**SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT PERTH**

**[2024] FAI 34**

PER B253-22

DETERMINATION

BY

SHERIFF CHARLES LUGTON

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

into the death of

**CHRISTOPHER MICHAEL RENNIE**

PERTH, 30 AUGUST 2024

The Sheriff, having considered the information presented at the Inquiry, determines, in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (hereinafter referred to as "the 2016 Act") the following:

1. **In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred):**

   That Christopher Michael Rennie died in legal custody within his cell (4.19) in C Hall, HMP Perth, 3 Edinburgh Road, Perth. Mr Rennie died on 19 July 2020 at a point prior to 14:17 hours. Mr Rennie's life was formally pronounced extinct at 15:07 hours on that date.

**2. In terms of section 26(2)(b) of the 2016 Act (when and where the accident resulting in death occurred):**

That the death was not caused by an accident. Therefore, no finding is made.

**3. In terms of section 26(2)(c) of the 2016 Act (the cause or causes of death):**

That the cause of death was hanging.

**4. In terms of section 26(2)(e) of the 2016 Act (any precautions which (i) could reasonably have been taken and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided):**

That there are no precautions which could reasonably have been taken that might realistically have resulted in the death being avoided.

**5. In terms of section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or any accident resulting in the death:**

That there are no defects in any system of working which contributed to the death.

**6. In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death):**

That the Scottish Prison Service ("SPS") operate a system by which prison officers make regular checks of prisoners within their cells at specified times during the course of the day. The officers are required

to undertake these checks in accordance with the requirements of SPS's locking/unlocking and numbers checks procedure.

That the procedure is set out in the following documents: Governors and Managers Action Policy ("GMA") 004A/19, dated 22 January 2019 (SPS production 2); GMA 016A/16, dated 28 March 2016 (SPS production 3); and Standard Operating Procedure for HMP Perth in relation to "Residential Numbers Checks", dated July 2022 (SPS production 4).

That it is specified within this documentation that checks are to be undertaken by two officers. There are particular requirements that the officers should open the door of each cell in order to see the face of, engage in a dialogue with and obtain a verbal response from the prisoner. These measures are designed to reduce the risk of suicide and to identify any person with a deteriorating health condition.

That after the prison officers return from lunch each day a "post-lunch" numbers check is routinely carried out.

That the last check to be carried out prior to the discovery of Mr Rennie's death was a post-lunch check. This was carried out at 13:29 by Prison Officer SK. Prison Officer SK walked swiftly past a series of cells, including Mr Rennie's cell, pushing against each of the doors as he went. When Prison Officer SK pushed Mr Rennie's cell door, Mr Rennie responded "Aye, I'm fine." The check did not comply with SPS's

requirements, as Prison Officer SK carried it out alone and he did not open Mr Rennie's cell door and see Mr Rennie's face.

That Prison Officer SK had not received training in relation to the locking/unlocking and numbers checks procedure. He learned the procedure by watching his colleagues. He was unaware of the requirements for officers to undertake such checks in pairs and to make a visual check of prisoners.

That prior to July 2020 it was common practice within HMP Perth for a single prison officer to undertake the post-lunch check, without cell doors being opened or a visual check of the prisoners being made. The prison officers had not been adequately trained and were not aware that all numbers checks, including post-lunch checks, should be undertaken by two officers and should involve opening the cell doors and seeing the faces of prisoners as well as obtaining a verbal response from them.

**Recommendations**

In terms of section 26(1)(b) of the 2016 Act, the Sheriff makes no recommendations.

**NOTE**

**Introduction**

[1] This Inquiry into the death of Christopher Michael Rennie took place at Perth Sheriff Court on 24 October 2023, 14 March 2024, 15 May 2024 and 16 August 2024. Prior

to the inquiry preliminary hearings were held on 12 January 2023, 14 March 2023, 20 April 2023, 5 June 2023 and 31 June 2023.

[2] Ms Graham, Procurator Fiscal Depute, represented the Crown, Ms Turner, Solicitor, represented SPS, Mr Rodgers, solicitor, represented the Prison Officers Association ("POA") and Ms Toner, Advocate, represented Tayside Health Board ("THB").

