on 17th January 2013: (Crown Production 6, p.80). He performed a thorough examination of the deceased. He thought that the consultation lasted about 10-15 minutes. He found no risk of self-harm and no suicidal ideation. The deceased displayed no bizarre behaviour. Dr Wallace specifically noted 'No suicidal ideation/thoughts of self harm'.

(d) Dr Wallace thought that he had probably heard about the deceased's attempted suicide the following Tuesday, (22nd January 2013). He did not work on Mondays. He was surprised to hear what had happened. There was no suggestion at his consultation with the deceased that this was a likely scenario.

(e) As to the letter from the Procurator Fiscal to the Governor, (Crown Production 5) Dr Wallace said in evidence that he had first seen the letter at some point in the last year. He had not seen it at that time of his consultation with the deceased on 17th January 2013.

(f) In the circumstances it is submitted that there was no reason for Dr Wallace to consider that the deceased presented a suicide risk, or even a risk of lesser self-harm, and that he should therefore be put on ACT. He was experienced in performing prisoner risk assessments. He performed a thorough examination. He found nothing to suggest that the deceased was at risk. He did not have the letter from the Procurator Fiscal.

There was no reason for him to put the deceased on ACT.

(g) It is further submitted that even if Dr Wallace had put the deceased on ACT, it would probably not have made any difference to the outcome. The deceased would have continued to present in a positive light. He would not have been considered to be at risk. Reference is made to paragraph 4 above. He would have been taken off ACT at the earliest opportunity.

29. Catriona Baxter

(a) Ms Baxter was a straightforward witness. She was credible and reliable. She had been a nurse for 11½ years and had worked at HMP Perth for 6½ years, before moving to Murray Royal Hospital in 2015.

(b) On 18th January 2013 Ms Baxter spoke to the deceased in his cell. Prison Officer Kevin Sclater's evidence was that he had asked her to see the deceased. He was not concerned about the deceased but he thought that Ms Baxter could view him more objectively, as she had not met him before. Ms Baxter's evidence was that she was on early shift. She said that Mr Sclater had told her that he had had a phone call from the Social Work department saying that they had had a phone call from the deceased's mother, who was concerned about the deceased's mental health. She said that it was

quite common for prison officers to get phone calls asking them to speak to prisoners or to get a nurse to speak to them. Mr Sclater spoke to Ms Baxter in the office in B Hall, which was a few metres from the deceased's cell. Mr Sclater told Ms Baxter that he had already spoken to the deceased and that he had no concerns about him.

(c) Ms Baxter said that a prison officer took her to the deceased's cell. Inside, the cell was in darkness and the TV was on, which was not unusual. The TV's sound was off. The deceased was lying on the top bunk, his head towards the far end. When Ms Baxter entered the cell, he sat up in bed. She asked him whether there was anything wrong, whether he was hearing voices or had any concerns. He just said no. She left it by saying that if there was anything he wanted to talk about then he should tell the nurses. She estimated that she was in the cell for about 5 minutes.

(d) Ms Baxter confirmed that she was ACT trained and that the possibility of putting the prisoner on ACT was always in her mind. At the time of the above conversation, however, it did not occur to her that he might need to be on ACT. He was sitting up talking in a normal manner. There was no indication that there was anything wrong. It was an unremarkable conversation. She told him that he could speak to the prison officers or nurses at any time. She asked open questions and gave him an opportunity to respond. As well as listening to his responses, she looked at him. She assessed his eye contact and his physical posture. She had no concern as a result of the conversation. She spoke to Mr Sclater and neither of them had concerns about the deceased.

(e) Ms Baxter said that if she had detected evidence of mental health issues, then she would have had two options, namely to have the deceased seen by the mental health

team or to put him on ACT. In the case of the deceased, however, neither seemed necessary. When she went to see him, she was looking for physical and mental signs. She could not avoid looking to see whether there were symptoms of a mental health issue. There were however no symptoms of an underlying issue. He was alert, conversing without hesitating and could sit up. There were no issues to be addressed.

(f) Ms Baxter made a record of her conversation with the deceased in the Encounter Report: (Crown Production 6, p.39). She confirmed that her entry there indicated that she had carried out a structured assessment of the deceased.

(g) She found out about the deceased's suicide attempt on 20th January 2013. She was shocked. Upon reflection, however, she did not think that she had missed anything. There was no indication that anything was wrong. If there had been anything wrong, for example if he had appeared distraught, then she would have noticed it and acted on it.

(h) Ms Baxter said that she had not seen the letter from the Procurator Fiscal to the Governor (Crown Production 5) before it was shown to her in cross-examination. She said that if she had seen it then she would have asked the deceased about it.

(i) To her recollection, she was not told that the deceased might have taken drugs. If she had been told that, her record of the conversation with the deceased in the Encounter Report, (Crown Production 6, p.39) would have been different. It would have been more focused on his presentation and whether he had taken anything. At that time she was familiar with issues around substance abuse. If she was asked to see someone who was thought to have taken a substance, she would look for signs like how alert they were, their pupils and their physical presentation.

(j) In the circumstances it is submitted that there was no reason for Ms Baxter to consider that the deceased was at risk of suicide, or even of other self-harm. She duly assessed him in his cell, by engaging him in conversation and observing his physical demeanour and mental presentation. She found nothing untoward. She spoke to Mr Sclater after she had spoken to the deceased. Neither found any reason for concern.

(k) It is also submitted that even if Ms Baxter had put the deceased on ACT, it would probably not have made any difference to the outcome. The deceased would have continued to present in a positive light. He would not have been considered to be at risk. Reference is made to paragraph 4 above. He would have been taken off ACT at the earliest opportunity.

Conclusions

30. It is therefore submitted that there was no defect in any system of working, insofar as relating to the assessment of prisoners by NHS staff at HMP Perth. Each member of the NHS staff who assessed the deceased at HMP Perth carefully assessed him. They each exercised their clinical judgment. None of them had any reason to put the deceased on ACT. Even if they had put the deceased on ACT, it is submitted that that would not have changed the outcome for the deceased.

31. In the circumstances therefore it is submitted that there was no defect in any system of working, so far as relating to Tayside Health Board or its employees, which contributed to either the deceased's death or to the accident which resulted in his death.

SHERIFFDOM OF TAYSIDE, CENTRAL & FIFE AT PERTH

SUBMISSIONS

for

THE PRISON OFFICERS'

ASSOCIATION (SCOTLAND)

in the

FATAL ACCIDENT INQUIRY

INTO THE DEATH OF JOHN

PERRY

[1] I represent the Prison Officers' Association (Scotland) (hereinafter referred to as "the POAS") in The Fatal Accident Inquiry into the death of John Perry, latterly a resident of Her Majesty's Prison, Perth. This is a mandatory Inquiry in terms of Section 1(1)(a)(2) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 as Mr Perry was in custody at time of his death.

[2] The members of the POAS that gave evidence are as follows:-

- Peter Lee
- Roderick Thomson
- David Scott Langlands
- Kevin Sclater
- Peter Ward

[3] Proposed Findings

It is respectfully submitted that the Court should, in making a determination under Section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, make the following findings:-

3.1. Section 6(1)(a)- “ Where and when the death and any accident resulting in the death took place”:

Mr John Perry died at Perth Royal Infirmary at 12:28pm on 23 January 2013 and that this was the consequence of his own actions in cell B1/4 at HM Prison Perth on 19 January 2013 between about 2:25pm and 3:45pm.

3.2 Section 6(1)(b) “The cause or causes of such death and any accident resulting in the death”:

The cause of death was ligature pressure on the neck by a shoelace (as per Crown Production 9 -Post Mortem Report)

3.3 Section 6(1)(c) “ The reasonable precautions, if any, whereby the death and the accident resulting in the death might have been avoided”:

No such finding is sought under this section.

3.4 Section 6(1)(d) “The defects, if any , in the system of working which contributed to the death or the accident resulting in the death”:

No such finding is sought under this section.

3.5 Section 6(1)(e) “ Any other factors which are relevant to the circumstances of the death”:

No such finding is sought under this section.

[4] I restrict these submissions to the evidence of the above noted POAS members who gave evidence during the course of this Inquiry. At the outset, I respectfully submit that each of the above noted POAS members provided their evidence in a proper, considered and candid manner. I respectfully submit that no POAS

member should attract any particular criticism and that there is no reasonable precaution that each member could have undertaken to which may have prevented the death of Mr Perry.

[5] Prison Officer Peter Lee

It is submitted that Prison Officer Lee was candid in providing his testimony and should be viewed as a credible and reliable witness. He is employed by the Scottish Prison Service (hereinafter referred to as “SPS”) and he has 9 years of service. He worked at the reception area at HM Prison Perth. He is trained in the SPS Suicide Risk Management Strategy (hereinafter referred to as “ACT”). He intimated that he had knowledge of the purpose and his role in its completion. He confirmed that he was passed the Prisoner Escort Form (hereinafter referred to as “PER”) as part of the system of working at the SPS. He confirmed that he signed the form. He was aware of the risk that Mr Perry had displayed “bizarre behaviour” and may be “banking drugs”. He informed that a sniffer dog was used to assess the risk and that this led to a negative result. A full body search of Mr Perry followed.

Mr Lee gave evidence that he completed part 1 of the ACT 2 Care Reception Risk Assessment form. He informed that he took the risk assessment very seriously. He estimated that his assessment took around 5-10 minutes to complete. He informed that his conclusion, based on his training and experience with ACT was that Mr Perry was not “at risk”.

He informed that there is nothing he could have done differently. It submitted that he has completed his part in the form in manner beyond criticism.

[6] Prison Officer Roderick Thomson

It is submitted Roderick Thomson was candid whilst providing his evidence and should be viewed as credible and reliable witness. He is in the employ of the SPS as a first line manager based at HMP Perth. He is highly experienced with has 28 years of service with the SPS. He is trained in ACT. He gave evidence that he was passed a letter prepared by Ms Charmaine Cole, Procurator Fiscal Depute from the Crown Office and Procurator Fiscal Service (Crown Production number 5) intimated concerns in relation to Mr Perry's demeanour being "bizarre" and the concern that Mr Perry may be "banking drugs". In response, he viewed Mr Perry in a separate holding cell and informed that he observed his manner as being normal. He informed that Mr Perry waiting in that cell for a dog handler to check if he has drugs in his possession. He then left a voicemail acknowledging receipt of the letter with its author. He thereafter intimated the contents of the letter to two or three nurses and the reception staff standing outside of his office. The letter was thereafter placed in a tray in his office which would later be placed in the prisoner's file as opposed to his medical file. This was in accordance with the system in operation by the SPS at this time.

Mr Thomson was asked which nurses that he presented this information to but, on account of the passage of time, he intimated that he could not recall.

However, he was clear in his evidence that he did intimate the contents of the

letter to the nursing staff. This evidence was unchallenged and there was no evidence heard that it was incumbent upon Mr Thomson to take any further precaution to ensure this information was received by any other party.

It is worth noting that Mr Thomson provided that it would not have made a difference if the letter had followed the ACT 2 Care booklet for Mr Perry as examinations by a prison officer, a nurse and a doctor were to follow in accordance with the system implemented by the SPS at that time. Further, it was accepted by Mr Thomson that the actual contents of this letter would not have caused him to think that Mr Perry was “at risk” of suicide or self-harm.

Further, it is submitted that the general theme of the contents of the letter were evident to Ian Duncan, nurse, on assessment as the PER form was marked with “psychiatric condition” box being ticked and “bizarre behaviour” amongst other concerns were clearly marked on that form. This information was considered careful by Ian Duncan, who is a highly experienced nurse, during his thorough examination and were not marked in the Health Care Risk Assessment section of the ACT 2 Care booklet as being relevant to Mr Perry’s “at risk” status. He informed that he scrutinised this form. He informed presentation was ‘perfect’. He stated that there were no red flags, no signs of erratic behaviour and made good eye contact with him.

[7] Prison Officer David Scott Langlands.

It is submitted that David Scott Langlands gave his evidence in a candid manner and should be viewed as credible and reliable manner. He is a prison officer of

the SPS. He has around 23 years of experience. He is ACT trained. He informed that he has placed prisoners on act before and that he will err on the side of caution when making a decision in this regard. He gave evidence that the first contact that he had with Mr Perry was on Friday 18 January 2013. He informed that he found Mr Perry to be quiet and polite with nothing that would draw his attention to him. He informed that Mr Perry asked him to use the telephone. He found him to be clear and concise in his speech. He informed that he had no cause to have any concern in Mr Perry's demeanour.

He informed that Mr Perry's cell mate Jamie Morrison then approached him and asked him if he could move cell. He was not intimidated with any particular reason other than "that they were not getting on". He stated that a concern in respect of Mr Perry's mental health was not raised with him. He informed that had a concern been raised then he would have spoken with Mr Perry in the first instance with reference made to the ACT process. He informed that it is common for prisoners not to get on and that it is common practice for prison officers to accommodate a move without further inquiry.

He informed that with benefit of hindsight there was nothing that he should have spotted with regard to Mr Perry's presentation in terms of the ACT process.

It is submitted that the evidence of Mr Morrison should not be preferred over that of Mr Langlands as he is not a reliable witness. He initially intimidated that he told a prison officer who is not a witness in this inquiry that he wished to move cell from the one he shared with Mr Perry. He intimidated that he could not recall

if he informed a prison officer of the reason he wanted to move which was because he might end up in a physical altercation with Mr Perry. He could not say with certainty which officer, if any, he intimated his concerns to in respect of the concerns he had over Mr Perry's mental health. It is respectfully submitted that this is not a proper basis to reject the testimony of Mr Langlands.

[8] Prison Officer Kevin Sclater.

It is submitted that Kevin Sclater was straightforward in providing his evidence and should be viewed as a credible and reliable witness. He is a highly experienced prison officer having worked with SPS for 23 years. He is trained in the ACT procedure. He first spoke with Mr Perry on Friday 18 January 2013 in relation to attending an induction. He informed that he had no concerns with the presentation of Mr Perry- whereby he answered sensibly and was clear and concise. He stated that he was no different from any other prisoner.

At lunch time, between 12:00 -12:30 p.m., Mr Sclater informed that he was approached by Mr Morrison about seeking a move from the cell he was sharing with Mr Perry- whereby he was asked "can I move cells – we're not getting on". In response, he informed that he would finish serving lunch and would process this request. He was clear that there was no mention of any behaviour that would be out of the ordinary from a routine request from a prisoner. At this time, Mr Sclater was asked by Mr Perry if he could use the telephone at lunch time. He said that he could use the telephone.

Mr Sclater informed by the time he finished serving lunch Mr Morrison had been moved cells.

He later received a telephone call at around 1.45- 2 p.m., by Richard Geddes. He was informed that Mr Perry's mother had been on the telephone and she was concerned that he was not making much sense and that he may have taken something. He was asked to speak to Mr Perry. He then went to see Mr Perry in his cell where he found him in the top bunk. He thereafter engaged in a conversation where Mr Perry gave him appropriate responses to questions posed such as stating that he was fine; he answered correctly that he was from Greenock, which accorded with Mr Sclater's correct identification of his west coast accent; that he was remanded by the police for possession of a knife; and that he was up in Court next Tuesday. He asked him why he did not move down to the bottom bunk and was informed that he would move down later. He asked if he had taken anything and Mr Perry informed him that he had not with the exception of tramadol outside. Mr Sclater observed him relax the more the conversation went on. He noted that Mr Perry was clear and concise in his speech. Mr Sclater had no concerns and did not have any reason to place him on ACT.

Although he did not have any concerns about Mr Perry, he wanted to ensure that he had not missed anything and asked for Nurse Kat Baxter simply for a second opinion. Kat Baxter, who is an experienced nurse, informed in her evidence that she could not remember the specific detail of the conversation with Mr Sclater,

but formed the impression that the request had something to do with a mental health issue. Kat Baxter performed a full assessment of John Perry covering both physical and mental health issues. She informed that she specifically asked whether he was hearing any voices and he answered that he did not. She gave evidence that he was exhibiting good body posture. She stated Mr Perry was maintaining good eye contact and he was clear and concise when he was speaking with her. She noted that he did not present as being under the influence of any substances and that there was symptomology present of an underlying mental health issue. She stated that she had no concerns and, accordingly, did not place him on ACT.

Mr Sclater noted in hindsight that he would not have done anything differently.

In respect of Richard Geddes' evidence on the point of what information he passed to Mr Sclater. It is contradicted by the evidence provided by Mr Sclater.

There is no basis to reject Mr Sclater's evidence as not being credible and reliable on that fact. On the basis of reliability, his evidence should be preferred. He noted his full and detailed position within a handwritten statement on Sunday 20 January 2013 after he heard of what happened in Mr Perry's cell on 19 January 2013. This statement was confirmed to be in accordance with his parole evidence. This is opposed to Richard Geddes' brief note compiled on Monday 21 January 2013 where he did not note any of the details in respect of the call he made with Mr Sclater.

It is submitted that there was no reasonable precaution that Mr Sclater could have done that would have prevented the death of Mr Perry. He carried out an assessment in line with the ACT procedure. Further, he sought a second opinion from a trained nurse Kat Baxter. If there should be a concern in respect of information handling and that his position is questioned, it is respectfully submitted that it would have had no practical effect as Kat Baxter had an understanding that the concern related to a mental health issue and she carried out both a physical and mental health examination.

It is submitted that the evidence of Jamie Morrison should not be preferred over that of Mr Sclater, in a similar manner to that of Mr Langlands, as Mr Morrison is not a reliable witness. He initially intimated that he told a prison officer who is not a witness in this inquiry that he wished to move cell from the one he shared with Mr Perry. He could not recall if he informed a prison officer of the reason he wanted to move was because he might end up in a physical altercation with Mr Perry. He could not say with certainty which officer he intimated his concerns to in respect of the concerns he had over Mr Perry's mental health. It is submitted that this is not a proper basis to reject the testimony of Mr Sclater.

Further, the testimony from prisoner Darren Bryne should not be accepted on the basis that it was confused and, accordingly, should be rejected as being unreliable. He conceded that he could have been mistaken if he overheard Mr Morrison informing Mr Sclater or another prison officer that Mr Perry was displaying symptomology of a mental health issue. Further, he accepted that he

could have spoken to Kevin Sclater but later in his evidence said he could not be sure. Further still, he stated it was 6:30 p.m. on Thursday 17 January 2013 when Mr Perry was moving cell. He said it was not Friday (18 January 2013). This cannot be accepted as Mr Perry did not move cells until the afternoon of Friday 18 January 2013 and Mr Sclater was not on shift on Thursday 17 January 2013.

[9] Prison Officer Peter Ward.

It is submitted that Peter Ward was straightforward and should be viewed as a credible and reliable witness. He is a highly experience SPS prison officer with around 24 years of service. He is trained in the ACT procedure. On Saturday 19 January 2013 he was working on the ground floor level of Hall B. He informed that lunch is served at around 11:15 a.m. and it can take around 15 to 20 minutes. He informed after this, the plates are collected and the prisoners are locked in their cells. He gave evidence that he collected a plate from Mr Perry's cell, whereby Mr Perry raised his head and acknowledged that Mr Ward was present. There was nothing in this interaction that would have justified placing Mr Perry on ACT. Mr Ward later that day opened up the cell and found Mr Perry lying underneath the bed frame. He responded appropriately and called correctly a "Code Blue".