**The legal framework**

[3] The 2016 Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 Rules") govern fatal accident inquiries. A fatal accident inquiry is held under section 1 of the 2016 Act and its purpose in terms of section 1(3) is to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. Conversely, the purpose of the inquiry is not to establish civil or criminal liability. The process is inquisitorial in character. The procurator fiscal represents the public interest at the inquiry. The present inquiry was mandatory in terms of sections 2(1) and (4) of the 2016 Act as Mr Rennie was in legal custody at the time of his death.

[4] In terms of section 26(1) of the 2016 Act as soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination. This section has no associated Explanatory Notes containing the sheriff's findings as to the circumstances of the death, and such recommendations (if any) as the sheriff considers appropriate.

[5] As regards the circumstances, the sheriff must make findings regarding: (a) when and where the death occurred; (b) when and where any accident resulting in the death occurred; (c) the cause or causes of the death; (d) the cause or causes of any accident resulting in the death; (e) any precautions which - (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided; (f) any defects in any system of working which contributed to the death or any accident resulting in the death; and (g) any other facts which are relevant to the circumstances of the death.

[6] In terms of section 26(4) the sheriff is entitled to make recommendations regarding (a) the taking of reasonable precautions; (b) the making of improvements to any system of working; (c) the introduction of a system of working; and (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

**The evidence**

***Agreed evidence and evidence led***

[7] Much of the evidence before the inquiry was agreed. The parties entered into three detailed and comprehensive Joint Minutes of Admissions.

[8] Parole evidence was led from Prison Officer SK on 24 October 2023 and Prison Officer PM on 14 March 2024.

**Productions and labels**

[9] The following productions and labels were lodged:

***Crown productions and labels***

1. Intimation of Death to Procurator Fiscal form, dated 23 July 2020 (Crown Production 1);
2. Post Mortem Examination Report authored by Doctor Alan Farnworth, Consultant Forensic Pathologist, Dundee (Crown Production 2);
3. Toxicology Report, dated 12th August 2020, authored by Doctors Hazel Torrance and Eleanor Miller, both Forensic Toxicologists (Crown Production 3);
4. Tayside Health Board medical records pertaining to Mr Rennie (Crown Production 4);
5. Timeline of events prepared by witness Tracey Darlington, Staff Nurse, NHS Tayside who worked in the Health Centre at HMP Perth until August 2020 (Crown Production 5);
6. Internal emails provided by witness Airlie Dewar, Mental Health Senior Charge Nurse, NHS Tayside who worked in the Health Centre at HMP Perth at the time of Mr Rennie's death (Crown Production 6);
7. Death in Custody Folder prepared by the Scottish Prison Service (Crown Production 7);
8. Book of photographs taken on 19 July 2020 at the locus by witness Robert Bishop, Scene Examiner and a member of the Scottish Police

Services Authority, Forensic Services, Scene Examination Unit, Dundee in the presence of Detective Constable Samantha Wilkie, Police Service of Scotland (Crown Production 8);

9. "Death in Prison Learning, Audit & Review" ("DIPLAR") Report prepared by SPS and NHS Health Scotland in respect of Mr Rennie (Crown Production 9);

10. "GMA 016A/16", a Governors & Managers Action document for the Scottish Prison Service. This sets out revised requirements during locking and unlocking procedures in prisons and is dated 28 March 2016 (Crown Production 10);

11. "Full Adverse Event Review" Report (also referred to as a "LAER") provided by NHS Tayside and approved on 4 August 2021 (Crown Production 11);

12. Psychiatric Report in relation to Mr Rennie's death, prepared by Doctor Fergus Douds, Consultant Psychiatrist, NHS Forth Valley, dated 13 June 2022 (Crown Production 12);

13. Timeline, prepared by Lizeath Margaret Mackenzie, Substance Use Caseworker, detailing her contact with the deceased from 4 February 2020 until his death on 19 July 2020 (Crown Production 16);

14. A disc containing CCTV footage from within C Hall, HMP Perth, that was seized by officers of the Police Service of Scotland on 28 July 2020. The footage from camera 373 shows Association Area South 1, which

points from one end of the corridor towards the grille gates and prison officers' station. Mr Rennie's cell is to the immediate left hand side, just out of view of the camera. The footage commences at 11:35:00 hours and ends at 15:49:56 hours. The footage from camera 374 shows Association Area South 2, which points from the grille gates and prison officers' station down towards the far end of the corridor. Mr Rennie occupied cell 19, one of the furthest away cells on the right hand side of the corridor from this camera viewpoint. The footage commences at 11:35:21 hours and ends at 15:14:20 hours (Crown Label 1);

15. A disc containing a number of recordings from within HMP Perth, as follows:

    a. Recordings of the radio messages in relation to the "Code Blue" on 19 July 2020;

    b. A number of telephone and mobile phone calls made by Mr Rennie between 19 June and 19 July 2020;

    c. The recordings of calls to telephone number [WITHHELD], which are conversations between Mr Rennie and witness Charlene Gilmour, Project Manager, Phoenix Futures. Charlene Gilmour was involved in a rehabilitation programme to support persons suffering with drug and/or alcohol addiction, including those within the prison system, and she had been

allocated Mr Rennie as a service user when he attended the programme previously;

d. The recordings of calls to telephone number [WITHHELD], which are conversations between Mr Rennie and his aunt, witness Margaret Cooper (Crown Label 2).

***SPS productions***

1. SPS Suicide Risk Management Policy called "Talk to Me" ("TTM"), dated June 2021 (SPS Production 1);
2. "GMA 004A/19", a Governors & Managers Action document for SPS. This sets out revisions to SPS's Locking Policy and is dated 22 January 2019 (SPS Production 2);
3. "GMA 016A/16", a Governors & Managers Action document for the SPS. This sets out revised requirements during locking and unlocking procedures in prisons, dated 28 March 2016 (SPS Production 3);
4. Standard Operating Procedure ("SOP") in relation to the Residential Numbers Check, dated July 2022 (SPS Production 4);
5. Attendance record sheet for the "Numbers Check Awareness Refresher" training for C Hall, HMP Perth, as at 22 September 2021 (SPS Production 5);
6. Session plan for refresher training on "HMP Perth numbers check and locking/unlocking procedures", dated October 2020 (SPS Production 6);

7. "Rule 41 Guidance" provided by SPS, dated September 2020 and updated in September 2022 (SPS Production 7);
8. Session Plan for "Locking and Numbers" training from the SPS College, undated (SPS Production 9);
9. PowerPoint Presentation for "Locking and Numbers" training, undated (SPS Production 10);
10. Version one of the Residential Officer Foundation Programme course descriptor on "Locking and Numbers" approved on 15 February 2022 (SPS Production 11);
11. Prisons Resource Library Standards on "Locking and Numbers", undated (SPS Production 12);
12. List of attendees who attended the "Lock and Unlock" training (SPS Production 13).

***THB productions***

1. NHS Tayside Prison Healthcare Standard Operating Procedure "Substance Use Team and Mental Health Team Joint Working Pathway," dated 8 March 2023 (THB Production 2).

All productions were agreed to be true and accurate.

**Affidavits and witness statements**

[10] The following Affidavits and Witness Statements were lodged:

1 Witness statement provided by CC, then a prisoner at HMP Perth, at 11:36 hours on 21 July 2020 to Detective Constable Rhiannon Laing, officer of the Police Service of Scotland, at HMP Perth;

2 Witness statement provided by SH, then a prisoner at HMP Perth, at 10:50 hours on 21 July 2020 to Detective Constable Mark Ross, officer of the Police Service of Scotland, at HMP Perth;

3 Witness statement provided by AM, then a prisoner at HMP Perth, at 10:17 hours on 21 July 2020 to Detective Constable Rhiannon Laing, officer of the Police Service of Scotland, at HMP Perth;

4 Affidavit of Andrew Hodge, Governor of HMP Perth since March 2020, notorised on 2 February 2023;

5 Affidavit of Jane Louise Brown, Learning and Development Manager at HMP Perth, notarised on 2 May 2023;

6 Affidavit of Airlie Rose Dewar, Clinical and Professional Team Manager for Perth and Kinross Adult Community Mental Health Teams, employed by NHS Tayside. Said affidavit was notarised on 8 March 2023;

7 Affidavit of Prison Officer SK, Residential Officer at HMP Perth, notarised on 24 October 2023;

It was agreed that the Affidavits and Witness Statements should be admitted in evidence and treated as the parole evidence of the witnesses, or part thereof.