[10] It is submitted, for completeness, that if the letter prepared by Procurator Fiscal Depute Ms Cole had been attached to the ACT2 Care booklet, there is no evidence it would have resulted in Mr Perry being placed on ACT or would have led for him to have remained on ACT for the period in time that would have

prevented him from taking the action that he did on Saturday 19 January 2013. The letter did not raise any specific issue that was not contained within the PER form. The letter was drafted from a standard pro-forma suicide letter where Ms Cole deliberately elected to edit the style to remove reference to self-harm and suicide. Ian Duncan completed a medical examination and his medical opinion was that Mr Perry to be 'perfect' in his demeanour. A similar and more extensive examination by Dr Wallace followed which took around 45 minutes to one hour to complete. At the conclusion of this examination, Mr Perry was not placed on ACT. Dr Wallace intimated that his examination was thorough and that Mr Perry did not present with suicidal ideation or being a risk of self-harm. Dr Wallace was asked what he would have done if he had seen the letter, and he stated that he would have asked further questions. It would then be dependent on what answers were forthcoming that would have led for him to place Mr Perry on ACT or make a referral to the mental health team. It is respectfully submitted that this is too tenuous a link to establish causation in respect of Section 6(1)(c) and Section 6(1)(d). However, if this submission is not accepted, it is respectfully submitted that evidence would have been required to have been led as to whether any mental disorder would have been identified by a practitioner in the mental health team; whether there was any treatment which was available that would have been prescribed to treat any acute symptoms of any mental health issue which may have caused Mr Perry not to act in the manner in which he did on 19 January 2013; and whether this would have deemed him to be "at risk" in

terms of the ACT process and whether this would have altered the process as to how his presentation would have been reviewed and assessed.

[11] In conclusion, on behalf of the POAS I formally record their condolences and my personal condolences to Pauline McLaughlin and Mr Perry's family.

IN RESPECT WHEREOF
IAIN CAHILL
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SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT PERTH

SUBMISSIONS FOR IAN DUNCAN

in

Fatal Accident Inquiry

into the death of

JOHN PERRY

Under the Fatal Accidents and Sudden

Deaths Inquiry (Scotland) Act 1976

It is respectfully submitted on behalf of Ian Duncan that the Learned Sheriff should, in making a determination under Section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, set out the following circumstances of the death of the late Mr John Perry:

1 In terms of section 6(1)(a) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 that;

2

3 (i) Mr Perry died at Perth Royal Infirmary at 12.28 pm on 23rd January 2013 (Joint Minute Paragraphs 3 & 15);

4

5 (ii) The accident which resulted in the death of Mr Perry occurred in Cell B1/04 of HM Prison Perth on 19th January 2013 between about 2.30pm and 3.45 pm.

6

72. In terms of section 6(1)(b) of 1976 Act that;

8

9(I) The cause of death was ligature pressure on the neck by a shoe lace (post mortem report, Crown Production 9)

10

11(ii) The cause of the accident which resulted in the death of Mr Perry was that he tied a shoe lace tightly around his own neck (post mortem report, Crown Production 9, Page 3)

3In terms of Section 6(1)(c) of the 1976 Act that;

IThere are no reasonable precautions whereby the death might have been avoided;

IIThere are no reasonable precautions whereby the accident which resulted in the death might have been avoided.

4In terms of Section 6(1)(d) of the 1976 Act that;

5(I) There were no defects in the system of working which contributed to the death;

6(ii) There were no defects in any system of working which contributed to the accident which resulted in the death.

5In terms of Section 6(1)(e) of the 1976 Act that;

6There are no other facts which are relevant to the circumstances of the death.

1. Summary

1.1 I represent the interests of Ian Duncan and therefore my submissions are briefrestricted to reflect this limited interest. I therefore respectfully invite your Lordship to make formal findings in terms of Section 6(1)(a) and (b) as stipulated above and further submit that the court has not heard evidence which should form the basis for a finding, or findings, under subsections (c), (d) or (e).

1.2 It is submitted on behalf of Ian Duncan:

1

2(a) That there are no reasonable precautions insofar as Ian Duncan is concerned whereby the death or accident which resulted in the death might have been avoided.

Section 6(1)(c)

3

4(b) That there was no defect in the system of working insofar as Ian Duncan is concerned which contributed wither to the death or to the accident which resulted in the death. Section 6(1)(d)

5

6(c) That there are no other facts which are relevant to the circumstances of the death.

c

2. Mr Ian Duncan

2.1 Mr Ian Duncan gave oral evidence in Perth Sheriff Court on 16th May 2016. He was a credible and reliable witness who gave evidence in a clear and straightforward manner. He qualified as a nurse approximately 40 years ago. He worked as a nurse at HMP Perth in January 2013 and still worked as as nurse at HMP Perth at the time of giving his evidence. He had worked as a nurse in various prisons and had worked in HMP Perth for just in excess of 8 years. He is a general nurse. He is ACT trained.

2.2 On 16th January 2013, Mr Duncan was working backshift in HMP Perth. He performed the Health Care Assessment of the deceased recorded in the ACT 2 Care booklet: (Crown Production 6, p.80). He saw the deceased at about 16.30 hours; (Clinical

notes, Crown Production 6, P.70) He finished completing the relevant section of the ACT 2 Care booklet at about 16:45 hours: (Crown Production 6, p 80). He spoke with the deceased for around 20 minutes and his assessment lasted on or around 15 minutes as supported by the notes. Mr Duncan stated that it was quiet on 16th January 2013. It was such a quiet day to the extent that he had never seen it so quiet in his life before. Mr Perry was the only admission. Accordingly, Mr Duncan had the time to perform the 5 strip urine test and check the results noting he would ordinarily check the results at night. Mr Duncan confirmed that the urine test came back negative and Mr Duncan recorded said result: (Crown Production 6, p70).

2.3 Mr Duncan stated that he remember the deceased clearly. He chatted with him for a considerable amount of time. Mr Duncan recalled that Mr Perry presented as a perfectly fit, polite young man. He wasn't too bothered about the situation he was in. He recalls that Mr Perry stated that he hated Barlinnie prison but that he didn't mind Perth. Mr Duncan went on to say that Mr Perry was a fine young man.

2.4 Mr Duncan created medical notes for Mr Perry (Crown Production 6, p.70) recording *inter alia* that this was Mr Perry's first time in Perth; that he was on no medications; that he smoked 10 daily, that he had a penicillin allergy (which he asterisked on the records), that there were no drug issues at present, that urine was taken with no abnormalities and most crucially for the current purpose, that there were no thoughts of self harm and no other health issues or problems. The entry time is noted as 16:30 and the notes are signed.

2.5 Mr Duncan stated that when he saw Mr Perry he had the Reception Risk Assessment: (Crown Production 6, p.79) in addition to the Personal Escort Record: Crown Production 3,p.25) Mr Duncan saw Mr Perry after the reception Officer who was also ACT trained had assessed him. Mr Duncan stated that if the Prison officer who had assessed the prisoner had concerns, he would ask him to come in and speak with the prisoner. Mr Duncan stressed that anyone can put a prisoner on ACT.

2.6 Mr Duncan confirmed that he had the Key Aims (Crown Production 6, p. 76)in mind when he assessed Mr Perry namely “To assume shared responsibility for the care of those at risk of self harm or suicide. To work together to provide a person centred caring environment based on individual assessed need where prisoners who are in distress can ask for help to avert a crisis. To identify and offer assistance in advance, during and after a crisis.”

2. 7 Mr Duncan furthermore advised that his assessment of a prisoner would start as soon as he saw him. Mr Duncan confirmed that he was aware of cues and clues (CP6) (part 2, section 2, p.78) and confirmed that none of these signs were applicable to the dealings with John Perry who conversed well. Mr Perry did not display any of these cues and clues. Mr Duncan confirmed that he would assess a prisoner as he was completing the form and would watch the reactions to questions. Mr Duncan went through a detailed list of questions with the deceased as per the Health Care Risk Assessment (Crown Production 6, p.80) after confirming that he understood the procedure, Mr Duncan recorded *interalia* that the deceased answered that he had not ever attempted self harm or suicide, did not feel suicidal and did not feel like hurting

himself at that time. Mr Duncan thereafter separately recorded that Mr Perry had no thoughts of self harm. Said notes were all written in real time. Mr Duncan said that Mr Perry conversed well and there was nothing of concern at all.

2.8 Mr Duncan confirmed that he received the PER form. (Crown Production 3 p.25)He initialled the form to record that he had seen it. He advised that was nothing on the form that gave cause for concern. Mr Duncan accepted that he scrutinised the form. He asked Mr Perry about any psychiatric condition as the box was ticked and Mr Perry denied it. He advised that there were no problems at all. There were no red flags. The box for suicide/self harm was not ticked. Mr Perry had good eye contact and no contact with psychiatrists. Mr Duncan saw no signs of erratic behaviour. Accordingly, Mr Duncan saw no reason to place the deceased on ACT. Mr Duncan stated that if he had any concerns, he would place a prisoner on ACT. He had no concerns in relation to Mr Perry and therefore did not place him on ACT.

2.9 Mr Duncan discussed the ACT 2 Care system. Mr Duncan advised that whilst some prisoners like being placed on ACT as they liked the peace and quiet and wanted time out, some didn't like it as they saw it as a punishment. Mr Duncan went on to say that not many liked being placed on ACT and most couldn't wait to get off the process quickly enough for various reasons including wanting to see their mates or phone their family.

2.10 Any member of staff could put a prisoner on ACT. Similarly, any member of staff could make a referral to the mental health team without utilising the ACT procedure.

d

2.11 With the benefit of hindsight, Mr Duncan upon being asked if there was anything he would have done differently, answered that he would not have. He would not have placed the deceased on ACT.

2.12 Reference was made in court to a letter from the Procurator Fiscal's Office (Crown Production 5) The author of the PF letter (Crown Production 5) namely Witness Charmain Gilmartin or Cole PF advised the court that she revised a standard pro forma suicide letter. She made a deliberate and conscious decision to edit the style pro forma letter and remove reference to self harm or suicide. She advised that there was no suggestion that Mr Perry was going to self harm or was suicidal.

2.11

2.13 Mr Duncan confirmed that he had not seen the Letter from the Procurator Fiscal Office (Crown Production 5) when he assessed the deceased. He first became aware of it when questioned by CID after the death of Mr Perry. This evidence was unchallenged. Nurse Duncan stated that if he was made aware of the Procurator Fiscal's letter that he would have noted this on the healthcare risk assessment form, photocopied the letter and clipped it on to to the front for the attention of the doctor. When shown the letter in court, Mr Duncan recognised that the letter made reference to bizarre behaviour but that the PER form also made reference to bizarre behaviour. When he met the deceased, he described him as perfect. He had no reason to put the deceased on ACT. There were no red flags. Consideration of this letter even with the benefit of hindsight did not alter his assessment of the deceased. It is submitted that the deceased did not exhibit any bizarre behaviour nor give Mr Duncan any cause for concern.

2.14 Mr Duncan saw the deceased on 16th January 2013. Prior to his assessment, the deceased was seen by other members of staff who were ACT trained. Post the assessment by Mr Duncan and prior to his passing on 19th January 2013, the deceased was seen by numerous members of staff who were Act trained including a doctor. No other staff member recorded any concerns that warranted the placing the deceased on ACT.

2.15 It is respectfully submitted that Mr Duncan presented as a credible and reliable witnesses. It is submitted that Mr Duncan had no cause to consider that the deceased posed a suicide risk and therefore should be placed on ACT. It is submitted that he fulfilled his professional duties to the appropriate standard. He was and is an experienced general nurse. He exercised his professional and clinical judgement and did not consider that the deceased should be placed on ACT based on the information available to him. Mr Duncan carried out a full and careful assessment/ interview of the deceased which commenced before the deceased entered the room. He had a long conversation with him without time constraints and assessed him throughout. He went through the Health Care risk assessment form with him, tested his urine and made separate notes regarding his health(CP 6, 70) He reviewed and considered the PER form in addition to the Reception Risk Assessment which had been carried out by Peter Lee who also did not consider the deceased to be at risk. It was his unchallenged evidence that he did not have the PF letter when he assessed the deceased. There was no record to show that he had see this document.

2.16 Mr Duncan advised that he was quite shocked when he learned that the deceased had taken his own life. With the benefit of hindsight, he did not think that he would or could have done anything differently. It is submitted that there was no reason for Mr Duncan to consider that Mr Perry presented a suicide risk and accordingly that there was no reason to place Mr Perry on ACT. He described the deceased as perfect. If he had been concerned but unable to put his finger on it, he would have put the prisoner on ACT. If he had concerns, he would err on the side of caution. If he had been concerned, he would have placed the deceased on ACT.

It is submitted that in the event Mr Duncan had placed the deceased on Act, in all likelihood it wouldn't have altered the outcome. It is submitted that in all likelihood the deceased would have continued to present in positive light as he appeared to do and did do so. It is submitted that it is more likely than not that he would not have been considered to be at risk and would have been removed from ACT at the earliest opportunity.

3. Conclusion

2.11

In light of the evidence heard and in light of the above, I respectfully submit that there is no reasonable precaution in so far as Ian Duncan is concerned whereby the death or accident which resulted in the death might have been avoided and that there was no defect in any system of working insofar as Ian Duncan is concerned which contributed either to the death or to the accident which resulted in the death.

IN RESPECT WHEREOF

Danielle Docherty
Fleming and Reid Solicitors
Instructed on behalf of Mr Ian

Duncan

SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE

AT PERTH

Inquiry under the Fatal Accidents and Sudden Deaths

Inquiry (Scotland) Act 1976

Into the Sudden Death

of

John Perry

before Sheriff Foulis

Written Submissions for

the Scottish Prison Service

Introduction

[1] I represent the interests of the Scottish Prison Service (the SPS) in this Fatal Accident Inquiry into the death of John Perry, latterly a resident of Her Majesty's Prison, Perth. This is a mandatory Inquiry in terms of section 1(1)(a)(2) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 (the Act) as Mr Perry was in legal custody at the time of his death.

[2] Mr Perry had been remanded in custody for further examination charged with contraventions of s49 (1) of the Criminal Law (Consolidation) (Scotland) Act 1995, s5 (2) of the Misuse of Drugs Act 1971 and s41(1) (A) of the Police (Scotland) Act 1967. On the 23 January 2013 he was accordingly in legal custody.

[3] At around 15:45 hours on Saturday 19 January 2013, prison officer Peter Ward opened cell B 1-4 in B hall, HMP Perth. He saw Mr Perry lying on the floor, with the

top of his body under the bed and with only his legs showing. There were no other prisoners or persons within the cell. Officer Ward asked after his welfare but received no response. He observed that Mr Perry's face was blue and both his eyes were open. Mr Ward called for assistance and prison officer Andrew Agnew attended immediately. Officer Ward took hold of Mr Perry's left arm and pulled him from under the bed to position him in a central location in the cell with his head facing the cell door. He noticed a white ligature around Mr Perry's neck which he attempted to remove by hand but without success.

- [4] Prison officer Andrew Agnew immediately called a "Code Blue" and within minutes Nurses Gail Livingstone and Mary Duffus and prison officer Craig Rennie arrived. Officer Rennie removed the ligature by cutting it with a pair of safety scissors. Despite the fact Mr Perry was showing no pulse or signs of respiration, was cyanosed and his pupils were fixed and dilated, CPR was commenced and a defibrillator and oxygen mask was attached. The nurses continued their efforts to resuscitate for the next 15 minutes before the ambulance crew arrived. Mr Perry was taken by ambulance to the Royal Infirmary of Perth where he was treated in the intensive care unit. He was kept alive by ventilator until shortly after noon on 23 January 2013 when after consultation with the family, the ventilator was switched off.

- [5] Life was pronounced extinct at 12.28 hours on the 23 January 2013.

[6] No person witnessed Mr Perry's death however the Inquiry heard evidence over 10 days from some of those persons who came into contact with Mr Perry in the days leading up to his death:

- Pauline McLaughlin (mother of the deceased)
- James Aitken (Police)
- Aitken Couper (Police)
- Pc Lesley Murray (Police)
- Michael Assenti (Police)
- Alan Boyd (Police)
- Procurator Fiscal, Charmaine Cole (nee Gilmerton)
- Mark Cooper (G4S)
- Catherine Lindsay (G4S)
- Graeme Appleby (Reception Prison Officer)
- Peter Lee (Reception Prison Officer)
- Roderick Thompson (FLM at Reception)
- Nurse Ian Duncan (Prison nurse)
- Dr Mark Wallace (Prison Doctor)
- Jamie Lee Morrison
- Darren Byrne
- David Davidson
- David Langlands (Prison Officer)
- Dr David Sadler (Police Doctor/Pathologist)
- Richard Geddes (Prison Social Worker)
- Kevin Sclater (Prison Officer)
- Nurse Catriona Baxter (Prison Nurse)
- Peter Ward (Prison Officer)
- Nurse Gail Livingston (Prison Nurse)
- Amanda Storer (Paramedic)
- Chief Inspector Gordon Milne
- Derek Pirie (Retired Residential Unit Manager)
- Lesley McDowall (SPS Health Strategy and Suicide Prevention Manager)
- Dawn Quigley (Head of Nursing)

[7] At the conclusion of the Inquiry, your Lordship is required to determine, in terms of the five subsections of section 6(1) of the Act: (a) where and when the death took place; (b) the cause or causes of the death; (c) the reasonable precautions, if any,

which might have prevented the death; (d) the defects, if any, in any system of working which contributed to the death; and (e) any other facts which are relevant to the circumstances of the death. In these submissions I will be inviting your Lordship to make formal findings only, i.e. to determine where and when the death took place, and the cause of the death in terms of section 6(1)(a) and (b) of the Act. In my submission, no evidence was before the court which should form the basis for a finding, or findings, under subsections (c), (d) or (e). The fact that John Perry sadly took his own life does not of itself imply that something could have been done to prevent the death.

The legal framework

- [8] I propose to set out in some detail the statutory framework of the Fatal Accident Inquiry regime. Thereafter, I will focus my submissions on the evidence which was before the Inquiry.
- [9] At the outset it should be borne in mind that the Sheriff, in his or her determination following a Fatal Accident Inquiry, must base the findings on the evidence which has been led at the Inquiry. In *Smith v Lord Advocate* 1995 SLT 379, Lord Cullen reduced those parts of the Sheriff's determination which fell within the specific findings listed in section 6(1) which were not supported by the evidence.
- [10] I also note that it is said by the authors of Macphail, *Sheriff Court Practice*, 3rd edition, edited by Sheriff Welsh QC, at paragraph 28.17 that: "... speculation must be

avoided; as with all the paragraphs of section 6(1) of the 1976 act, there has to be evidence which satisfies the Sheriff on the material points.”

Section 6(1) (a) and (b)

[11] Subsections (a) and (b) of section 6(1) require your Lordship to determine where and when the death and any accident resulting in the death took place (a), and the cause or causes of the death and any accident resulting in the death (b). It is submitted that Mr Perry’s death was not an “accident” (see, e.g., the definition of accident in *Fenton v Thorley* [1903] AC 443, per Lord Linley at 453: “any unintended and unexpected occurrence which produces hurt or loss...”) and that your Lordship is required to determine only where and when the death took place. In terms of determining the cause of death, it is the norm for this to be a matter of medical evidence (see MacPhail, *Sheriff Court Practice*, at 28.15 and 28.16).

Section 6(1) (c)

[12] Subsection (c) requires your Lordship to determine “the reasonable precautions, if any, whereby the death, and any accident resulting in the death, might have been avoided”. In reaching a decision on whether to make such a finding, it is submitted that your Lordship should bear in mind that the purpose of a Fatal Accident Inquiry is not to determine any question of civil or criminal liability. In *Black v Scott Lithgow Ltd* 1990 SC 322, Lord President Hope stated: “There is no power [in section 6(1)] to make a finding as to fault or to apportion blame between any persons who might

have contributed to the accident...it is plain that the function of the sheriff at a Fatal Accident Inquiry is different from that which he is required to perform at a proof in a civil action to recover damages. His examination and analysis of the evidence is conducted with a view only to setting out in his determination the circumstances to which the subsection refers, in so far as this can be done to his satisfaction. He has before him no record or other written pleadings, there is no claim of damages by anyone and there are no grounds of fault upon which his decision is required."

[13] The position was more recently confirmed by Lord President Hamilton in *Global Santa Fe Drilling v Lord Advocate* 2009 SLT 597 where at page 604 paragraph [28] he observed under reference to *Black* that although the Sheriff presiding at a Fatal Accident Inquiry has judicial duties, he or she does not sit to determine the rights or obligations of parties.

[14] As Carmichael notes in *Sudden Deaths and Fatal Accident Inquiries*, 3rd edn at para 5.75, "the precise wording of section 6(1) (c) must be kept in mind. What is required is not a finding as to a reasonable precaution whereby the death "would" have been avoided but whereby the death "might" have been avoided." I also refer your Lordship to the well-quoted passage of Sheriff Kearney's determination (Glasgow, 17 January 1986), following the Inquiry into the death of *James McAlpine*, in which his Lordship said: "...the court must, as well as being satisfied that the precaution might have prevented the accident or death, be satisfied that the precaution was a reasonable one...the phrase 'might have been avoided' is a wide one which has not, so far as I am aware, been made the subject of judicial interpretation. It means less

than 'would on the balance of probabilities have been avoided' and rather directs one's mind in the direction of lively possibilities." This passage in the learned Sheriff's determination has been quoted with approval in many determinations since 1986 and appears to be the basis of Carmichael's formulation at para. 5.75, which in turn was quoted with approval as recently as October 2014 by Sheriff O'Carroll in the Inquiry into the death of *John Moody* (Stirling, 10 October 2014).

[15] In addition, Sheriff Ruxton, in the Inquiry into the death of *Kathryn Beattie* (Glasgow, 4 July 2014), considered that "...the term 'might' should be applied in the sense that it incorporates a notion of something qualitatively more than a remote possibility: a possibility with some substance or potential rather than a fanciful or notional possibility."

[16] The Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 received Royal Assent on the 14 January 2016. The Act attempts to clarify the interpretation of section 6(1) (c). Section 26(2) (e) of Act repeals section 6(1)(c) and provides that the Sheriff will determine: "Any precautions which (1) could **reasonably** have been taken, and (2) had they been taken, might **realistically** have resulted in the death or any accident resulting in the death, being avoided" (emphasis added). It is submitted that section 26(2)(e) does not create a new finding but instead puts the preferred interpretation of 6(1)(c) in plain terms. As stated in the explanatory notes to the Act and the policy memorandum published alongside the Act, the inclusion of the word "reasonably" removes the possibility of the finding being interpreted as meaning a precaution which could have been taken

which might “foreseeably” have prevented the death. It does not matter whether the risk was foreseeable as the purpose of an FAI is to look back at events at the time with the benefit of hindsight (see the determination by Sheriff Brian Lockhart, as he then was, issued on 20 July 1993 following the Inquiry into the Railway *Accident* at Newton). Furthermore, the inclusion of the word “realistically” qualifies the word “might” and suggests that for such a finding to be made there would have to be more than a slight, or remote or fanciful, chance that the precaution might have prevented the death. This, it is submitted, is in accordance with how section 6(1) (c) has been interpreted previously (as in the determination of Sheriff Ruxton, *supra*, at para 17).

Section 6(1) (d)

[17] Subsection (d) requires your Lordship to determine “the defects, if any, in any system of working which contributed to the death or any accident resulting in the death.” Similar considerations, it is submitted, apply to a finding under this subsection with the difference that the evidence must be sufficient on the balance of probabilities to justify the finding (see Carmichael at para 5.76). In the *James McAlpine* Inquiry (references above), the learned Sheriff considered: “In deciding whether to make any determination under section 6(1)(d) as to the defects, if any, in any system of working which contributed to the death or any accident resulting in the death the court must, as a pre-condition to making any such recommendation, be satisfied that the defect in question did in fact cause or contribute to the death.”

[18] Carmichael goes on to state that the phrase “system of working” should be interpreted widely and for the purposes of Inquiries under section 1(1) (a) (ii), deaths in legal custody, should include any system, or lack of system, of working such as supervision where necessary, or routine in any custodial institution, where such has contributed positively to the death or accident resulting in the death. It is submitted that “contributed positively” requires your Lordship to be satisfied, on the balance of probabilities, of a causal-link between the system or lack of system and the death in question.

Section 6(1) (e)

[19] Subsection (e) requires your Lordship to determine “any other facts which are relevant to the circumstances of the death.” While the wording of this paragraph gives your Lordship wide scope (see Carmichael para 5.77), and unlike in subsections (c) and (d) there is no requirement for there to be a causal connection between the “fact” and the death, there is nonetheless a requirement for the facts established under this head to be relevant to the circumstances of the death.

[20] As Carmichael notes, there is a tendency for Sheriffs to use subsection (e) findings as a substitute for findings in fact. It is respectfully submitted that this is not a proper use of the subsection (e) head, and that subsection (e), like the previous subsections, is more akin to a finding in law. It is submitted that while (e) findings have been appropriately used by Sheriffs to make recommendations, and to list observations which are relevant but which lack a causal link to the death, it is

important to bear in mind the words “relevant to the circumstances of the death.” In my submission, this requires the observation or recommendation to be based upon evidence heard in the Inquiry which related to the death. Simply because evidence was heard in an Inquiry into a death does not mean that that evidence related to the death: it may be that when all of the evidence adduced is considered that it is possible, and indeed preferable, for the Sheriff to disregard certain evidence as being not relevant to the death. If facts are established at the Inquiry, and these facts give rise to concern, they must still be facts that are relevant to the circumstances of the death before they may be part of a determination under subsection (e). If the Sheriff has heard evidence which is of concern to the court but which does not relate to the death, it is respectfully submitted that the Sheriff should make observations in a note attached to the determination without making a finding under any of the section 6(1) subsections.

SPS Current Suicide Risk Management Strategy: ACT 2 CARE

[21] Prior to considering the evidence, it is necessary to explain briefly the background to the SPS Suicide Risk Management Strategy (the “ACT 2 Care strategy”, or “ACT”, in short) and the strategy’s implementation and the training of SPS and NHS staff. It should also be highlighted at this stage that in November 2011 the provision of healthcare in the SPS estate was transferred from the SPS to the NHS. It is the responsibility of the NHS to ensure that their staff are trained but that training on ACT is to be provided by the SPS.

- [22] ACT 2 Care was introduced by the SPS in its current form in 2005, with a version of the strategy having been in place since 1998. ACT stands for Assessment Context Teamwork. This sophisticated suicide prevention strategy has simple stated aims: “to assure a shared responsibility for the Care of those ‘at risk’ of self-harm or suicide. To work together to provide a person centred caring environment based on individual assessed need where prisoners who are in distress can ask for help to avert a crisis. To identify and offer assistance in advance, during and after a crisis.”
- [23] All prisoners entering, or re-entering, a prison go through a reception risk assessment process. Prisoners are seen by a prison officer and a nurse immediately upon admission and by a doctor within 24 hours of admission. A series of questions is asked of the prisoner, the answers to which, together with the presentation of the prisoner, allow the assessor to mark the prisoner as being ‘at risk’ or as being of ‘no apparent risk’. If any of the three assessors marks the prisoner as being ‘at risk’, an ACT document is raised immediately. At that juncture, a decision is made on how to safeguard the prisoner ranging from allowing the prisoner to remain in his cell but with certain items removed, or placing the prisoner in a cell with another prisoner (a buddy system), to placing the prisoner in an anti-ligature cell with a ‘high risk’ status which involves being observed every 15 minutes. Prisoners who are ‘at risk’ of suicide must be cared for in a safe environment. This does not automatically mean a ‘safe’ cell and being stripped of own clothing and belongings. ACT 2 Care is about identifying an appropriate safe environment, where the prisoner feels safe, comfortable and relaxed.

- [24] Within 24 hours of being placed on ACT, a case conference is convened at which the prisoner together with a prison officer familiar with the prisoner and a member of healthcare staff are present. The case conference will decide how to continue to safeguard the prisoner. The case conference might decide to maintain the safeguards at the same level as when the ACT document was raised, to alter the safeguards, or to remove the prisoner from ACT altogether. Isolation is always the last resort.
- [25] Any individual working within a prison may raise an ACT document should they have concerns about a prisoner at any time. It is not restricted to when a prisoner enters or re-enters an establishment. All staff are trained on 'cues and clues' and precipitating factors and are alive to prisoners' moods changing when, for example, parole is refused, a bereavement is suffered, release is approaching, or the anniversary of their crime or incarceration arrives.
- [26] The ACT regime has been tweaked over the years and has been the subject of positive judicial comment. In the Inquiry into the Death of *Ryan McNeil* (Inverness, 11 October 2013), Sheriff J Gilchrist QC observed: "While making a prisoner subject to ACT 2 CARE procedures is designed to reduce instances of self-harm and prevent possible suicide, it can result in a prisoner being subjected to a considerable degree of scrutiny and suffering additional loss of already restricted personal freedoms. If not used appropriately it can have an adverse effect on a prisoner's state of mind. It was apparent from the evidence that the procedures in place within HMP Inverness to identify those potentially at risk of suicide or self-harm are well

understood and well put into practice. I had no difficulty in concluding that the system strikes the necessary balance between being effective and proportionate (in other words it provides a mechanism for providing appropriate care and support where necessary without imposing undue or unwarranted restrictions on personal liberty or dignity)."

- [27] In the Inquiry into the Death of *Andrew Duthie* (Glasgow, 4 April 2008), Sheriff Linda Ruxton observed: "All prison staff receive core training in ACT procedures which is supplemented by compulsory refresher courses every year. It was clear from the evidence that all of the staff who came into contact with Mr Duthie were well versed in the ACT principles and fully aware of the need for vigilance and to be sensitive to any behavioural changes that might indicate that an individual prisoner was at risk of self harm... In Scotland, the evidence is that the approach enshrined in the ACT strategy appears to be working."
- [28] In the Inquiry into the Death of *Steven Allan* (Glasgow, 29 November 2007), Sheriff Martin Jones QC was "satisfied that the regime at Barlinnie Prison in Glasgow has a system well recognised by all staff which is effective for identifying and assisting vulnerable prisoners particularly those who may have ideas of self harm or suicide."
- [29] In the Inquiry into the Death of *Dylan Stickle* (Aberdeen, 31 March 2009), Sheriff JK Tierney stated that: "The Act 2 Care strategy is a carefully thought out strategy designed to meet the known risk that a proportion of prisoners will attempt to kill themselves or to harm themselves... The whole purpose of the ACT strategy is to

minimise the risk of suicide whilst the prisoner is in prison. It is, as I have said, a well thought out strategy which seeks to address the particular needs of the individual prisoner at the time he is undergoing ACT”.

- [30] In the Inquiry into the Deaths of *Stuart Rose and James Bell* (Glasgow January 2014) Sheriff Swanson stated that: “There is a sophisticated system in place within the Scottish Prison Service to identify those prisoners at risk of suicide and self harm.....From what I have heard about it in evidence I think that that Act 2 Care system is a good one.”

Talk to Me - The Prevention of Suicide in Prison Strategy

- [31] A national review of ACT, commenced in January 2014, and took account of the newly published Scottish Government’s Suicide Prevention Strategy 2013-2016 and adopted a multi-disciplinary and multi-agency approach. The revised strategy will be known as “Talk to Me”, the Prevention of Suicide in Prison Strategy. The key aim is to assume shared responsibility for the care of those “at risk” of suicide; to work together to provide a centred care pathway based on an individual’s needs, strengths and assets and provide a supportive environment where people in our custody can ask for help.
- [32] In December 2016, the new strategy will be implemented across the Scottish Prison Estate. This was spoken to in evidence by Lesley McDowall. To summarise, the fundamental key principles and changes are as follows:

- [33] **Key Aims/Principals**

- The prevention of suicide is everyone's business and all members of the prison community must take immediate action when heightened risk is identified.
- The strategy provides an improved person-centred care approach to prevention of suicide in prisons and all staff should commit to ensure the best possible care for those in custody. Care is central to everything the SPS do and can only be achieved through effective multi-disciplinary teamwork.
- The multi-disciplinary approach enables the whole prison community, including people in the prison to work together to identify vulnerable individuals, share information and encourage those "at risk" to accept help and support.
- Through the use of the strategy, SPS will promote and encourage: improved family involvement where the individual has given consent, improved care-planning and communication through the case conference process; less dependence on "anti-ligature" clothing and accommodation and an improved culture of contact and support.
- The strategy promotes an asset-based approach which focuses on the strengths of the individual while addressing their needs.
- The SPS create a positive environment which reduces the stigma and discrimination regarding mental health and encourages those at increased risk to ask for help and to talk about suicide issues.
- The care of people in prison who are "at risk" should involve supported relationships and regimes and where possible reflect normal routine while allowing for engagement in the therapeutic interventions. The use of safer cells should be limited to exceptional circumstances.
- Post-incident support following a death, attempted suicide or incident of severe self-harm for all staff and people in prison should be of high importance for local management. Use will be made of the appropriate arrangements in place to support families.

[34] **Main changes**

- The revised strategy will be known as "Talk to Me", the Prevention of Suicide in Prison Strategy.
- The local ACT coordinator will now be known as the local suicide prevention coordinator.

- The Local ACT group will now be known as the local suicide prevention group.
- The National Suicide Management group will now be known as the National Suicide Prevention Management Group.
- A concern form has been introduced to record concerns raised about an individual in custody from either external callers or internal partners which may result in them being supported on strategy.
- It is no longer an automatic requirement for a doctor to assess every admission within 24 hours as part of the reception process or following the first case conference. This is in line with the Healthcare in Prisons (Scotland) Directions 2011.
- A pre-case conference healthcare assessment should be completed by a healthcare professional and the same person should attend the case conference where possible.
- Individuals will no longer be assessed as **high or low risk**; assessment outcomes will be either “**at risk**” or “**no apparent risk**”.
- If an individual is located in a safer cell for 72 hours or more a unit manager must attend the next case conference and all subsequent case conferences until they are accommodated in normal accommodation.
- Anyone who is supported on the strategy within 6 weeks of any possible release date should have a reintegration case conference to address any concerns relating to that release.
- Single leaf paperwork has been developed to enable scanning and electronic storage.
- Improved governance arrangements have been introduced with an additional audit process. Following closure of the case all paperwork should be forwarded to the local suicide prevention coordinator who will ensure a minimum of 20% are audited.

[35] The Evidence at the Inquiry

In the main, all the witnesses who came to court to give evidence took their obligations to the court seriously and gave their evidence in a careful and

considered manner. However the evidence of Darren Byrne and James Morrison should be treated with caution, which I will expand upon in my submissions.

[36] **Witness 1: Pauline McLaughlin** - the mother of Mr Perry gave evidence on day one of the Inquiry. She explained that she had two sons, Graeme and John. She described John as always anxious and could not control his nerves. He was explosive and could just blow. In his teenage years, he started smoking cannabis and at the age of 16, he was sent to prison. When he came out of prison John was binge drinking, taking more drugs such as cannabis and valium and was getting into more trouble. Mrs McLaughlin felt that John had never got over the death of his father. John was sent to prison again in 2010. Mrs McLaughlin explained that there were rumours that John was involved in an armed robbery in Greenock. She told John to move to Perth, although he had no connections there, to make a new life. John moved to Perth on the 21 March 2012. Mrs McLaughlin had a good relationship with her son and continued to visit him in Perth on a regular basis. Throughout 2012 John's life became more chaotic with drugs and she felt he was becoming paranoid. On Christmas day in 2012, Mrs McLaughlin told John that he needed to get a grip or he would end up in hospital, prison or the morgue. It was only a matter of time. During January 2013, after listening to Mrs McLaughlin John made an appointment with his GP, went out jogging, bought healthy food and drinks. Mrs McLaughlin conceded that the more John tried to help himself physically the more he became mentally imbalanced. On the 12 January 2013, she

visited John in Perth and told him to go back to his GP to get referred to a psychologist. He never did visit his GP.

[37] A number of telephone recordings were played in court between Mrs McLaughlin and Mr Perry whilst he was at HMP Perth between 16 January 2013 and 19 January 2013.

[38] **First call: Wednesday 16 January 2013 at 20:12 hours (of note this phone call took place 3 hours and 27 mins after the nurse risk assessment).** Mrs McLaughlin accepted that during that phone call her son was lucid and able to give an explanation as to why he was in prison.

[39] **Second call: Thursday 17 January 2013 at 19.11 hours (of note this call took place after the Doctor Risk assessment at 11.20 hours that morning).** Mrs McLaughlin accepted that her son sounded rational.

[40] **Third call: Friday 8 January 2013 at 11.32 hours.** Mr Perry sounds rational and is able to advice of the hall and cell number he is in.

[41] **Fourth call: Friday 18 January 2013 at 11.42 hours.** Mr Perry tells Mrs McLaughlin he is ok. She pleads with him to get help. Mr Perry puts the phone down and says he will call back.

[42] **Fifth call: Friday 18 January 2013 at 12.02 hours.** Throughout the call Mr Perry does not respond much to questions put to him and plays down his problems. Mrs McLaughlin is distressed throughout but becomes worse when Mr Perry admits to using heroin.

- [43] **Sixth call: Friday 18 January 2013 at 15.14 hours (this call was after the call to Mr Geddes, social worker at 13.30 hours and the conversations Mr Sclater and Nurse Baxter had with Mr Perry).** Mr Perry sounds rational and calm and is able to recount what happened at the police station and accepts it is the stupidist thing he has ever done. Mrs McLaughlin accepted that her son told her that he would not harm himself and that is why she was so shocked when she learned of his death.
- [44] **Seventh call: Friday 18 January 2013 at 18.58 hours.** Mrs McLaughlin accepted that despite telling her son to seek help, he was not receptive to doing anything to help himself. She further conceded that she could see the difference between her other son, Graham and John's behaviour. Graham acknowledged he was not right and accepted medical help but the John would not.
- [45] **Eighth call: Saturday 19 January 2013 at 08.36 hours.** Mrs McLaughlin is again heard urging her son to seek help. John tells her that he was going to request to speak to someone right then.
- [46] **Ninth call: Saturday 19 January 2013 at 10.39 hours.** Mr Perry phones Mrs McLaughlin but no one answers.
- [47] **Tenth call: Saturday 19 January at 14.24 hours.** Mrs McLaughlin advised that when that call ended, something niggled her. With hindsight she accepted that her son knew what he was going to do. She further accepted that if her son was not willing to accept help then how could others have helped him.
- [48] Mrs McLaughlin accepted that when she first received a call from the police on Tuesday 15 January 2013, she never told them that her son may have mental health

problems. She further accepted that when she spoke to Mr Richard Geddes, social worker on Friday 18 January 2013 she was asked if her son would hurt himself. Her reply was "I don't know".

Tuesday 15 January 2013

[49] **Witness 2: DC James Aitken** - His evidence is that he is the custody sergeant at Perth Police station and has 26 years' experience in the police. His duties involved having overall control of the custody suite and cells. He was responsible for receiving and assessing individuals who are brought into custody. He would decide if individuals should lawfully be in custody and assess whether they were suitable to remain in custody. He is well versed in dealing with individuals who have mental health issues. DC Aitken explained that if an individual has health issues and requires medical treatment they can be referred to a police doctor or nurse or taken by ambulance to Perth Royal Infirmary. There is 24 hour nursing staff available, primarily based in Dundee. If an individual behaves out of character then he would speak to them and identify any issues. If an individual is violent or aggressive, they would be given an opportunity to calm down. In addition, criminal history and intelligence check are carried out which assists with an assessment of an individual. In examination in chief, DC Aitken confirmed that on the 15 January 2013 at 17.00 hours he was on the charge bar at Perth police station. Mr Perry came into the police station with a holdall bag. He looked agitated, was pale and sweaty. Mr Perry advised that he wanted to speak to someone from CID. He was taken into

a side room but Mr Perry refused to tell DC Aitken who he was. This is not unusual. DC Aitken's evidence was that Mr Perry was coherent, talked sensibly and did not appear to be under the influence of drink or drugs. DC Aitken's evidence is corroborated by the CCTV footage (Crown Production 16 to 19). The CCTV footage shows Mr Perry to be calm, compliant and able to answer questions at the charge bar. During the custody process, DC Aitken explained that Mr Perry was orientated, knew who and where he was. He was able to answer questions and his impression of Mr Perry was not of him being in immediate danger to himself or needing immediate psychological intervention. On being asked whether he had taken drugs or alcohol within the last 24 hours, Mr Perry replied "No". On being asked whether he was suicidal or would self harm he replied "Have, I fuck". DC Aitken's impression of Mr Perry was that he was banking drugs and deliberately engaging with police to get arrested to bring drugs in HMP Perth. The custody process concluded at 18.47 hours. Thereafter Mr Perry was subjected to a full body search because of previous drug convictions. He remained compliant throughout the search. Thereafter Mr Perry was moved to cell 3, an observation cell. At 19.25 hours Mr Perry asked to speak to a Detective Sergeant. DC Couper and DC Carsewell attended at the cell. The CCTV footage at 20.06.38 hours shows Mr Perry coming out of the cell. He is then intercepted by the officers. DC Aitken was not involved in restraining Mr Perry but confirms that Mr Perry was being held on the ground, until Velcro leg restraints were obtained to control him in a more effective manner. The CCTV footage shows that at 20.11 hours Mr Perry is placed back in the cell. After

the incident Mr Perry was put on constant observations. DC Aitken confirmed that Mr Perry settled down and there were no further incidents throughout the night. DC Aitken's evidence is that Mr Perry was fit to be detained in custody and did not need immediate psychological intervention.