**Submissions**

[11] In advance of a hearing on submissions on 16 August 2024 the parties lodged helpful written submissions, in which they succeeded in being both thorough and succinct. I heard additional, oral submissions from the parties at the hearing. I will not narrate the parties' submissions, but I have taken account of them while writing this Determination. I am most grateful to agents and counsel for their considerable assistance.

**Factual circumstances**

[12] Having regard to the information presented to the Inquiry, I found the following facts to be established:

***Christopher Rennie***

(1) Christopher Rennie was born on 20 March 1984. He died on 19 July 2020, aged 36 years old.

(2) Mr Rennie was a convicted prisoner at HMP Perth, 3 Edinburgh Road, Perth. He was the sole occupant of cell 4.19, located on the top floor of C Hall within HMP Perth.

***Mr Rennie's incarceration***

(3) In July 2016 Mr Rennie was sentenced to 13 months imprisonment under a recall to prison by the Parole Board for Scotland, under Section 16 of the Prisoners and Criminal Proceedings (Scotland) Act 1993. He also received a sentence of 47 months imprisonment in relation to a conviction for assault and robbery, to run concurrently with his recall to prison. His earliest date of liberation at that time was 10 December 2021. He was (4)

(4) On 19 December 2019 Mr Rennie was released on parole from HMP Castle Huntly. On 28 January 2020 Mr Rennie appeared at Kirkcaldy Sheriff Court in relation to a number of allegations, including offences of housebreaking with intent to steal and wilful fire-raising, and he was remanded in custody.

(5) On 5 February 2020 he was recalled to prison under Section 17 of the Prisoners and Criminal Proceedings (Scotland) Act 1993 for a breach of licence conditions. He was required to serve the remainder of his sentence and his earliest date of liberation was 10 January 2025.

(6) On 2 July 2020 Mr Rennie was sentenced to 23 months imprisonment at Falkirk Sheriff Court in relation to theft by housebreaking and wilful fire-raising. Mr Rennie would have been eligible for parole after serving half of that sentence, with a yearly review thereafter until 10 January 2025 if not released prior to that date.

*Locking and unlocking and numbers checks procedure*

(7) SPS operate a system by which prison officers make regular checks of prisoners within their cells at specified times during the course of the day. These checks are referred to as the locking/unlocking and numbers checks procedure.

(8) The details of the procedure are set out in the following documents: Governors and Managers Action Policy ("GMA") 004A/19, dated 22 January 2019 (SPS production 2); GMA 016A/16, dated 28 March 2016 (SPS production 3); and Standard Operating Procedure for HMP Perth in relation to "Residential Numbers Checks", dated July 2022 (SPS Production 4).

(9) Checks carried out under the procedure are required to be undertaken by two officers. There is a specific requirement that each cell door should be unlocked and that both officers should see the face of and obtain a verbal response from the prisoner. The documents refer to the need for officers to engage in a dialogue with prisoners in a pro-social manner. These measures are designed to reduce the risk of suicide and to identify any person with a deteriorating health condition.

*Suicide risk management*

(10) SPS have devised and implemented a Suicide Risk Management Strategy called "Talk to Me" ("TTM") (SPS Production number 1). TTM replaced

"ACT to Care" on 5 December 2016. TTM is a multi-agency suicide prevention strategy for identifying and caring for those at risk of self-harm or suicide. Both SPS staff and NHS staff receive training in TTM. Anyone who has unescorted contact with prisoners is responsible for placing someone on the strategy if they identify a risk.

(11) The process of placing a prisoner on TTM involves completing an initiation form. An assessment then takes place to determine whether that prisoner is "at risk" of suicide. If a prisoner is assessed as "at risk" following the assessment, an appropriate care plan will be put in place. The care plan will be individually tailored to that prisoner to appropriately manage the identified risk. This may include, for example, placing the prisoner in a safer cell, safer clothing or perhaps from removing certain items. A safer cell is one with no ligature points. Safer clothing and bedding is harder to be torn or ripped and therefore used to fashion a ligature. All prisoners on TTM have a maximum contact level. This means that staff must interact with them at regular intervals, in line with an agreed timeframe.