[50] **Witness 3: DC Aitken Coupar** – His evidence is that he is based at Perth police station and has 19 years' service in the police. In examination in chief, he confirmed that on the 15 January 2013, he was asked to speak to Mr Perry. He stated that individuals do come in on occasion and request to speak to CID. When he spoke to Mr Perry he seemed troubled and his story was all over the place. He spoke coherently but did not tell him anything of significance. Mr Perry was paranoid, rambling and saying someone was going to murder him but they would make it look like a suicide. Mr Perry openly told him that he had a knife in his possession. Mr Perry put his right hand in his pocket. DC Coupar took hold of his right hand and shouted for assistance. A kitchen knife with a 3 inch blade was found. Mr Perry was searched and no other weapons were found. DC Coupar's impression was that Mr Perry was deliberately trying to get arrested to be remanded in prison as he was bringing in drugs. A small piece of cannabis was recovered from Mr Perry. At 20.00 hours that night DC Coupar received a call to say that Mr Perry wished to speak to CID. When DC Coupar opened the cell door Mr Perry forced his way out of the cell. There was an altercation in the corridor. Mr Perry had to be restrained and was returned to the cell.

[51] **Witness 4: PC Lesley Murray** – Her evidence is that she is based at Perth police station and has 11 years' service in the police. In examination in chief she confirmed that on 15 January 2013 she was in the public inquiry office at Perth Police Station. At 17.15 hours she heard a call for assistance. She entered the room with DC Coupar and Mr Perry. A knife was on the table. DC Coupar arrested Mr Perry for having a knife in a public place. Her impression of Mr Perry was that he was

agitated, sweating and paranoid. As a result he was placed on 30 minute observations. She confirms that she completed the PER form (Crown Production 2).

Wednesday 16 January 2013

[52] **Witness 5: Sergeant Michael Assenti** – His evidence is that he is now retired but was the custody sergeant at Perth Police Station for 6 years. In examination in chief, he advised that when he came on duty on the 15 January 2013 at 19.00 hours he was advised that Mr Perry had been placed on 30 minute observations. There were two issues highlighted: 1) Mr Perry deliberately got arrested as he was banking drugs to take into HMP Perth and; 2) his demeanour was strange, erratic behaviour. Sergeant Assenti spoke to Mr Perry on the morning of the 16 January 2013 to advise that he would require to travel to Dundee to be seen by a police doctor for a fitness to plead assessment. Normally the police doctor would assess individuals at the police station in Perth but Doctor Sadler was unavailable to attend that morning due to work commitments. Sergeant Assenti spoke to Nurse Roe over the telephone and advised that there had been a vast improvement in Mr Perry's demeanour overnight. An opinion was expressed that Mr Perry could have been under the influence of drugs when he first appeared at the police station and the improvement in his demeanour might be due to the substance wearing off. Mr Perry refused to go to Dundee. He was agitated and saying that he did not trust the police. Sergeant Assenti advised that the only option available would have been to forcibly remove Mr Perry from his cell and to transport him to Dundee. Sergeant Assenti spoke to the Procurator Fiscal Charmaine Cole regarding Mr Perry and his refusal to leave the cell. Sergeant Assenti thought that it was appropriate to discuss this with Mrs Cole. In particular, whether Mr Perry should attend court without a fitness to plead assessment. Mrs Cole advised that Mr Perry should attend court. It was Sergeant Assenti's evidence that regardless of any improvement in Mr Perry's demeanour it was prudent for him to have been assessed by a police doctor regarding his fitness to plead. When Sergeant Assenti went to put handcuffs on Mr Perry a struggle

ensued. Handcuffs and leg restraints required to be applied. G4S staff were advised of the incident. Sergeant Assenti confirmed that he made two entries on the PER form – “erratic demeanour/behaviour and maybe be banking drugs in order to take to HMP Perth. No specific Intel.”

[53] **Witness 5: Colin Boyd** – His evidence is not controversial. He has 34 years’ service’ in the police. He attended Mr Perry’s cell on the 16 January 2013 at 10.30 hours. His duty was to serve papers provided by the Procurator Fiscal on Mr Perry, which he did.

[54] **Witness 6: Mark Cooper** – He is employed by G4S and has been based at Perth Sheriff court for over 9 years. In fairness, he does not remember Mr Perry due to the number of prisoners he has to deal with on a daily basis. He accepted that his evidence can be inferred from the forms contained in Crown Production 3. In examination in chief, he advised that individuals who are held in the court cells are checked through the hatch in the cell door two to three times an hour. If they are at risk, five times an hour. Mr Cooper accepted that the records (page 25 to 28 of Crown Production 3) record that Mr Perry was checked 5 or 6 times an hour. That suggests that Mr Perry was deemed vulnerable although he could not say for certain why Mr Perry was checked 5 to 6 times. This was not uncommon, and this can occur once or twice a month.

[55] **Witness 7: Procurator Fiscal, Charmaine Cole (nee Gilmerton)** – Her evidence is that she is a senior Procurator Fiscal Depute now based in Dundee, previously Perth. In examination in chief, she confirmed that she attended Perth Sheriff Court personally on Wednesday 16 January 2013. She accepted that she had obligation to satisfy herself that Mr Perry was fit to attend court to plead. She takes her obligations very seriously. On arriving at court she spoke to G4S staff who had concerns about the logistics of bringing Mr Perry into the court room due to the suspicion of banking drugs. No other concerns were brought to her attention. She had no concerns. Mr Perry spoke to his solicitor and no concerns were raised by him. The solicitor advised that he had no difficulty taking instructions and was

moving for bail. If the solicitor had raised any concerns Mrs Cole would have continued the case under section 52 of the Criminal Procedure (Scotland) Act 1995 without plea for a psychiatric assessment. Thereafter she would have contacted the police doctor and referred Mr Perry to a local psychiatrist. A decision was taken to convene the court in the cells, based on the suspicion that Mr Perry was banking drugs. A motion was made for bail which was opposed. Mr Perry was unhappy about the fact bail was opposed but this was not out of the ordinary in Mrs Cole's experience. The sheriff ordered that Mr Perry be remanded in custody. Mr Perry understood what was happening. Mrs Cole confirmed that she wrote a letter addressed to the Governor at HMP Perth (Crown production 5 page 36). The letter was typed prior to the court appearance. She confirmed that she revised a standard pro forma suicide letter. She made a deliberate and conscious decision to edit the style pro forma letter. She accepted that there was no suggestion that Mr Perry was going to self harm or was suicidal. She specifically removed reference to that from the style pro forma letter. She conceded that she was not advising that Mr Perry needed an immediate psychiatric assessment. An assessment would only be required if Mr Perry continued to exhibit further bizarre behaviour. Mrs Cole handed the letter to G4S staff in a sealed envelope. She accepted that as the case progressed her concerns regarding Mr Perry diminished. The next morning she received a voicemail message from HMP Perth to confirm that they had received the letter.

[56] **Witness 8: Catherine Lindsey** – Her evidence is that she has been a prison custody officer with G4S for 10 years. Her duties involve transporting prisoners. She does not specifically recall Mr Perry. In examination in chief, she remembers receiving the PER form and recorded on that was – psychiatric condition, violent, conceals weapons, erratic behaviour. The journey from Perth Sheriff Court to HMP Perth was uneventful and they arrived at 14.45 hours. The transfer takes around 10 minutes. Mrs Lindsey explained that when they arrive at HMP Perth the procedure is that the G4S van drives into the vehicle lock. They then escort the prisoner to the

reception area and hand over the prisoner's paperwork and property. Prison Officer Peter Lee signed the PER form. On cross examination by Mr Williams, Mrs Lindsey accepted that throughout the transfer Mr Perry was subdued and quiet.

[57] **Witness 9: Prison Officer Graham Appleby** – His evidence is that he has been employed as a prison officer by the SPS for 18 years' and works at the reception area at HMP Perth. He is ACT trained. In examination in chief, he was shown Crown Production 4 and confirmed that this is a warrant for authority to hold Mr Perry at HMP Perth. On receipt of a prisoner, they receive the PER form. He confirmed that the PER form highlights previous risks and conditions. He recalls Mr Perry. When Mr Perry was admitted to HMP Perth he was placed on the BOSS chair, searched, property listed and interviewed by a prisoner officer. With regard to Mr Perry's demeanour he described him as calm, quiet, nothing untoward at all. There were no problems. Officer Appleby was shown Crown Production 22 the CCTV footage of the reception area. The CCTV footage shows Mr Perry being received in the reception area at around 15.03 hours and placed in the waiting area. Mr Perry is wanded by a metal detector and then walks back into the waiting room with no handcuffs on. Officer Appleby confirmed that Mr Perry was not aggressive in any way. At 15.3.39 hours, Mr Perry is taken out of the holding area and placed in the BOSS chair. Although the CCTV had no audio, Officer Appleby confirmed that Mr Perry was not complaining. At 15.03.32 hours the CCTV footage shows that Mr Perry is calm and looking out the window. 15.06.10 hours Mr Perry is seen looking at the notice board which informs you of visits. Officer Appleby confirmed that Mr Perry was not shouting and not making demands. He explained that on the day of Mr Perry's admission there were five members of staff on shift at the reception area. Mr Perry was the only admission that afternoon. The individuals that were working in the reception area were Roderick Thompson, Andrew Jamieson, Peter Lee and Mark Taylor. Mark Taylor was working behind the desk on the computer as he was responsible for booking in prisoners. Officer Jamieson was responsible for wanding prisoners. Officer Appleby was responsible for removing Mr Perry

from the G4S van into the reception area and checking the warrant. Officer Lee carried out the reception risk assessment. Roderick Thomson was the manager of the reception area and he was located in an office 10 to 15 yards away. Officer Appleby advised that Mr Thomson was accessible to all the staff in the reception area. Officer Appleby advised that he believes that HMP Perth received a phone call prior to Mr Perry's admission to advise that he might be banking drugs. That is the reason why he was kept separate in the holding area. Officer Appleby confirmed that he received the PER form and also an envelope. The envelope was marked for the attention of HMP Perth the Governor. Even though it was addressed to the Governor it was not always practical to pass a letter to the Governor. Officer Appleby did not see what was in the envelope. The envelope was passed to Mr Thomson. No further issues were brought to his attention. On cross examination, by Mr Williams it was put to him that Mr Perry's family are of the opinion that he got himself deliberately arrested as a cry for help. Officer Appleby stated that Mr Perry did not come across like that. There was no mention of anything and he did not appear to be under the influence of drugs or alcohol. Officer Appleby stated that looking back with hindsight he would not have done anything differently.

[58] **Witness 10: Prison Officer Peter Lee** – His evidence is that he is employed as a prison officer by the SPS at HMP Perth and has 9 years' service. He is based reception. He advised that the reception team at HMP Perth is a dedicated team and it is a specialist post. All the individuals who work within the reception area work very closely together. He is ACT trained. In examination in chief, he confirmed that before Mr Perry can be admitted to HMP Perth the reception staff require to see the warrant and PER form. He was shown the PER form. He confirmed that he signed it and advised that information on the PER form can be historical. Officer Lee carried out the reception risk assessment on Mr Perry. His evidence is that when you assess a prisoner, you look at how they present. There is no way of ascertaining whether they are telling the truth but you go with your gut feeling. It is down to experience. You can challenge the prisoner by checking to see if they have

previously been on ACT whilst in prison. Officer Lee advised that the SPS have a PR2 system. The system is like a set of traffic lights. It tells you if an individual has previously been on ACT. If a person has previously been on ACT, the box is black. If the box is blank, they have never been on ACT. If the box is red, they are currently on ACT. On checking the PR2 system in connection with Mr Perry, the box was blank, indicating that Mr Perry had never been on ACT. If an individual had been on ACT previously this would trigger further enquiries by the prison officer. Officer Lee advised, that just because a prisoner has been on ACT previously, does not mean that you automatically place them on ACT. It simply flags up a concern. Officer Lee recalled that concerns had been raised with regard to Mr Perry. They had received notification but he could not remember the source, that Mr Perry may be banking drugs. That was common knowledge between the reception team and due to this security were informed. When Mr Perry was admitted, the security team were in place together with the dog handler and the security manager. The sniffer dog resulted in a negative result. Thereafter Mr Perry was subjected to a full body search. When asked about the significance of Mr Perry's property that he brought in (i.e. a holdall bag) Officer Lee accepted that it did amount to a significant amount of property. He was referred to Crown Production 13, page 205, the prisoner's property card. Mr Perry signed the form off and that was countersigned by another prison officer. A list with regard to Mr Perry's property was completed prior to the reception risk assessment. With regard to Mr Perry's demeanour, Officer Lee advised that he made good eye contact. Officer Lee also takes into consideration an individual's tone of voice, and any physical marks on the person. He takes the reception risk assessment very seriously. It does not regard it as a tick box exercise. With regard to the reception risk assessment, Officer Lee confirmed that Mr Perry answered all the questions. The purpose of the assessment is to identify if an individual is suicidal or at risk of self harm. The assessment took between 5 to 10 minutes. He assessed Mr Perry as "not at risk". With regard to completing part 1 of the assessment form, Officer Lee confirmed that you ask questions such as: if they

have any problems contacting family and friends and you also look at non-verbal responses. Even before the reception risk assessment commences you are assessing the prisoner from the moment they walk in the reception area. With regard to placing someone on ACT, Officer Lee advised that you always err on the side of caution. You do not play percentage games. He confirmed that after the reception risk assessment is completed all details are logged onto the PR2 system. He could not recall whether he was shown a copy of the Procurator Fiscal's letter. If any letters/correspondence are received at reception, the procedure is to pass them to a supervisor that being Roderick Thomson. Officer Lee stated that if he could replay the situation again, there is nothing that he would have done differently. Mr Perry came across as a likeable, helpful individual who engaged with staff and was compliant throughout.

[59] **Witness 11: First Line Manager Roderick Thompson** – His evidence is that he is currently employed by the SPS as a first line manager based at reception in HMP Perth. He has 28 years' experience. His office is adjacent to the reception area. His role is to give advice and guidance regarding reception risk assessments. He is trained in ACT. In examination in chief, he advised that prison Officer Andrew Jamieson came into his office and handed him a letter. He could not recall who the letter was addressed to. The concerns that were raised in the letter were psychiatric issues and in possession of drugs. Upon receiving the letter, he went to see Mr Perry who was being held in a separate holding area. He looked at him through the glass door. His assessment was that he was acting normal for a prisoner being held in the holding area. Mr Perry was kept separate on the basis that they thought he may be banking drugs. Security and a dog handler were called. Upon receiving the Procurator Fiscal's letter, Mr Thompson telephoned Mrs Cole and left a message on her answerphone confirming he had received the letter. His evidence was that he brought the letter to the attention of the staff in the reception area. In examination in chief, he was asked specifically who he showed the letter to. He could not recall but does remember that there were two or three nurses standing outside his office

having a conversation. He showed the nurses the letter together with the reception staff, including Officer Lee. He narrated the contents of the letter and the reference to bizarre behaviour. Mr Quither asked whether he received any feedback from prison Officer Lee following the risk assessment. Mr Thompson could not recall. If there had been any concerns then these would have been communicated to him. His impression of Mr Perry was that he was not acting bizarrely and he had no reason to treat him any differently from any other admission. There was no cause for concern. On being questioned by his Lordship, Mr Thompson confirmed that once he showed the letter to the nursing staff he put the letter in a tray in his office. The letter would then be taken by a clerk to the general office and placed in the prisoner's file. That would be done within two to three days. He accepted that the copy of the Procurator Fiscal's letter would not be in possession of the doctor the following day when the doctor risk assessment was carried out. The system at that time was to file the letter in the prison records and not the medical records. Since Mr Perry's death the system has changed. All letters, faxes and emails are now copied. A copy is placed in both the medical and prison records. On cross examination by Mr Williams, it was put to Mr Thompson that if the Procurator Fiscal's letter had been circulated more widely and in particular, if the doctor had seen the letter then there is a possibility that Mr Perry would have been referred to a psychiatrist. Mr Thomson advised that he did not think it would have made a difference. In depth interviews were conducted by a prison officer, a nurse and a doctor. On cross examination by Mr Stuart, it was put to him that there was nothing in the Procurator Fiscal's letter that would cause you to think that Mr Perry was at risk or self harm or suicide. Mr Thomson accepted that.

Thursday/Friday 17 and 18 January 2013

[60] **Witness 12: Jamie Morrison** - His evidence is that he was in custody in B hall in at HMP Perth in January 2013. On Thursday 17 January 2013 he shared a cell with Mr Perry. On the first night Mr Perry stayed up all night and smoked a

packet of tobacco. The next day, Friday 18 January 2013 he thought Mr Perry was acting weird as he told him the TV was talking to him. Mr Perry made Mr Morrison feel uneasy. Mr Morrison presumed Mr Perry's behaviour was due to him taking speed. Mr Morrison's evidence was that he spoke to one of the prison officers at lunchtime and requested to move cells. Initially he thought it was Officer Alex Christie but accepted it could also have been Officers Kevin Sclater or David Langlands. His evidence was that he told the prison officer "It could end up being a roller book" (i.e. a fight). He could not remember if the prison officer asked him why he wanted to move cells. Mr Morrison then changed his evidence and advised that he told two prison officers, at least one, that Mr Perry needed to see mental health. Mr Morrison could not remember the prison officers he spoke to or whether the prison officers said anything in response. Mr Morrison was told by a prison officer he would be moved after lunchtime. Mr Morrison moved cell that afternoon. On Saturday 19 January 2013 Mr Morrison asked a prison officer to go back to Mr Perry's cell as he had forgotten his underwear and socks in his kit bag. That same afternoon he saw Mr Perry use the phone in the hall. He saw Mr Perry slam the phone down, leaving the phone swinging. In cross examination by Mr Cahill, Mr Morrison accepted that he could not recall who and how many prison officers he spoke to on the 18 January 2013 about Mr Perry. Given the inconsistencies with Mr Morrison's evidence, his evidence should be treated with caution and in my submission not accepted.

- [61] **Witness 13: Darren Byrne** - His evidence is that he was in custody, in B Hall, the bottom flat in HMP Perth in January 2013. He cannot remember who Jamie Morrison is. In examination in chief, his evidence was that the individual who shared the cell with Mr Perry was moaning to prison officers at the desk. He heard Mr Morrison say get him or me moved. Initially, Mr Byrne thought that the prison officers were either Kevin Sclater or John? His evidence initially was that Mr Morrison definitely said to the prison officers that Mr Perry was hallucinating. On questioning from his Lordship, Mr Byrne confirmed that he

overheard the conversation, he chipped in and said something like "He is tripping; put him in the obs cell". Mr Byrne had no recollection as to whether anyone else was with him at the time but there may have been another prisoner. He then stated that he spoke to Officer Kevin Sclater, told him to watch Mr Perry and put him in a suicide cell. He further stated that he had a few chats with the prison officers and that Mr Perry was all right on the Friday and Saturday. Mr Perry was not hysterical, they talked. On re-examination by Mr Cahill, it was Mr Byrne's evidence that on the day Mr Morrison was moved out of the cell that is when he spoke to Officer Sclater. The conversation took place at the desk. Mr Morrison was moaning to the staff behind the desk. Despite saying in examination in chief that Mr Morrison said Mr Perry was hallucinating; on cross examination he conceded that he did not know if Mr Morrison said Mr Perry was hallucinating to either Officer Sclater or other prison officers. Mr Byrne accepted that he could have been mistaken that he overheard Mr Morrison saying that Mr Perry was hallucinating. He then stated that it might have been him that said Mr Perry was hallucinating. On being questioned that he could not state categorically that it was Officer Kevin whom he talked to, he accepted this. He accepted that he was not 100% sure that he actually spoke to Officer Sclater. On cross examination by Mr Reid, Mr Byrne was asked to clarify when Mr Morrison was moved to another cell. Mr Byrne advised that it could have been the night Mr Perry came into the prison (Wednesday 16 January 2013) or the next again night (Thursday 17 January 2013). He then went on to say that Mr Morrison was moved the day after Mr Perry was admitted to prison. It was put to Mr Byrne that his timescale is different from the evidence of Mr Morrison. In my submission, Mr Byrne was neither credible nor reliable and his evidence should not be accepted. There are a number of inconsistencies with his evidence and at best his evidence was confusing. Mr Byrne is unclear as to which prison officer he spoke to and when. He is unclear as to when he overheard the conversation with Mr Morrison, what was actually said, and to whom, and the date when Mr

Morrison moved cell. His evidence is that Mr Morrison moved cell on a Thursday not Friday. Mr Byrne could not have spoken to Officer Sclater as he was not on duty on Thursday the 17 January 2013.

[62] **Witness 14: David Davidson:** His evidence is that he was in custody, in B Hall, the bottom flat in HMP Perth in January 2013. In examination in chief he confirmed that he remembers Mr Morrison as he was known as Porky. He remembers Mr Morrison moaning to prison officers on the Friday (18 January 2013) that Mr Perry should have been on suicide watch. He first met Mr Perry on the Friday when he bumped into him when he was speaking to Mr Morrison. It was Mr Davidson's impression that Mr Perry was anxious and not happy. On the Saturday morning (19 January 2013), Mr Perry entered Darren Byrne's cell. Mr Perry was quiet and he asked Mr Byrne for a smoke. They asked how he was coping and he did not answer. Mr Davidson recalled that on the Saturday, Mr Perry kicked off on the phone. He went mental, slammed the phone down. He never witnessed the incident but he heard about it. Mr Davidson advised that he was concerned about Mr Perry but he did not raise his concerns with any of the prison officers. On cross examination, by Mr Williams, he accepted that Mr Perry did not say anything to him that would suggest that he was suicidal. He further accepted that even though he had concerns he never spoke to any of the prison officers but spoke to Mr Morrison. In hindsight he should have reported his concerns to the prison officers.

[63] **Witness 15: Prison Officer Scott Langlands -** His evidence is that he has been employed by the SPS for the past 23 years' and has worked at HMP Perth for 15 years. His role as a residential officer includes looking after the general wellbeing of prisoners. He is ACT trained. In 2013 he was based in B Hall. B Hall can accommodate 203 prisoners. In examination in chief, he confirmed that on Friday 18 January 2013 he was working an early shift which is from 07.00 to 13.00 hours. He does not recall Mr Perry. His first contact with Mr Perry was on the Friday. His first impression of him was that he was quiet, polite and there was

nothing which would draw your attention to him. He was unremarkable. Officer Langland's evidence is that on the Friday, Mr Morrison approached him and asked to move cell. The move took place at lunchtime. Mr Quither asked whether Mr Morrison volunteered any information regarding Mr Perry in respect of concerns or his behaviour. Officer Langlands confirmed no. In particular, there was no mention of Mr Perry hearing voices or any issues with mental health. The next contact Officer Langlands had with Mr Perry was when he came back from using the telephone. He told him that Mr Morrison had moved cell. No reason was given. He explained that sometimes you give a reason and sometimes you don't. Officer Langlands received no verbal response from Mr Perry but that is not unusual. Officer Langlands further advised that if he had any concerns regarding Mr Perry then he would have placed him on ACT. Mr Perry would have been placed in one of the safe cells 1/5 or 1/6. Depending on how Mr Perry presented he would either be on 15 minute or hourly observations. A case conference would then be convened within 24 hours. He had no further dealings with the Mr Perry. Officer Langlands accepted that Mr Morrison spoke to him but he told him that he was not getting on with Mr Perry. The cell move was arranged on the basis of them not getting on. He moved Mr Morrison because there were available cells. Officer Langlands denied Mr Morrison telling him that Mr Perry had been behaving weirdly and been up all night watching TV and smoking. In cross examination by Mr Cahill, he confirmed that when Mr Perry spoke to him he asked to use the telephone. There was nothing that stood out. He has put prisoners on ACT before. He always errs on the side of caution. He did not identify anything out of the ordinary in respect of Mr Perry. He further advised that it is not unusual for a prisoner in a remand hall to request to move cell. On being questioned by his Lordship, Officer Langlands confirmed that he was working on the bottom flat in the hall. There are 3 officers on duty on the bottom flat and there are 28 cells. If someone requests a cell move, then you look at what available cells there

are on the flat or you look to accommodate them on another flat. There are 34 cells on the second flat and 34 on the third flat. He further confirmed that he knows who Mr Morrison is. If he passed him he would know who he was. His recollection is that his first communication with Mr Perry was when he asked him to use the telephone. That conversation took place at his cell door. Mr Morrison was in the cell at the time. Thereafter he served lunch and then collected the plates from the cells. His Lordship on questioning asked how the conversation between him and Mr Morrison started. Officer Langlands could not remember the exact words of the conversation but it was along the lines of "We are not getting on. Can I get a move?" He accepted what Mr Morrison told him. Officer Langlands advised Mr Morrison that he would arrange a move as he knew of another empty cell that Mr Morrison could move to. In my submission, Mr Langlands gave his evidence in a straight forward manner and did his best to assist the court. He was a wholly credible and reliable witness and his evidence should be accepted over Mr Morrison's and Mr Byrne's.

- [64] **Witness 16: Richard Geddes (Social Worker)** - His evidence is that he is a social worker based at HMP Perth. He does not routinely have contact with remand prisoners. He is ACT trained. With regard to the information he may receive regarding a prisoners' welfare, he conceded that the process has changed. Any information in respect of the welfare of a prisoner is passed to officers on the gallery where the prisoner is situated and contact is made with the hall manager. In examination in chief, Mr Geddes advised that he was working at HMP Perth on Friday 18 January 2013 from 08.00 to 17:00 hours. He received a message that Pauline McLaughlin had telephoned at 13.10 hours having previously spoken to clerical staff. The information that was passed to Mr Geddes was that a prisoner's mum had phoned and that she was concerned. He telephoned Mrs McLaughlin back at 13.10 hours. He recalls that Mrs McLaughlin was quite upset on the phone. She spoke about her concerns regarding her son and his recent behaviour. She had concerns regarding the telephone calls that she had

with her son. Her son seemed to contradict what he was saying and told her that the TV had been talking to him. Mr Geddes asked Mrs McLaughlin directly whether she was concerned that her son might do something to harm himself. Mrs McLaughlin stated that she did not think so but was more concerned about the way he was talking. Mr Geddes conceded that he does remember all the conversation but there was no discussion with regard to whether he was taking drugs. On cross examination by Mr Cahill, Mr Geddes accepted the phone call may have lasted 10 to 15 minutes. Following the phone call he checked the PR2 system and Mr Perry was not on ACT. His evidence is that he told Mrs McLaughlin that he would raise her concerns with prison officers on Mr Perry's landing. Immediately after the phone call he phoned the hall and spoke to Officer Kevin Sclater. Officer Sclater advised that he would go and speak to Mr Perry. Mr Geddes was shown Crown Production 10 (page 191). He accepted that he wrote the note regarding the telephone call with Mrs McLaughlin on Monday 21 January 2013. In cross examination, Mr Cahill put to Mr Geddes that he may be mistaken with regard to what he told Officer Sclater, which he accepted. He accepted that if Officer Sclater gives a different account of the telephone conversation then he would accept that he is mistaken. It was put to Mr Geddes, by Mr Cahill, that what he told Officer Sclater was that Mrs McLaughlin had been on the phone and that she was concerned that Mr Perry was not making sense and appeared to be under the influence of something. Mr Geddes asked Officer Sclater to check on Mr Perry. On questioning by his Lordship, the reference to under the influence was put to Mr Geddes. Mr Geddes stated that he told Officer Sclater about the TV speaking to Mr Perry but not about drugs. It was further put to Mr Geddes, by Mr Cahill that it will be Officer Sclater's evidence that he was not advised about the TV talking to Mr Perry. In reply Mr Geddes stated that he is pretty sure that he told Officer Sclater about the TV. In cross examination by Ms Phillips, he further accepted that it would have been open to him to have contacted the Mental Health Team after the telephone call

with Mrs McLaughlin. He could have done this by picking up the telephone or e-mailing them. He did not contact the Mental Health Team.

- [65] **Witness 17: David Sadler (Police Doctor and Forensic Pathologist)** - His evidence is that he has been a forensic pathologist since 1990. He is currently based at the University of Dundee. In 2013 he had a dual role of a principal pathologist and on call doctor for Tayside Police. In 2013 the procedure was to bring prisoners to Dundee centrally from the surrounding areas of Tayside, Dundee, Arbroath and Perth. That was the only practical way for Doctor Sadler to implement his dual role. It was not a protocol but a request by Doctor Sadler to reduce the amount of travelling time to the various police stations. Doctor Sadler was first contacted in connection with Mr Perry on Tuesday 16 January 2013. He was contacted by the custody nurse, Sandy Roe based in Dundee. The procedure in 2013 was that the police station phoned a custody nurse in Dundee as they are the first point of contact. With regard to the fitness to plead examination, Doctor Sadler advised that this is a cursory examination. A brief mental state examination. The examination is quick and easy. For example he will ask the individual in custody where they are, who they are and the date to establish whether they are orientated in place and time. He also asks questions to gain an understanding of whether the individual has an understanding of their situation and the implications. Doctor Sadler confirmed that he has carried out around 60 to 70 fitness to plead assessments over three years. With regard to Mr Perry, Doctor Sadler advised Nurse Roe that Mr Perry should attend Dundee given his work commitments on the morning of Wednesday 16 January 2013. Mr Perry was not brought to Dundee as he refused to attend. Doctor Sadler took a phone call from Sergeant Assenti and advised him that he could not travel to Perth to see Mr Perry until late morning/lunchtime that day due to work commitments. If they had any further concerns regarding Mr Perry then they should return him to his cell until he could see him. Doctor Sadler accepted that he was advised that Mr Perry was exhibiting bizarre behaviour and appeared to

be intoxicated on drugs. He further accepted that the decision reached regarding Mr Perry's fitness to plead was in conjunction with the information provided by Sergeant Assenti. He further conceded that he is not in a position to diagnose a psychiatric illness as one would need to be seen by a psychiatrist. Doctor Sadler further conceded in cross examination that when Mr Perry attended court, his solicitor had no difficulty or concerns. That speaks for itself. In terms of assessing fitness to plead, one has to assess whether the individual has an understanding of the legal situation. He further advised that he was a corroborator for Dr Whyte (now deceased) who performed the post mortem on Mr Perry. He explained that death by asphyxia can take a few minutes, so death may have occurred just before Mr Perry was found. One normally loses loss of consciousness within 20 seconds and then death progresses over a minute or two. That would not leave much time for intervention.

[66] **Witness 18: Nurse Ian Duncan** - His evidence is that he is currently employed by the NHS and has worked with them for the past 40 years. He has worked at HMP Barlinnie, HMP Saughton and HMP Castle Huntly. He is ACT trained. At HMP Perth there are 26 nurses. Four are psychiatric nurses. In examination in chief, Nurse Duncan advised that when individual is admitted a prison a healthcare risk assessment is carried out. With regard to the background information of a prisoner, he confirmed that you can access the computer system and check for basic health issues and whether there have been any suicide attempts. There is also information on an individual's prison history. Nurse Duncan recalls that Wednesday 16 January 2013 was a very quiet day. Mr Perry was the only admission. Nurse Duncan was provided with a copy of Mr Perry's PER form. There was nothing recorded on the PER form which raised concerns. He interviewed Mr Perry for around 20 minutes. He took a urine sample from Mr Perry. The urine sample tests for diazepam, opiates, methadone and buprenorphine. Mr Perry's urine sample was negative. Nurse Duncan's impression of Mr Perry was that he was fit, polite young man. He did not

appear bothered about the situation he was in. During the interview, Mr Perry presented well and he made good eye contact. Nurse Duncan stated that when he carries out the assessment he concentrates on psychiatric, drug and alcohol issues. He asked Mr Perry whether he had any current issues and he said no. There were no red flags with regard to Mr Perry having any psychiatric condition. Nurse Duncan stated that if he had any concerns about Mr Perry he would have placed him on ACT. If an individual is placed on ACT then an ACT book is opened up and the book travels with them to the hall. An individual may be placed in an anti-ligature cell and put on 15, 30 or 60 minute observations with a case conference the following day. Nurse Duncan advised that some prisoners want to be put on ACT as they like the peace and quiet. Some however class it as a punishment as they are not allowed TVs. The majority of prisoners do not like being put on ACT and cannot get off it quick enough. They want to be out and about in the hall, to make phone calls and to get cigarettes. In examination in chief, Nurse Duncan was shown a copy of the Procurator Fiscal's letter (Crown Production 5). He confirmed that he first became aware of the letter when he was interviewed by CID on the day Mr Perry died. He was asked whether the letter would that have made a difference to his assessment. Nurse Duncan confirmed no. He had no concerns and Mr Perry was conversing well. There were no red flags. On cross examination by Mr Williams, Nurse Duncan stated that Mr Perry sailed through the risk assessment process. The letter alone would not cause him to place Mr Perry on ACT. If he had any concerns about Mr Perry then it would have been open to him to contact the Mental Health Team and to speak to one of the psychiatric nurses. Nurse Duncan explained that if Mr Perry had been placed on ACT then that would not that have made a difference as it is likely that Mr Perry would have been placed on ACT for 48 hours and then removed from it. On cross-examination by Mrs Docherty, Nurse Duncan was asked what he would have done if he was made aware of the Procurator Fiscal's letter. Nurse Duncan confirmed that he would have noted

this on the healthcare risk assessment form, photocopied the letter and clipped it to the front for the doctor's attention.

- [67] **Witness 19: Doctor Wallace:** - His evidence is that he is a general practitioner and has worked within HMP Perth for the past 16 years'. He is a dual qualified lawyer and doctor. His qualifications are MB BS (June 2000), Diploma of Royal College of Obstetricians and Gynaecologists (April 2002), MRCP (August 2004) and RCGP Certificate in the Management of Drug Misuse in Primary Care (2011/2012). He has worked at various prisons including HMP Perth, HMP Edinburgh, HMP Barlinnie, HMP Shotts, HMP Addiewell, HMP Glenochill and HMP Cornton Vale. He is ACT trained. Doctor Wallace confirmed that he has a psychiatric background as he spent one year at Rosslynlee Hospital, dealing with adult psychiatry. His duties included assessing patients on a daily basis, engaging with them and organising their management. In general practice, he also has experience of patients with mental health problems. He has further worked at Royal Edinburgh Hospital on a 6 month psychotherapy post. In examination in chief, he explained that at HMP Perth there are 2 or 3 psychiatrists who conduct clinics 3 to 4 times a week. In addition there is a Mental Health Team which comprises of 3 nurses who work Monday to Friday. It is usually a mental health nurse who would refer a prisoner to a psychiatrist as opposed to a doctor. Doctor Wallace advised that he finds his psychiatric background very useful especially in dealing with prisoners who have drug and mental health issues. He advised that any new admissions or transfers to HMP Perth must be seen by a doctor who carries out a doctor risk assessment within 24 hours. On average he would see 10 to 15 prisoners a day, 4 days a week. He has carried out several thousand doctor risk assessments. Most of the time these assessments would be carried out in the morning. When he carries out an assessment he generally has the ACT book, previous medical records, the reception risk assessment and the nurse's medical notes. The assessment is not a full psychiatric assessment but a modified version. The assessment starts as soon

as an individual walks into the room. You are checking to see whether the individual is coherent, has good eye contact, good mood and is reactive. You assess their speech and ascertain whether there are any obvious psychotic symptoms. He always asks if they are on remand, expecting a sentence, have suicidal ideation or delusional ideas. It is a quasi-psychiatric assessment and that's how he conducts it. By asking those questions you can obtain a lot of information from an individual. Individuals give a lot away without knowing it. He confirmed that he has more perceptiveness due to his psychiatric background and his experience. Doctor Wallace further advised that just because an individual is depressed you would not necessarily assess them as "at risk". Doctor Wallace remembers Mr Perry, albeit not the consultation itself. The assessment took 45 minutes to an hour. If he had any concerns regarding Mr Perry then he would have placed him on ACT or spoken to the Mental Health Team. In examination in chief, Doctor Wallace was asked whether it is usual for individuals that are assessed as "not at risk" to then go on to take their own life. Doctor Wallace explained that the vast majority of people would not present in that way. They have to make a decision to commit suicide. It can be a stress reaction, mental health problems but quite often suicide attempts are impulsive and usually under the influence of alcohol. Mr Perry was however clear and concise. Doctor Wallace stated that he always errs on the side of caution and would place an individual on ACT, if required. When Doctor Wallace heard that Mr Perry had taken his own life the following Tuesday he was surprised as there was no suggestion that this was a likely scenario for Mr Perry. When a patient dies, it is practice for Doctor Wallace to look back at the notes to see what happened. On looking back at Mr Perry's notes Doctor Wallace noted that Nurse Baxter went to see Mr Perry on Friday 18 January 2013. There was nothing in Nurse Baxter's entry that raised any alarm bells. On cross examination by Mr Stuart, Doctor Wallace confirmed that Nurse Baxter is a good and very experienced nurse. She has a lot of experience in dealing with prisoners with mental health problems.

On being questioned by his Lordship, it was put to Doctor Wallace that if a prisoner told him about their offence is that a relevant factor. Doctor Wallace advised that an individual's offence is not relevant to the assessment. His Lordship asked whether he had seen the letter from the Procurator Fiscal. Doctor Wallace stated that he was shown a copy of the letter last year. On cross examination by Mr Williams, Doctor Wallace was asked whether there was anything that could have been done differently to save Mr Perry. Doctor Wallace stated that it might have been better for Mr Perry to have been seen by the Mental Health Team. On questioning by his Lordship, he asked whether sight of the Procurator Fiscal's letter at the time of his consultation would have had any bearing on his assessment. Doctor Wallace confirmed yes, he may have done a number of things such as:

- Placed Mr Perry on ACT
- Spoken to the Mental Health Team to review him
- Discussed the terms of the letter with Mr Perry and asked him more questions.

Doctor Wallace did however accept that it is very difficult to speculate what route he would have taken. He would not have looked at the letter in isolation. Much would depend on what further information came out of questioning Mr Perry. The next step would have been dependent upon Mr Perry's answers. On cross examination by Mr Cahill, it was put to Doctor Wallace that his assessment of Mr Perry was thorough. Doctor Wallace confirmed that it was. He had no concerns with regard to Mr Perry in respect of suicidal ideation, thoughts of self harm or other risks. He could not say whether he would have placed Mr Perry on ACT immediately; only that he would have asked further questions. Doctor Wallace accepted that he did not know what Mr Perry would have said in response to the questions. He cannot speculate on what he would have done. On cross examination by Ms Phillips, it was put to Doctor Wallace that if he had referred Mr Perry to the Mental Health Team or a psychiatrist he could have refused to see them. Doctor Wallace accepted that.