(12) Mr Rennie was not on TTM at the time of his death.

***Recent medical care***

(13) On admission to HMP Perth on 28 January 2020, Mr Rennie was assessed by health care staff and tested positive for illicit substances. He had a

wound on his lower right leg. No thoughts of suicide or self-harm were reported at that time. He was prescribed the following repeat medication: Cetirizine – 10mg tablets (1 daily), Gabapentin – 300mg capsules (3 times daily) and Buprenorphine – 10mg (1 daily). Mr Rennie was originally prescribed a diazepam detoxification to manage benzodiazepine withdrawals. His Opiate Substitution Therapy ("OST") was subsequently reviewed, and the Buprenorphine prescription was changed to Espranor 8mg. The strength of the Espranor was reviewed and altered a number of times in the months that followed after discussions with Mr Rennie, as documented in his medical records. Gabapentin was prescribed to him for nerve pain.

(14) Mr Rennie was not noted as having had a recent history of self-harm. He had been on suicide prevention measures on three previous occasions during custodial sentences. Two of these were for a one day period, and then in October 2019 for a period of one week following the death of a family member.

(15) Mr Rennie received medical treatment and care from prison health care staff in the months prior to his death.

(16) Charlene Gilmour was Mr Rennie's allocated worker for a rehabilitation programme for those with addiction issues. On 3 February 2020 she visited Mr Rennie in prison and found his mood to be low and noticeably flat. He did not intimate any intention of self-harm or suicide at that time

and she was not particularly concerned given his recent recall to custody. Mr Rennie continued to engage with the programme after re-entering the prison system, until meetings were suspended due to the COVID-19 pandemic. Ms Gilmour was a recognised contact on Mr Rennie's prison issue mobile phone and received a number of telephone calls from him whilst he was in prison.

(17) On 30 June 2020 Ms Gilmour received a telephone call from Mr Rennie. He was due to appear in court the following day in relation to criminal proceedings. Ms Gilmour noticed a considerable difference in Mr Rennie's mood and was concerned that he was thanking her and in her view appeared to be saying goodbye. She made contact with HMP Perth to raise a concern and told staff that she was concerned his mood was lower than normal based on the comments made. Prison staff advised her that they would check on Mr Rennie.

(18) Ms Gilmour did not receive any further information or follow up from the prison. She received a telephone call from Mr Rennie the following day. He apologised for being upset and advised her that he had been prescribed medication to assist his sleep.

(19) Mr Rennie had weekly telephone calls with his aunt, Margaret Cooper, while he was in HMP Perth and exchanged written letters with him. Although he appeared low in mood at times, nothing was discussed on the calls that alarmed or concerned her that he may have been suicidal.

(20) On 30 June 2020 Tracey Darlington, Mental Health and Substance Misuse Nurse, based at HMP Perth, became aware of the concerns raised about Mr Rennie and attended at C Hall to speak with him. She was advised by prison officers that he appeared fine and had recently had a telephone call with his aunt. She spoke to Mr Rennie and he expressed concerns about his court hearing the following day but denied suicidal ideations or planning. She did not initiate TTM at that time. She asked Mr Rennie if he had spoken with anyone from the mental health team and he mentioned Kirsty Morton.

(21) Nurse Darlington returned to the office and spoke with Kirsty Morton, who had seen Mr Rennie in passing from time to time. Nurse Darlington sent an email to Kirsty Morton and to Louise Markie, who was due to be the reception nurse the following day when Nurse Darlington was off. In the email she advised that Mr Rennie may need to be considered for TTM on return from court, depending on the outcome of his hearing. Nurse Darlington saw Kirsty Morton on her return from her days off, who advised that she had not had time to see Mr Rennie but no concerns had been flagged up to her or the team.

(22) On 1 and 2 July 2020 Lizeath Mackenzie, Substance Use Case Worker, based at HMP Perth, spoke with Mr Rennie. She anticipated an improvement in Mr Rennie's mood following the outcome of his court hearing on 2 July 2020. But his mood remained low. He denied suicidal

ideations but Ms Mackenzie assisted with a referral to the mental health team for low mood and he was subsequently triaged by Nurse Darlington.