[68] **Witness 20: Prison Officer, Kevin Sclater** - His evidence is that he is a prison officer employed by the SPS based at HMP Perth. He has 23 years' experience. He is ACT trained. In examination in chief, he explained that with every new admission, they are allocated a cell, provided an admissions pack and there is a brief discussion of how the hall regime works. On Wednesday 16 January 2013, Mr Perry was located in A Hall (first night centre) and then moved to B Hall the following day (Thursday). All new admissions spend their first night in the first night centre. They are assessed with regard to how they are feeling, whether they are vulnerable and have any immediate issues that need to be dealt with. Every prisoner requires to attend an induction session. At induction every prisoner is given a brief outline about the prison regime. On Friday 18 January 2013 at around 08.30 hours, Officer Sclater spoke to Mr Perry in his cell about attending induction. Mr Perry asked whether he required to attend and Officer Sclater said yes. The induction was due to start at 08.45 hours. At most his conversation with Mr Perry lasted about 5 minutes. When speaking to Mr Perry, he had no concerns. He was clear and concise as to what he was asking about and answered sensibly when Officer Sclater spoke to him. There was nothing in Mr Perry's demeanour which would have caused Officer Sclater to have placed him on ACT. Officer Sclater stated that if there were any issues raised at induction then the person conducting the induction would telephone the hall and advise them. So for example, if a prisoner attended induction and was expressing that he was going to self harm or commit suicide then that would be communicated to the hall staff and the prisoner would be placed on ACT. There were no concerns raised following Mr Perry's attendance at induction. Officer Sclater stated that on Friday at lunchtime, Mr Morrison approached him and asked whether he could move cells as he was not getting on with Mr Perry. He responded by saying "Let me get finished serving lunch and then I will then deal with it". He did not make any further enquiries as to why they were not getting on. Officer Sclater was clear in his evidence that Mr Morrison did not

tell him that Mr Perry said that the TV was speaking to him. There was no mention of any strange behaviour. Officer Sclater further confirmed that asking to be moved to another cell is a frequent request by prisoners. If prisoners are not getting on then it is best to move them. Officer Sclater confirmed that no other prisoner approached him with regard to Mr Perry. In examination in chief, it was put to Officer Sclater that Darren Byrne in evidence stated that he told him that Mr Perry should be placed in a suicide cell. Officer Sclater could not recall that and does not remember who Darren Byrne is. Officer Sclater further confirmed that Mr Perry asked to use the phone after he had the conversation with Mr Morrison. There was no change in his demeanour and he was not apprehensive. When Officer Sclater finished serving lunch he told Mr Morrison that he could move cell. At around 13.45/14.00 hours that day he received a telephone call from Richard Geddes. Mr Geddes told him that Mr Perry's mother had been on the telephone and she was concerned that he was not making much sense and that he may have taken something. Mr Geddes did not tell him that Mr Perry's mother had concerns regarding him being suicidal or at risk of self harm. Mr Geddes asked him to speak to Mr Perry. As soon as he came off the phone he communicated the content of the phone call to Officer Agnew. He then went to see Mr Perry in his cell. Mr Perry was lying on the top bunk, on his stomach, his head towards the TV. He asked Mr Perry how he was and Mr Perry looked up. Mr Perry replied that he was fine and asked why he was asking. Officer Sclater told Mr Perry that his family had been on the telephone and they were concerned. Mr Perry's response was "No I am fine". Officer Sclater's evidence was that Mr Perry was not annoyed. He noticed that Mr Perry had a west coast accent and asked where he was from. Mr Perry told him that he was from Greenock, had been lifted by the police for being in possession of a knife and was up in court on Tuesday. Mr Perry told him that he would probably be remanded for a further period. Officer Sclater asked Mr Perry whether he had taken anything and he said no, only tramadol outside.

Officer Sclater asked him why he had not moved to the bottom bunk and he replied that he would move down later. Officer Sclater's impression was that Mr Perry was relaxed. There were no signs that he had taken anything as he was clear and concise when he spoke to him. If he had been under the influence, then Officer Sclater would have put him on observations. He had no concerns regarding Mr Perry and that is the reason why he did not place him on ACT. Officer Sclater went back to the desk and told Officer Agnew about his conversation with Mr Perry. Within 20 to 30 minutes, Nurse Catriona Baxter was in the hall. Officer Sclater asked Nurse Baxter to talk to Mr Perry. Although he was not concerned about Mr Perry he wanted to make sure that he had not missed anything. Nurse Baxter was an impartial person and he wanted to see whether she could gain any further information from Mr Perry. Officer Agnew accompanied Nurse Baxter to Mr Perry's cell. At the time Officer Sclater was 10 yards away at the hall desk. Nurse Baxter reported to him that she found Mr Perry to be a bit apprehensive but he was clear and concise. Officer Sclater first heard about Mr Perry taking his own life when he received a telephone call from his manager on Sunday 20 January 2013. He was shocked to hear the news. Officer Sclater's evidence is that he was satisfied with the way that he dealt with Mr Perry and with hindsight would not have done anything differently. On cross examination by Mr Williams, it was put to Officer Sclater, that Mr Morrison's evidence is that he asked to move cell around mid-morning on the Friday. Officer Sclater stated that Mr Morrison first spoke to him regarding moving cell whilst he was in lunch queue. Again Mr Williams put to Officer Sclater that other prisoners spoke to him with regard to how Mr Perry was acting. Officer Sclater disputed that. There was nothing that stood out in relation to Mr Perry. He was not showing any signs of withdrawing. He was clear, concise in his speech and appeared relaxed. In cross examination by Mr Cahill, it was put to Officer Sclater that we had heard evidence that a prisoner spoke to him on the Thursday 17 January 2013 regarding Mr Perry. Officer Sclater confirmed that is

incorrect as he was not working on the Thursday. He further confirmed that Mr Geddes did not tell him anything about the TV talking to Mr Perry. Officer Sclater gave his evidence in a clear and concise manner. He was both credible and reliable and in my submission his evidence should be accepted over Mr Byrne, Mr Morrison and Mr Davidson.

- [69] **Witness 21: Nurse Catriona Baxter** - Her evidence is that she is currently employed by the NHS at Murray Royal, Hospital, Perth as a staff nurse. She has 11 ½ years' experience working as a nurse. She is ACT trained. She left HMP Perth in December 2015 after working there for 6 ½ years there. She explained that the nursing team at HMP Perth work the following shifts: early shift – 07.00 hours to 13.30 hours, backshift – 13.30 to 21.00 hours. At the weekend, nurses work from 08.00 hours to 18.30 hours. There is an on call doctor for HMP Perth. She confirmed that HMP Perth has a Mental Health Team which works Monday to Friday from 08.00 hours to 16.00 hours. They work on a self-referral system. All hall, nursing staff and doctors can also refer. In examination in chief, Nurse Baxter stated that she remembers having a conversation with Officer Sclater on Friday 18 January 2013. At around 14.00 hours, she attended B hall to dispense medication. Officer Sclater approached her and advised that he had received a telephone call from a social worker and that Mr Perry's mother had raised concerns. Officer Sclater advised her that he had already spoken to Mr Perry and that he had no concerns but asked that she speak to him again. Officer Agnew took her to Mr Perry's cell. When she arrived at the cell it was in darkness and the TV was on. Mr Perry was lying on the top bunk. The sound of the TV was off. She explained that there is nothing unusual about that as sometimes prisoners like to sleep in the late afternoon. When she entered the cell, Mr Perry sat up. She told Mr Perry that she wanted to have a word with him. Officer Agnew remained outside the cell door. Nurse Baxter's evidence is that she asked Mr Perry if there was anything wrong, whether he was hearing voices or had any concerns. Mr Perry answered no. She stated that Mr Perry was exhibiting good

body posture, maintained good eye contact and was clear and concise in his conversation. He did not appear nervous or on edge and there was nothing of concern. Those factors give you an indication of how a person is feeling. Nurse Baxter advised Mr Perry that if he had any issues then he could contact the nursing or hall staff at any time. The conversation lasted around 5 minutes. Nurse Baxter stated that she did not place Mr Perry on ACT as she had no concerns. It was an unremarkable conversation. If she had any concerns with regard to Mr Perry then there are two options open to her (1) refer him to Mental Health or (2) place him on ACT. When she heard that Mr Perry had taken his own life she was shocked. However she is satisfied that she did not miss anything. On cross examination by Mr Williams, she was shown a copy of the Procurator Fiscal's letter (Crown Production 5). She confirmed that she had not seen that letter. She found the terms of the letter surprising given her interaction with Mr Perry as he appeared to be normal. Mr Williams asked, with hindsight, is there anything else that she would have done differently. Nurse Baxter confirmed no. If she had sight of the Procurator Fiscal's letter she would have challenged Mr Perry about the contents of the letter but whether she would have placed him on ACT would really depend upon the responses from Mr Perry. If Mr Perry had reassured her enough then she would still have no concerns. The letter alone would not be sufficient to have placed Mr Perry on ACT. On questioning by his Lordship, Nurse Baxter confirmed that she was asked to see Mr Perry because there were concerns regarding his mental health not because he taken drugs. During her time at HMP Perth she was regularly asked to see prisoners who had taken substances. She explained that you look to see how alert an individual is and the size of their pupils. You also look at them physically, how they are presenting and their speech. She recorded the interaction on VISION (Crown Production 6) she believes on the Sunday 20 January 2013. If she thought that Mr Perry had taken drugs the entry in VISION would have been different. It would be more focused on presentation and

whether she thought Mr Perry had taken drugs. She explained, that when entering information on VISION it is a combination of what you remember and possibly things that you have written down. On cross examination by Mr Stuart, she was referred to Crown Production 6 page 39 of the medical notes and asked whether the entry reflects her assessment of Mr Perry. She confirmed that it did.

Saturday 19 January 2013

[70] **Witness 22: Prisoner Officer Peter Ward** - Mr Ward's evidence is that he is employed by the SPS as a prison officer based at HMP Perth and has 24 years' experience. He has been working in B Hall for approximately a year. B Hall is a remand hall but at times there is an overspill and convicted prisoners are accommodated there. In examination in chief, he stated that on Saturday 19 January 2013 he was working on the ground floor level of Hall B. Lunch is served at around 11.15 hours and at most it can take 15 to 20 minutes. Thereafter plates are removed and prisoners are locked in their cells. He remembers collecting a plate from Mr Perry's cell. When he entered the cell, Mr Perry raised his head and acknowledged he was there. He removed the plate and closed the cell door. Officer Ward explained that once the plates are collected there is a numbers check and staff then have their lunch. During that time prisoners are locked in their cells between 12.00 and 14.00 hours. Thereafter the cells are opened up for exercise. Exercise is from 14.00 to 15.30 hours. If prisoners opt out of exercise they are allowed free association into each other's cells. On that day, within 25 to 30 minutes it started to snow and the prisoners were brought back into hall. From what Officer Ward remembers, Mr Perry did not opt for exercise that day. He made no further enquiry about that as this is a common occurrence. Officer Ward brought the prisoners back into B Hall at around 14.55 hours and thereafter there was open association which allows prisoners to have showers, make telephone calls and speak to other prisoners. As he was locking up for teatime, he was approached by Mr Morrison who said that he had left his kit bag

in Mr Perry's cell. He unlocked the cell and opened the door. He saw Mr Perry lying on the floor, underneath the bed frame. His legs were in the centre of the floor and his torso under the bed. He spoke to Mr Perry but got no response. Officer Ward entered the cell and looked underneath the bed and realised that something was seriously wrong. The whites of Mr Perry's eyes were dark in colour and his face was grey/blue. He left the cell and called a Code Blue. He then returned to the cell and pulled Mr Perry from underneath the bed into the centre of the cell. Mr Perry's head was facing the door. Officer Rennie attended and they were about to commence CPR when they noticed a tied ligature around Mr Perry's neck. Officer Rennie cut the ligature and within minutes a number of medical staff was in attendance at the cell. Officer Ward noticed a ligature tied around the top of the bunk. Officer Ward accompanied Mr Perry in the ambulance to hospital. On the way to hospital Mr Perry went into cardiac arrest. The paramedic commenced chest compressions and continued until they reached hospital. Officer Ward was shown CCTV footage for Saturday 19 January 2013. At 14.22.50 hours Officer Ward is seen going into Mr Perry's cell. Mr Ward confirmed he asked Mr Perry whether he wanted to go out for exercise. At 14.23 hours Mr Perry is seen coming out of his cell, going back in and then goes back out to use the telephone. He is seen on the telephone at 14.24 hours. At 14.25 hours Officer Ward is seen to walk past Mr Perry. At 14.25 hours Mr Perry slams the phone down. Officer Agnew places the phone back on the cradle. At 14.26 hours, Mr Perry closes his cell door.

- [71] **Witness 24: Nurse Gail Livingston** – Her evidence is that she is employed by the NHS and works as a staff nurse at ward 6 at Perth Royal Infirmary. She previously worked at HMP Perth but left in January 2014. She worked at HMP Perth for around 2 years. She has been qualified as a nurse for the past 7 years. In examination in chief, she advised that on Saturday 19 January 2013 she was working from 08.00 hours to 18.00 hours. She had just entered B Hall to do the afternoon medication when she heard shouting and someone asking for a nurse.

She then heard a Code Blue and went to Mr Perry's cell. She saw Mr Perry on the floor and he still had a ligature around his neck. He was cyanosed, and his head was swollen. Nurse Livingston took his pulse. There was no pulse and he was not breathing. She touched him and he was still warm and flexible. She and another nurse commenced CPR. She could not recall whether Mr Perry's eyes were open. She thought he was dead when she first entered the cell. They carried out CPR as per protocol and continued until the paramedics arrived. They stopped every so often to feel for a pulse. They felt a femoral pulse albeit, output was poor.

[72] **Witness 25: Paramedic Amanda Storer** – Her evidence is that on Saturday 19 January 2013, the ambulance service received a call at 15.52 hours to attend HMP Perth. The ambulance arrived at HMP Perth at 15.58 hours. When she attended to Mr Perry he was cyanosed and unresponsive. She checked for a pulse and attached monitor leads which confirmed a pulse. It was agreed that they would transfer Mr Perry to hospital. They mobilised Mr Perry by placing him on a trolley and then transferred him into the ambulance. She was in the back of the ambulance with Officer Ward. They arrived at the hospital at approximately 16.29 hours. During the journey, Mr Perry started to deteriorate and she required to commence CPR. Mr Perry's colour was changing and the rhythm changed to a flat line. Mrs Storer did not expect the situation to change and she did everything that she could have done. It was no surprise to her that Mr Perry passed away.

[73] **Witness 26: Chief Inspector Gordon Milne** - Chief Inspector Milne's evidence is that he is employed by Tayside Police at Divisional HQ in Dundee. He has 27 years' service. In examination in chief, he explained that John Vine introduced a pilot project in conjunction with the NHS Tayside to provide custody nurses. It was a nurse led service in based in Dundee. The pilot with the NHS was Government supported. He first became involved in October 2009 when he conducted a review. In 2009 the NHS provided funding to provide nurses in

Dundee to support a network of doctors. The pilot was deemed to be a success and the current model was rolled out and is the current regime. As at January 2013 there were two nurses based in Dundee that could be contacted for advice 24 hours a day, 7 days a week. The nurses who are on duty are seen as a gateway to a further medical assessment. There is an option to be seen by the doctor but quite often the nurse will phone the doctor. He explained that a common reason for doctors and nurses to travel to Perth or Arbroath is to medicate prisoners. That responsibility has now been taken away from the custody sergeants. A decision was made to locate the nurses in Dundee as Dundee has a higher number of individuals than Arbroath or Perth. There are 12500 individuals taken into custody per year. 58% of those are Dundee, 24% in Perth and 18% in Arbroath. The whole process is centralised and travelling time is fairly precise. Mr Milne confirmed that the model is successful. There is now round the clock on call medical advice. The nurses have access to information through the NHS database. Nurses can obtain GP contact details and access full medical records. Mr Milne confirmed that there is now a bank of 12 nurses providing this service and a doctor is always on call. With regard to who has the final say as to whether a doctor should attend a police station to carry out a fitness to plead assessment is ultimately a decision for the doctor. If a sergeant is unhappy about a doctor's decision then they can refer to the duty inspector or take the individual to hospital. That however would be the exception to the rule. Mr Milne explained that it would always have been open to Sergeant Assenti to have taken Mr Perry to hospital if that was deemed appropriate. He advised that the custody officer plays an important role. Sergeant Assenti needed to ensure that (1) Mr Perry was being lawfully held (2) the paperwork was in place and (3) he was satisfied that he had no concerns regarding Mr Perry's fitness to appear in court. In cross examination by Mr Williams, he was asked, whether there was anything that could have been done differently with regard to Mr Perry. Mr Milne confirmed that in January 2013 there was a system in place which

functioned. Decisions had to be made by Doctor Sadler, the nurse, the procurator fiscal and Sergeant Assenti. They are all judgement calls. In cross examination by Mr Stuart, it was put to him that under the previous system, if a sergeant wanted to speak to a doctor that may not happen immediately or a doctor may not be in a position to attend the police station. Mr Milne confirmed that was correct and that could lead to delay. Mr Milne in cross examination, further accepted that there are multi agency divisions. A sergeant, a procurator fiscal, a nurse, Doctor Sadler and a solicitor can all raise concerns. The court also has a duty. There is layer upon layer of protection for individuals. On being questioned by his Lordship, Mr Milne confirmed that if a custody sergeant is not happy with the recommendations given by the medical staff at Dundee then they can make their own decision but only if the chief inspector is notified. His Lordship summarised that the main aim and function of the system is to protect the welfare of prisoners in police custody. Mr Milne confirmed that was correct, and stated that when an individual is handed over to G4S to appear at court, that brings the role of the police to an end insofar as the individual's welfare is concerned.

- [74] **Witness 27: Derek Pirie -** His evidence is that he was previously employed by the SPS as a residential unit manager at HMP Perth. He has 36 years' service but is now retired. His role was to ensure that staff and first line managers carried out their duties correctly. In examination in chief, he confirms that on Saturday 19 January 2013, he was working from 08.00 hours to 18.00 hours. He was in charge of the prison that weekend. He recalls hearing a Code Blue in B hall. The Code Blue was broadcast over the radio throughout the prison. He immediately attended at Mr Perry's cell. When he arrived, the first line manager was outside the cell and there were at least two other prison officers' present and nursing staff. He was told that Mr Perry had tried to hang himself. Mr Perry was attended to by paramedics and taken by ambulance to Perth Royal Infirmary. His role that day was to ensure that the cell was sealed, the Governor notified as

well as SPS HQ. He advised that he tried to contact Mr Perry's relatives to notify them but could not obtain a telephone number for the next-of-kin. He notified the police and asked that they make contact with the next-of-kin. He explained that following a suicide in prison, an internal investigation is carried out called a SIDCARR. He led the SIDCARR review. He was shown a copy of the PER form (Crown Production 2). He confirmed that a high number of prisoners have psychiatric conditions when they enter prison. With regard to the entries of erratic behaviour on the PER form, he advised that he was not particularly concerned about those entries. As part of the SIDCARR investigation he reviewed the ACT documentation and the Procurator Fiscal's letter which he located in the central office within the reception area. In cross-examination he was asked, whether the content of the Procurator Fiscal's letter gave him concern. He advised that the term "bizarre demeanour" did give rise for concern but conceded that the main thrust of the letter was in relation to Mr Perry banking drugs. As part of his investigation, he spoke to the reception Officer Peter Lee. Officer Lee was adamant that Mr Perry presented as no cause for concern. Mr Pirie had no difficulty in accepting that it was appropriate for Officer Lee to assess Mr Perry as "not at risk". Mr Pirie was shown a copy of the SIDCARR report (Crown Production 35 – page 646). He explained that following a death in custody all information is collated and all the deputy heads and staff who are involved in the death are called to a meeting. The purpose of the meeting is to highlight any deficiencies and to discuss what improvements can be made. Mr Pirie confirmed that he took the minutes of the meeting and then completed the first draft of the SIDCARR report. The SIDCARR report is then sent to the Governor to make any amendments. The SIDCARR is then circulated to all the individuals involved in the death and then there is a further meeting to discuss the final report. He confirmed that the NHS has their own internal review. With regard to one of the points raised, he advised that Mr Geddes, the social worker, should have telephoned Pauline McLaughlin back to advise of the

action he had taken. Mr Geddes himself accepted this in evidence. Mr Pirie further advised that in terms of the information he collated there was nothing to suggest that Mr Perry would self harm or commit suicide. If Mr Perry had been placed on ACT on either 16 or 17 January 2013 and if he continued to present well, then in all likelihood he would have been taken off ACT within 24 hours. On cross examination by Mrs Docherty, Mr Pirie stated that there was an error in the SIDCARR report at page 662 in relation to "This document was viewed by reception and nursing staff". His position was that the Procurator Fiscal's letter was not shown to NHS staff on reception. On cross examination by Ms Phillips, Mr Pirie accepted that the SIDCARR investigation was thorough. In attendance at the meetings was Nurse Duncan who carried out the healthcare risk assessment. It was put to him by Ms Phillips, that it is somewhat surprising that no individual picked up on this error. He accepted that he may be mistaken in saying that the Procurator Fiscal's letter was not shown to the reception or nursing staff.

- [75] **Witness 28: Lesley McDowall** - Her evidence is that she is employed by the Prison Service as the Health Strategy and Suicide Prevention Manager. Mrs McDowall is the prison service's Suicide Prevention Lead. She has held this role since 2010 prior to which she has, among other things, been in charge of healthcare at HM Prison Cornton Vale. She qualified as a registered nurse in 1996 and has worked for the SPS since 1997. She has unrivalled experience of the ACT regime and has provided core ACT training since 1998. She has recently been working with partner agencies with regard to the SPS suicide risk management strategy. She is responsible for reviewing every death in custody. In examination in chief, she explained that there is an internal learning review within 8 weeks of every death in custody. This is now known as DIPLAR, previously SIDCARR. Where possible she will attend all DIPLAR meetings to obtain an overview of all the deaths in custody. When carrying out the DIPLAR review you look at all the information available. Mrs McDowall advised that she

receives every sheriff's determination following a Fatal Accident Inquiry. If there are any recommendations, then she will liaise with the prison to ensure the action points are implemented. She explained that the current suicide risk management strategy called ACT2CARE was implemented in 2003 and reviewed in 2006. For the last two years there has been an ongoing review of the ACT2CARE strategy. Mrs McDowall explained that a new suicide risk management strategy will be implemented in December 2016 and renamed "Talk to Me". There has been input from NHS Healthboards, Families Outside, Samaritans, Choose Life and Breathing Space. All these groups have worked with the SPS to assist in writing the new strategy. The new strategy will remove the doctor risk assessment from the process. An individual will no longer be assessed by a doctor within 24 hours of admission to prison. She explained that the doctor has been removed from the process following an internal review. She audited over 1,000 risk assessments and no doctor placed any individual on ACT. As result, a view was reached that there was no benefit in having a doctor review an individual. She explained that currently all staff are undergoing training. Currently all staff has to attend a full day's training course in ACT with an annual refresher course. Any member of staff who has access to a prisoner must be trained in ACT. Mrs McDowall advised that when completing the ACT documentation, this should form part of an interview with the individual. The person who is interviewing must ask open ended questions to establish a relationship. When assessing an individual you also take account of any other additional information. She explained that if an individual is assessed as "at risk" at reception then an ACT book is opened up and reasons are recorded as to why the individual is placed on ACT. An immediate care plan is then prepared and a case conference is arranged within 24 hours. At times a case conference can be held immediately. All staff are encouraged to err on the side of caution. Should they have any concerns regarding an individual then they should place the individual on ACT. She further explained that if a prison officer on reception has

any concerns then they should pass that information on to the nurse who is carrying out the healthcare risk assessment as individuals tend to divulge more information to them especially if they are on medication. Mrs McDowall was referred to the Procurator Fiscal's letter (Crown Production 5). She confirmed in her view that the letter would not have altered the prison officer or nurse's assessment with regard to Mr Perry. There is nothing recorded on the ACT documentation which would suggest that Mr Perry should be placed on ACT. Furthermore there was nothing in the Procurator Fiscal's letter to indicate that Mr Perry was at risk of suicide or self harm. Mrs McDowall accepted that an individual should be removed from ACT at the earliest opportunity. If an individual is presenting as no risk then staff are advised to remove them from ACT. Mrs McDowall was referred to Crown Production 36, a document headed up "Rates of Death by Suicide in Custody in Scotland" dated 15 December 2014. She confirmed that she prepares this report on an annual basis and this is submitted to the National Risk Suicide Management Group. She advised that the number of deaths by suicide in custody in Scotland has remained fairly static for 10 years with between 6 and 10 deaths by suicide per year. The figures for 2015 are 4 deaths in custody. She advised that the approximate annual number of prisoners entering the Scottish Prison estate is 26,000. There are around 8,000 prisoners in the Scottish prison estate at any one time. The number of self harm incidents annually equates approximately to between 1.5 and 2% of the total annual prison population. She confirmed that these statistics demonstrate that the SPS suicide risk strategy is working. This strategy keeps people safe. If you compare the statistics to England, Scotland has remained static whereby there has been a significant increase in deaths in custody in England. In cross examination by Mr Stuart, Mrs McDowall was asked whether it would be practical for a psychiatrist to carry out the healthcare risk assessments. Mrs McDowell confirmed it would not be practical given the length of time an interview would take. For example at HMP Barlinnie you may have up to 70

admissions per night. If every prisoner was interviewed by a psychiatrist then there would be a back log and delays in processing prisoners. She further advised that the SPS has consulted with the Mental Welfare Commission in respect of this point and their position is that there is no requirement for a psychiatrist to form part of the healthcare risk assessment process. This would not reduce the number of suicides.

Evidence was led from Mrs McDowall in relation to the new prevention of suicide in prison strategy called "Talk to Me" referred to in the introduction of these submissions.

[76] **Witness 29: Dawn Quigley** - Her evidence is that she is currently employed by the NHS and is head of prison nursing based at HMP Perth. She has held that post for the past two years and is responsible for the nursing teams at HMP Perth and Castle Huntly. In examination in chief, she explained that there are 2500 admissions to HMP Perth per annum and between 200 to 250 admissions per month but this can vary. Currently the prison population at HMP Perth is 640. HMP Perth receive admissions Monday to Friday from 12.00 to 20.00 hours. It is the policy of HMP Perth that all admissions are seen by a nurse within 4 hours. Currently the primary care nursing team comprises of 16 registered nurses with 3 mental health nurses in post. Nursing coverage is 24/7. The nursing team work 365 days per annum from 07.00 to 21.30 hours. The Mental Health Team work Monday to Friday from, 08.00 to 16.00 hours. She explained that the role of the general nurses is to assist with primary care, run clinics, triage or minor ailments, cover reception and provide emergency response. The Mental Health Team is responsible for carrying out mental health assessments, providing treatment and support planning. They are supported by the two psychiatrists who visit HMP Perth three times a week. With regard to mental health assessments, these include mild to moderate health conditions but can also include more complex conditions such as psychosis. The mental health nurse is responsible for following up care and making any referrals to the psychiatrist. She explained that prisoners access health care at HMP Perth by a self-referral

system. A prisoner can either speak to a prison officer who will self-refer or they complete a self-referral form. She further confirmed that all admissions to HMP Perth are conducted by a general nurse as opposed to a mental health nurse. She stated that it is better for a general nurse to carry out the healthcare risk assessment as opposed to a mental health nurse as both an individual's physical and mental status is assessed. Currently there are only three mental health nurses in post at this time. There is an opportunity to fill a fourth post but suitable candidates have not been forthcoming. She further confirmed that HMP Barlinnie and HMP Addiewell are all using general nurses to conduct the healthcare risk assessment. In cross examination by Mr Reid, she accepted that the national recruitment of mental health nurses is a problem across Scotland not just for the Scottish Prison Estate.

Discussion

[77] The Scottish Prison Service does not seek findings against any party to this Inquiry. I do not seek to make any substantial submissions in relation to the evidence heard prior to Mr Perry's admission to HMP Perth on the afternoon of 16 January 2013. My submissions will focus on Mr Perry's time in custody at HMP Perth for the period 16 to 19 January 2013.

[78] In my submission, the concerns or issues which were the main focus at the Inquiry which are relevant to the SPS are:

1) Should a mental health nurse or psychiatrist carry out the healthcare risk assessment?

In my submission, both the ACT2CARE and the new "Talk to Me" strategy state it is best practice for a mental health nurse to assess admissions as part of the reception risk assessment. The policy does not say it "must be" it states "it is best practice". Mrs McDowall in her evidence confirmed that it is best practice for a mental health nurse to carry out the assessment but that it is a matter for the NHS as opposed to the Scottish Prison Service. Mrs Quigley in her evidence

stated that a general nurse is more appropriate to carry out the reception risk assessment as both an individual's physical and mental status is assessed. Although Nurse Duncan is not a mental health nurse he has years of experience and is well versed in carrying out the reception risk assessments. Even if a mental health nurse had carried out the assessment in relation to Mr Perry, in my submission, that would not have made a difference. They would still have assessed Mr Perry as "not at risk". All the evidence suggests that Mr Perry was presenting well and there was nothing in his demeanour which would cause any individual to place him on ACT. In any event, no evidence was led as to how a mental health nurse would have conducted the reception risk assessment differently from a general nurse. With regard to a psychiatrist carrying out the assessment, in my submission that is neither appropriate nor practical. Mrs McDowall confirmed in evidence that the SPS has consulted the Mental Welfare Commission in respect of this point and their position is that there is no requirement for a psychiatrist to form part of the healthcare risk assessment process. A psychiatrist would not reduce the number of suicides.

2) Did Roderick Thompson communicate the contents of the Procurator Fiscal's letter to the medical and reception staff on the 16 January 2013?

In my submission, the evidence of Roderick Thompson should be accepted in that the content of the letter was communicated to the reception and medical staff. His evidence was unchallenged on this point. In hindsight however, Mr Thompson accepted that he should have made a copy of the letter and provided a copy to Nurse Duncan. The system has now changed in that all letters are now copied and placed in both the individual's prison and medical records.

3) If Nurse Duncan and Doctor Wallace had been provided with a copy of Procurator Fiscal's letter would that have had a bearing on their assessment of Mr Perry?

In my submission, even if they had been provided with a copy of the letter, they would still have assessed Mr Perry as "not at risk". The letter did not raise

concerns about Mr Perry being at risk of self harm or suicide. Mrs Cole specifically adapted the pro forma suicide letter to delete reference to Mr Perry being at risk of self harm or suicide as she had no concerns. The letter is not looked at in isolation. How an individual presents at interview is the paramount consideration. Nurse Duncan in evidence confirmed that the letter would not have made a difference to his assessment of Mr Perry. He had no concerns and Mr Perry was conversing well. There were no red flags. Like Nurse Duncan, Doctor Wallace carried out a thorough assessment of Mr Perry and spent 45 minutes to an hour with him. Doctor Wallace had no concerns and assessed Mr Perry as “not at risk”. Doctor Wallace stated that if he had seen the letter this would have prompted him to ask Mr Perry further questions. Depending upon the answers to the questions, he may have placed Mr Perry on ACT or referred him to the Mental Health team. However of importance, Doctor Wallace accepted that it is very difficult to speculate what route he would have taken. Much would depend on Mr Perry’s answers. In my submission, no one can second guess how Mr Perry would have responded and what course of action Doctor Wallace would have taken. To do so is mere speculation and this should be avoided. *Esto* even if Mr Perry had been referred to the Mental Health Team or to a psychiatrist, no evidence was led to suggest 1) whether Mr Perry would have consented to a mental health assessment and 2) if he had consented, whether he would be diagnosed with a mental health illness 3) and if so, what treatment or medication he would have been prescribed and whether this would have alleviated any alleged psychotic symptoms and ultimately prevented his death and 4) whether he would have been placed on ACT. No causal link can therefore be established.

4) Should Mr Perry have been placed on ACT during the period 16 to 19 January 2013?

In my submission during the period 16 to 19 January 2013, Mr Perry came into contact with a number of individuals namely: Sergeant Assenti, Mr Boyd, Mrs

Cole, his solicitor, Mrs Lindsey, Mr Cooper, Officer Appleby, Officer Lee, Roderick Thomson, Nurse Duncan, Doctor Wallace, the individual who carried out the induction interview, Officer Langlands, Officer Sclater, Officer Agnew, Officer Ward and Nurse Baxter. Not one person thought that Mr Perry was at risk of self harm or suicide. Of importance, Doctor Wallace has a psychiatric background and has years of experience spent. He spent up to 45 minutes to an hour interviewing Mr Perry on Thursday 17 January 2013. It was a very thorough interview and he had no concerns at all. There was conflicting evidence with regard to what information was communicated to Officer Sclater from Mr Geddes. Regardless of whether it was concerns in respect of Mr Perry's mental health or whether he was under the influence of drugs, the phone call prompted both Officer Sclater and Nurse Baxter to speak to Mr Perry in his cell. In my submission it makes no difference what the concerns were; as both Officer Sclater and Nurse Baxter are trained in ACT. In particular Nurse Baxter is well versed in dealing with prisoners who are under the influence of drugs. Given Mr Perry's presentation and demeanour, in my submission it would not have been appropriate to place him on ACT during his time in custody at HMP Perth. To put an individual on ACT is a matter of judgement that takes place in the dynamic environment of prison. It is important for prison staff to balance the personal freedoms of a prisoner against the need to protect the prison community (including the prisoner) from harm. It is therefore essential that restrictions upon freedoms are imposed only so far as "necessary" and not to stigmatise prisoners with excessive restrictions upon their liberties and treating them differently when it is not necessary to do so. *Esto* even if there was evidence to suggest (which is denied) that Mr Perry should have been placed on ACT, in my submission on the balance of probabilities it is more likely than not that he would have been removed from ACT by Saturday the 19 January 2013.

[79] In my submission, no evidence came out at this lengthy Inquiry which would support any finding under section 6(1) c, d or e; there is no reasonable precaution

identified which might have prevented Mr Perry's death nor was there a defect in any system of working identified which caused, or contributed to, the death. In order for a finding to be made under those subsections, it must be remembered of the need to be a causal connection between the precaution and the death in the case of (c). An identified defect in an existing system of working which "positively" (or on the balance of probabilities) caused or contributed to the death in the case of (d).

[80] Furthermore, in my submission there has been a policy change at HMP Perth in that all correspondence which accompanies the prisoner when they are admitted, is now copied and placed in both the prisoner and medical records which negates the need for any determination to be made under section 6 (1) (e), or for any recommendations to be made. There is no evidence to suggest that any "lessons learned" has not been implemented. There were, in my submission, no other facts adduced in evidence which were relevant to the circumstances of the death which ought to be subject to an (e) determination.

Proposed Findings

[81] I invite your Lordship to make the following findings:

Section 6(1) (a)

I respectfully submit that your Lordship can rely upon Crown Production 9 and determine in terms of section 6(1) (a) that the death occurred on the 23 January 2013 at 12.28 hours.

Section 6(1) (b)

Relying on the same production, I respectfully submit that the cause of death was ligature pressure on the neck (shoe laces) and invite your Lordship to determine same. The findings under subsections (a) and (b) are, in any event, a matter of agreement between the parties.

Section 6(1) (c)

In my submission, no findings should be made under this subsection.

Section 6(1) (d)

In my submission, no findings should be made under this subsection.

Section 6(1) (e)

In my submission, no findings should be made under this subsection.

Conclusion

[82] Mr Perry took his own life on 19 January 2013 at HMP Perth. Based on the evidence which was heard at the Inquiry, there was, in my submission, nothing which could have been done to prevent the death. As Sheriff Ruxton remarked in the Inquiry into the death of *Andrew Duthie* (supra), “there will always be prisoners who...give no indication that they are in crisis, display no outward signs that they are suicidal and whose actions are entirely unforeseeable.” Unfortunately in my submission this is such a situation.

[83] I conclude by mentioning the family of Mr Perry, in particular Pauline McLaughlin who listened to sometimes distressing evidence throughout the Inquiry. I offer my personal condolences, and the condolences of the Scottish Prison Service, to the entire family.

IN RESPECT WHEREOF

Sarah Phillips

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SAN/SPS0001.105

SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT PERTH

SUBMISSIONS

on behalf of Dr David Sadler

in causa

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

INTO THE DEATH OF

JOHN PERRY

In light of the evidence lead at the Inquiry and having considered the submissions thereon of the Crown and of all other parties to the Inquiry, submissions on behalf of Dr David Sadler are brief.

Submissions

It is respectfully submitted on behalf of Dr David Sadler that the learned Sheriff should set out the following circumstances in his findings in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, section 6:

s6(1)(a) Where and when the death and any accident resulting in the death took place:

- (i) That Mr Perry died at Perth Royal Infirmary on 23rd January 2013 at 12.28pm;
- (ii) That this was a direct result of his attempt to take his own life on 19th January 2013 in cell B1/04 of HMP Perth.

s6(1)(b) The cause or causes of such death and any accident resulting in the death:

The cause of death was certified in the Post Mortem examination as ligature pressure on the neck (shoe lace);

- (i) The cause of this was Mr Perry's attempt at suicide by tying a shoe lace tightly around his neck on 19th January 2013.

s6(1)(c) The reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided:

- (i) That there are no reasonable precautions that could have been taken by Dr Sadler whereby the death might have been avoided. Any involvement of Dr Sadler was limited to ascertaining whether Mr Perry could understand the court procedure and was able to appear at court. A physical examination by him was deemed unnecessary when he was able to instruct his solicitor and the court (procurator fiscal and presiding Sheriff) was satisfied of his understanding. It is therefore most likely that had Dr Sadler met with Mr Perry he would have concluded that he was fit to plead and the matter would have progressed in the same way that it did.
- (ii) That there are no reasonable precautions that could have been taken by Dr Sadler whereby the accident or suicide might have been avoided. He was able to assess Mr Perry in Dundee in the morning or to attend Perth later in the day but was not called upon to do so.

s6(1)(d) The defects, if any, in any system of working which contributed to the death or any accident resulting in the death:

- (i) There were no defects in any system of working which contributed to the death. The system for medical assistance and examination at police stations was working with no defects. Mr Perry refused to be seen initially albeit could have been seen in Dundee that morning. Dr Sadler could then also have attended at Perth later in the day and was not called upon to do so due to the concerns for Mr Perry's understanding having diminished. The system of working adopted by Dr Sadler was not defective;
- (ii) There were no defects in any system of working which contributed to the accident or suicide which resulted in the death for the reasons stated above. It operated as it was intended to.

s6(1)(e) Any other facts which are relevant to the circumstances of the death.

There are no other facts which are relevant to the circumstances of the death.

Summary

1. Introduction

- 1.1 The Inquiry into the death of Mr Perry investigated the process of Mr Perry presenting at Perth Police Office on 15 January 2013; his arrest and detention there; followed by his court appearance at Perth Sheriff Court on 16 January

2013; his admission to Perth Prison, and the happenings therein on the lead up to his attempt at taking his own life on 19 January 2013.

- 1.2 As far as the submissions on behalf of Dr Sadler are concerned, these will be limited only to events at the police station and at Perth Sheriff Court when he was involved in matters in his capacity as Police Casualty Surgeon, or Forensic Medical Examiner as the position was also referred.

2. Events at Perth Police Office

- 2.1 The Inquiry heard that Mr Perry presented himself at Perth Police office on 15th January 2013 at around 5pm. He requested to speak with CID and whilst doing so produced a knife from his bag.
- 2.2 Mr Perry was arrested and ultimately charged with contraventions of section 49(1) of the Criminal Law (Consolidation)(Scotland) Act 1995, for possession of this knife, section 5(2) of the Misuse of Drugs Act 1971, for possession of cannabis, and of section 41(1)(a) of the Police (Scotland) Act 1967 for resisting arrest.
- 2.3 There was evidence heard of Mr Perry behaving in an erratic and bizarre manner throughout the evening of 15th January 2013. There was also a concern that he may have been banking drugs. As such, Sergeant Assenti made contact with Nurse Rowe and with Dr David Sadler, based at Dundee, in order to arrange for Mr Perry to be examined for 'Fitness to Plead.'

- 2.4 Dr Sadler gave evidence to the Inquiry on 30th March 2016 and it is submitted that he was both credible and reliable.
- 2.5 Dr Sadler advised that he was engaged in autopsy work on the morning of 16th January 2013 and requested that Mr Perry be brought to Dundee to have the Fitness to Plead examination conducted.
- 2.6 Dr Sadler was unable to attend at Perth Police Office at that moment in time however gave evidence that he advised the Sergeant that, if the need still existed, he could attend later in the morning or early in the afternoon. This is also confirmed in Production number 2 for Tayside Health Board, Custody Nursing Records. These were read to the Court during Dr Sadler's evidence.
- 2.7 Sergeant Assenti was unhappy about having to take Mr Perry to Dundee due to logistical concerns and his demeanour however confirmed that if it had to be done it would have been.
- 2.8 Sergeant Assenti gave evidence that it was an unusual request for them to attend at Dundee however this was contradicted by Charmaine Gilmartin (Procurator Fiscal Depute), Dr Sadler, Mark Cooper (G4S) and Chief Inspector Gordon Milne who all indicated it was a regular and normal procedure for prisoners to be taken to that centralised location for medical examinations. Dr Sadler indicated that at that time it was the preferred option, to have prisoners seen centrally as it was quicker and more efficient due to other duties that he required to perform (autopsy). Sergeant Assenti's evidence about Dr Sadler's refusal to attend Perth is also contradicted in a similar way. It is submitted that

Sergeant Assenti's evidence cannot be relied upon in this regard and that Dr Sadler's evidence should be preferred.

2.9 Mrs Gilmartin was concerned on reading the Police Report received by her on Mr Perry's case and contacted the police to query the matter. She was advised by Sergeant Assenti that although Mr Perry's demeanour had improved overnight, he was to be taken to Dundee for a fitness to plead examination to be 'on the safe side'. He advised that a possible explanation for his behaviour could be that he was attempting to smuggle drugs into prison. (Crown Production number 35)

2.10 In any event, Mr Perry refused to leave his cell to be taken to the examination and Sergeant Assenti did not press this further. He left it at that and decided to discuss the matter with the Procurator Fiscal.

2.11 Sergeant Assenti then made further contact with Dr Sadler advising him of this development. He also advised Dr Sadler of the improvement in Mr Perry's demeanour overnight. Given the information provided in relation to the potential banking and influence of drugs, Dr Sadler opined that Mr Perry could have been under the influence of drugs when he first appeared at the police station and the improvement in his demeanour could be due to the substance wearing off.

2.12 This information was also conveyed to Mrs Gilmartin who decided that a fitness to plead assessment was not necessary. This appears as a note contained within Crown Production number 35.

2.13 Mr Perry was transferred to Perth Sheriff Court at 10.25am according to the information noted on his Personal Escort Record (PER), Crown Production number 3.

2.14 Dr Sadler heard nothing further about the requirement for a 'Fitness to plead' examination. His understanding had been that if there was any concern about Mr Perry, he would be returned to the cells for Dr Sadler to see him. Had he been willing to be assessed and had been brought to Dundee that morning he would have been seen prior to being taken to Perth Sheriff Court.

2.15 If a person refuses to be seen by a Police Casualty Surgeon whilst in police custody he cannot be forced to do so.

3. Events at Perth Sheriff Court

3.1 Mr Perry was received by G4S at Perth Sheriff Court on 16th January 2013.

3.2 The Inquiry heard from witness Mrs Gilmartin that he was kept in a separate cell and handcuffed due to the concern that he may have been banking drugs.

3.3 Mr Perry was not kept on constant observations by G4S, as Mark Cooper indicated that there was nothing on the PER to state that he should be, and there was nothing in Mr Perry's demeanour that day to change their mind on that. Had there been anything, it would have been noted.

3.4 Mrs Gilmartin's concerns about Mr Perry from her reading of the police report and considering the unusual circumstances of the offence (that he walked into the police station with a knife), were two-fold:

- (a) That there may be a reason he wanted to be remanded in custody, it was suspected he was banking drugs to take in with him;
- (b) Behavioural concerns, he was described as irrational, paranoid and aggressive.

- 3.5 She therefore attended court to see Mr Perry herself as a 'third check', having spoken to Sergeant Assenti and he to Dr Sadler. She advised that the obligation is on her to see if he is fit to go through court.
- 3.6 Mrs Gilmartin spoke with G4S who had no concerns; and with Mr Perry's defence agent, Mr Adams, who had no difficulty in taking instructions from him. She gave evidence that there was nothing to indicate to her that Sergeant Assenti was deeply concerned about him, nor was it an emergency case.
- 3.7 Had there been any concerns Mrs Gilmartin advised the Inquiry that she would have contacted the Police Doctor or if so sufficiently concerned, even have bypassed that and gone straight to the psychiatrist. Time was not an issue and not something she took into account as the presiding Sheriff was good at sitting on if time was required to get these examinations conducted.
- 3.8 After making her enquiries Mrs Cole was satisfied that Mr Perry was fit to plead. His behaviour was appropriate throughout the hearing. She indicated that it was her duty, and that of the court to ensure this was the case before he was processed.
- 3.9 Evidence was heard that the 'Fitness to Plead' assessment is to see only if Mr Perry was able to understand the court procedure. Not to diagnose any

underlying medical condition. Police Casualty Surgeons like Dr Sadler have no mental health qualification. Dr Sadler indicated that any Fitness to Plead examination is brief and involves asking the prisoner questions about where they are, what date it is, why they are in custody, and why they are going to court. This is to check their orientation and understanding of the situation and the implications of court.

3.10 Given that there was no difficulty in Mr Adams obtaining instruction from Mr Perry and that there had been a vast improvement in his demeanour, it was not deemed necessary for Dr Sadler to attend later in the day, nor for Mr Perry to be forcibly taken to Dundee, nor for any ambulance to be called. He was successfully processed through court.

3.11 Mr Perry's hearing was conducted in the cells of Perth Sheriff Court. Mrs Gilmartin advises that this was a decision taken due to G4S concern over the potential concealment of drugs. They had kept him separate and handcuffed so that any drugs could not be recovered whilst in his cell that morning. It would therefore have caused them a logistical problem in moving him to the court room. He did not refuse to come out of his cell at Perth Sheriff Court.

3.12 Mr Perry was remanded in custody due to the nature of the offence and his schedule of previous convictions.

3.13 Mrs Gilmartin told the Inquiry of how she had drafted a letter to be placed with Mr Perry's property given the previous bizarre behaviour and the potential concealment of drugs. She indicated that someone could be fit to plead but still

suffer a mental illness and she was advising the prison to keep an eye on him.

She specifically removed the reference to self-harm or suicide that was contained in the style letter used as that was not a concern of hers.

3.14 Any assessment by Dr Sadler would have been limited to his fitness to plead at court.

4. Procedure for Fitness to Plead Assessment

4.1 Chief Inspector Gordon Milne advised the Inquiry of a pilot project in 2009 to work with NHS Tayside to create a nurse-led service with forensic services covering Arbroath, Perth and Dundee. This was deemed a success and was thereafter rolled out.

4.2 The previous system caused problems often due to the reluctance of GPs to become engaged in this type of work. Any attendance by a GP was not guaranteed to be instant and would often require a wait due to their engagement in other business.

4.3 With the new system, a bank of 12 nurse practitioners are on duty and available 24/7. These nurses are a permanent fixture. They are based in Dundee and can travel depending on what the medical need is. The police have instant access to medical advice. This is a robust system.

4.4 Compared to the previous system, Chief Inspector Milne referred to this as a 'godsend'.

- 4.5 The procedure of Sergeant Assenti phoning and being able to speak with Nurse Rowe and to Dr Sadler is evidence that the system is working.
- 4.6 Chief Inspector Milne advised that Dr Sadler was, and is, always available for the nurses to contact and was able to attend Perth later in the day to see Mr Perry were that to be required. Sergeant Assenti and the Procurator Fiscal ultimately took the decision that that was not necessary.
- 4.7 The police also have the option of taking a prisoner to hospital if they deemed the case an emergency.
- 4.8 For a short period in 2013 Dr Sadler was the only Police Casualty Surgeon engaged in this work and attended to this in addition to his Post Mortem duties. Dr Lowe then filled this position full time with Dr Sadler assisting with cover when necessary. Dr Sadler was able to fulfil both his roles with the arrangements in place.
- 4.9 Once the prisoner is transferred to court, the responsibility of their supervision transfers to them.

5. Conclusions

- 5.1 It is submitted that there can be no criticism of Dr David Sadler or his handling of matters in relation to the proposed arrangements for a 'Fitness to Plead' assessment.
- 5.2 That the system in place for detainees to be assessed was working and had no deficiencies.

5.3 That there is no causal link between the lack of 'Fitness to Plead' assessment by Dr Sadler on 15th January 2016, and Mr Perry's attempt to take his own life on 19th January 2016 given the limited scope and purpose of this type of examination. Mr Perry was also assessed within the prison setting, by medics, on three separate occasions, with no finding of concern. These assessments were conducted after his appearance at court and each of these would be more thorough than any 'Fitness to plead' examination that would have been carried out by Dr Sadler.

5.4 The arrangements suggested for Mr Perry to be seen by Dr Sadler, and his eventual attendance at court without seeing him, did not contribute to his death.

IN RESPECT WHEREOF
Karen Railton
Solicitor for Dr Sadler
DAC Beachcroft Scotland LLP

FATAL ACCIDENT INQUIRY

DEATH OF JOHN PERRY

SUBMISSIONS FOR THE CHIEF CONSTABLE

THE FATAL ACCIDENT AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT

1976

Section 6(1)(a)

Where and when the death and any accident resulting in the death took place.

John Perry died at 12.28 pm on 23 January 2013 at Perth Royal Infirmary, all as narrated in paragraphs 3 and 15 of the Joint Minute of Agreement.

Section 6(1)(b)

The cause or causes of the death and any accident resulting in the death.

Death was caused by ligature pressure on the neck by a shoelace and the cause of the accident resulting in the death was that John Perry tied a shoelace tightly around his own neck, all as narrated in Crown Production 9, the Post Mortem Report.

Section 6(1)(c)

The reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided. There were/are no reasonable precautions whereby the death and/or the accident which resulted in the death might have been avoided.

Section 6(1)(d)

The defect, if any, in the system of working which contributed to the death or any accident resulting in the death. There were/are no defects in the system of working which contributed to the death and/or to the accident which resulted in the death.

Section 6(1)(e)

Any other facts which are relevant to the circumstances of the death. There are no other relevant facts.

SUMMARY

The Fatal Accident Inquiry investigated the facts and circumstances surrounding the death of John Perry from his arrival at Perth Police Office on 15 January 2013 through to his death in Perth Royal Infirmary on 23 January 2013.

The Submissions on behalf of the Chief Constable are restricted to the period of time Mr Perry spent at Perth Police Office, the circumstances surrounding his subsequent transfer on 16 January 2013 to appear at Perth Sheriff Court and matters relevant thereto.

Perth Police Office

1. Mr Perry arrived at Perth Police Office at around 5 pm on 15 January 2013. He brought a holdall with him.

He asked to speak to someone from the CID and as a result was interviewed by CID Officers. In the course of the interview he produced a knife from his holdall and he was arrested. He was ultimately found to be in possession of cannabis.

2. The end result was that Mr Perry was charged with three offences, namely contraventions of the Criminal Law (Consolidation) (Scotland) Act 1995, Section 49(1) (possession of a knife), the Misuse of Drugs Act 1971, Section 5(2) (possession of cannabis) and the Police (Scotland) Act 1967, Section 41(1)(a) (resisting arrest).
3. Mr Perry's behaviour raised a concern with Police Officers that he might have been "banking" drugs in order to take them into prison. He was generally exhibiting erratic and bizarre behaviour and as a consequence he was placed on a system of checks every thirty minutes and this was ultimately raised overnight to constant observation.
4. The following morning it appeared that Mr Perry had calmed down which would have been consistent with the wearing off of the effects of any drugs he might have taken prior to his attendance at Perth Police Office.
5. On the morning of 16 January the Custody Sergeant was Michael Assenti. He was the early shift Custody Sergeant having taken over from Sergeant Letham at around 0640.
6. Sergeant Assenti decided that as Mr Perry was due to attend Court, a Fitness to Plead examination should be arranged given the combination of Mr Perry's behaviour and the suspicion that he might be banking drugs.
7. Sergeant Assenti phoned Sandra Rowe, one of the Custody Nurses based in Dundee. He was advised by Sandra Rowe that Mr Perry would need to travel to

Dundee to have an examination as Doctor David Sadler, the acting Force Medical Examiner could not travel to Perth until either late morning or around lunchtime.

When Sergeant Assenti advised Mr Perry that he would have to go to Dundee Mr Perry refused to go although any final decision was one for the Custody Sergeant and not for the prisoner.

8. Sergeant Assenti did however speak to Doctor Sadler and the discussion included a possible change in behaviour due to drugs coming out of a person's system.

9. Doctor David Sadler explained the situation as it was in January 2013. NHS Tayside were attempting to fill the position of Force Medical Examiner but as at January 2013 and indeed for a few months, Doctor Sadler was the only Doctor covering this position.

As a result he preferred if possible that prisoners be brought to Dundee for examination rather than his having to travel to Perth or Arbroath. There were very significant time restraints on him given he had a duty to carry out Post Mortems in Dundee.

10. Doctor Sadler confirmed that when he was approached on the morning of 16 January by the Custody Nurse Sandra Rowe he had said that he would prefer the prisoner to come to Dundee because he (Doctor Sadler) had to carry out a Post Mortem. He confirmed he had a telephone discussion with Sergeant Assenti when he had told the Sergeant he could not travel to Perth until late morning or lunchtime. If the prisoner had been brought from Perth to Dundee he would have been able to see him in Dundee.

11. Sergeant Assenti called the Procurator Fiscal's Office and spoke to a Depute Fiscal, Mrs Gilmartin, to outline his concerns in relation to Mr Perry. He advised the

Depute that there had been a vast improvement in Mr Perry's demeanour overnight and that he appeared fine that morning. It was agreed that Mr Perry could appear without a fitness to plead assessment being necessary.

12. At Court Mr Perry refused to leave the cell and as a result a Hearing had to be convened in the cells. Mr Perry was legally represented.

13. Bail was opposed by the Crown, was refused and Mr Perry was remanded in custody. He was then transferred from Perth Sheriff Court to HMP Perth.

14. The Depute had a concern about the position generally and as a result sent a letter addressed to the Prison Governor which set out her concerns.

15. Chief Inspector Gordon Milne who had responsibility for custody prior to January 2013, gave evidence.

He explained the background to the custody medical provision as it existed in January 2013. In particular he spoke to the introduction of a pilot scheme in 2009. Under this project Custody Nurses were introduced. The Nurses were provided by NHS Tayside.

16. The new service was based in Dundee. Ideally there would be two Nurses on duty at any one time. They were available to travel if necessary to the Custody Suites at Perth and Arbroath.

17. The project gave Police Officers access to medical services through the Custody Nurses on a 24 hour a day basis.

18. The project was considered to be a success. As a consequence these new services became permanent, were in operation as at January 2013 and as Chief Inspector Milne confirmed, are still in operation.

19. On being asked for his view of how these arrangements had worked in the case of Mr Perry, Chief Inspector Milne said the system had operated as it should have done. Sergeant Assenti had spoken to the Custody Nurse Sandra Rowe as the initial contact and following that discussion had then been able to speak to Doctor David Sadler operating at the time as the Force Medical Examiner.

20. In his evidence Chief Inspector Milne also spoke to the contrast between the position as it existed prior to the 2009 pilot project and the change as a result of that pilot.

It had been suggested to the Chief Inspector that in the “old days” the local GP would have been just around the corner and able to attend quickly.

He said that the pre-2009 system depended on GPs. This in turn meant it depended on GPs being available and indeed willing and able to attend. He commented that some GPs were reluctant to become involved with the system. In addition pre-2009, it was quite common for several Police Vehicles to be at an Accident and Emergency Unit at the same time which was hardly an efficient use of Police resources.

21. The system as it was in 2013 allowed a Custody Sergeant like Sergeant Assenti to speak directly to a Nurse. The Nurse in turn had, if necessary, further access, whether it be to the Force Medical Examiner (Doctor Sadler in this particular case) or indeed other specialists.

Most of the nurses had been in place since 2009 and had been recruited and trained for what had that time had been a new role. One significant advantage was that the nurses were responsible for prescribing medication. This gave a greater certainty that prisoners

would receive the appropriate medication for their conditions and take away from the Custody Sergeant and Custody staff any responsibility for medication.

22. There was no evidence to support any Finding that had Mr Perry been seen by a Doctor prior to his transfer to Perth Sheriff Court, there would have been any different an outcome. Sergeant Assenti was able to speak direct to the acting Force Medical Examiner Dr Sadler and it was considered that Mr Perry was fit to be transferred. Thereafter he went through the court process and then the HMP Perth admission process, the latter including several assessments.

Conclusions

In respect of Mr Perry's attendance at Perth Police Office and his subsequent transfer to Perth Sheriff Court, there were no reasonable precautions which could have been taken whereby the death or accident resulting in the death could have been avoided.

There was no defect in any system of working at Perth Police Office or in Tayside Police (as it then was). The medical services system was robust and had been operating successfully since 2009. It is still operating successfully.

The system operated on 16 January 2016 successfully and exactly as it was intended to do. The Custody Sergeant used it to contact and speak to a custody nurse who then provided access to the acting Force Medical Examiner. The Custody Sergeant was then able to take an informed decision to send the late Mr Perry to Perth Sheriff Court.

ORAL SUBMISSIONS 21st December 2016

On that day the following submissions were made by the various parties.

Crown.

The deceased was seen by a doctor. At every stage, the deceased had the opportunity to speak to persons but chose not to do so. His behaviour was not directly indicative of self harm. He had been annoyed by M/s Baxter's intrusion. His taking his own life was a spur of the moment decision taken and carried out in the afternoon as opposed to during the night. The assessment under the ACT2care process can only be carried out on the basis of what is observed and communicated. Sadly Mr Perry was a troubled man who had not sought assistance notwithstanding the pleas of his mother.

The family

Mr Williams submitted that if Mr Perry had been examined by a doctor in police custody or at court he may have been declared unfit and made the subject of hospital detention. If things were not right, there was all the more reason for him being examined.

In the prison, mental health nurses were better able to assess someone with issues such as Mr Perry. Whilst his suicide appeared to be a spur of the moment reaction to the telephone call with his girlfriend, the warning signs were there that all was not well and steps should have been taken.

Tayside Health Board

There was no basis for finding that an examination at the police station would have made any difference. Mr Perry had settled down and his behaviour had improved

significantly. Any 'fit to plead' assessment was a brief procedure which had a limited role. When admitted to prison, the ACT2care assessment was better carried out by general nurses. It was a broad assessment, as opposed to one aimed solely at mental health issues. Suicide was not necessarily prompted by mental health issues. It could be an impulsive matter. Nurse Ian Duncan had access to Mr Perry's medical records and thus had sight of his medical history in prison. There was no basis for criticising Nurse Baxter.

Answering matters raised on behalf of the family directly, Doctor Sadler was available. There was no issues regarding resources. The refusal to leave the cell at court was due to the suspicion that Mr Perry may have banked drugs. No one who dealt with Mr Perry in police custody or at court said that something did not quite fit with his behaviour. The assessment process worked well. There was no evidence that Mr Perry required any greater supervision than other prisoners. He did not meet any of the ACT2care criteria or that he was a borderline case.

Prison Officers and Ian Duncan

Nothing to add to written submissions.

Scottish Prison Service

In response to the submissions made on behalf of the family, there was no evidence as to lack of resources. Doctor Wallace carried out a thorough assessment. If he had had sight of the letter from Mrs Gilmartin, he would have probed further but it was speculation as

to whether he would have placed Mr Perry on ACT2care. If he had been referred to a psychiatrist would he have consented to such a referral? What would the diagnosis have been?

Doctor Saddler

There was no causal link between any involvement by Doctor Sadler. In any event there was no basis for criticism.

Police

A system had been put in place in 2009 which was still in place. Police Sergeant Assenti had direct access to medical advice. The system worked.