(23) On 2 July 2020 Airlie Dewar received a self-referral for low mood in relation to Mr Rennie. On 3 July 2020 another referral for low mood and struggling was received and Mr Rennie was listed for a telephone consultation with the GP to take place on 23 July 2020.

(24) On 7 July 2020 witness Airlie Dewar and mental health triage nurse Eleanor Morelli triaged the referrals they had received. They agreed to speak to Nurse Darlington to see if she could support Mr Rennie. They were aware of his scheduled GP appointment.

(25) Nurse Darlington and Ms Mackenzie raised concerns about Mr Rennie at an allocations meeting for referrals. An email was sent by Pauline Ogilvie on 10 July 2020 to a number of NHS staff, including Airlie Dewar and Eleanor Morelli, advising that the referral for Mr Rennie had not been received and it had potentially been missed due to poor communication between teams. A multi-disciplinary team meeting was suggested. This did not take place.

(26) By 17 July 2020 Nurse Darlington had not received any referral from the mental health team in relation to Mr Rennie, but had been to see him that day.

(27) On 16 July 2020 Ms Mackenzie again saw Mr Rennie and found his mood to be flat at the beginning of the consultation but improving as their meeting progressed. Mr Rennie spoke about things in the future and because of this Ms Mackenzie was not concerned and did not initiate TTM at that time. This was the last time she saw Mr Rennie. On her return to the office she spoke with colleague Eleanor Morelli who advised her that Mr Rennie was on a 4-6 week waiting list to be seen by the mental health team, and that it would be quicker for him to be assessed for medication by the GP, given that a GP appointment was scheduled on 23 July 2020.

(28) On 17 July 2020 Nurse Darlington was due to have a telephone appointment with Mr Rennie. Staff were unable to bring him to the telephone and so she attended at C Hall to speak with him. Mr Rennie advised that he had contemplated suicide but changed his mind and denied any current suicidal ideations. He stated that he had spoken to his community support worker, Charlene Gilmour, and said his goodbyes. This conversation had taken place on 30 June 2020. Mr Rennie believed that if she had not contacted the NHS staff in the prison he would be dead. He spoke of having attempted to make a noose but having later disposed of it. He requested anti-depressants and input from the mental health team and a psychiatrist. Nurse Darlington agreed that she would take steps to liaise with the mental health team to arrange

input from a psychiatrist and to discuss anti-depressant medication. Mr Rennie appeared to Nurse Darlington to be pleased with that outcome. Mr Rennie stated that he had no intention of committing suicide and spoke of the future. Following the discussion Nurse Darlington did not assess him to be an immediate risk and she did not initiate the TTM Suicide Prevention Strategy at that time.

(29) Ms Gilmour received further telephone calls from Mr Rennie following his court appearance and his mood remained flat. She received a further telephone call on 19 July 2020 and had a general conversation with Mr Rennie before the call ended abruptly for an unknown reason. Mr Rennie did not call her back. She did not raise any further concerns with the prison.

***Circumstances of Mr Rennie's death***

(30) Mr Rennie's death occurred in cell 4.19, C Hall, HMP Perth, 3 Edinburgh Perth ("the locus") on 19 July 2020.

(31) At around 08:40 hours Mr Rennie attended at the dispensary hatch in C4 hall to obtain his medication. He was given 6mg of Espranor (3 x 2mg tablets) and dissolved these on his tongue with water in the presence of nursing staff. No concerns were raised by Mr Rennie to the nursing staff at that time.

(32) At about 11:29 hours Mr Rennie left his cell to collect his lunch. He returned to his cell at 11:31 hours with his lunch and at that time all cells were locked up to allow staff to go for their break.

(33) At about 11:42:23 hours two prison officers conducted a check of Mr Rennie's cell. One officer unlocked and opened Mr Rennie's cell door, before stepping forward and looking inside. The officer moved away and the second officer stepped forward and appeared to look inside, before pulling the door closed and locking it. The check was captured on CCTV.

(34) At about 11:55:16 hours a male officer walked past a number of cell doors, including that of Mr Rennie, and pushed against each of them briefly with his hand without stopping. This was captured on CCTV.

(35) At 13:29 a further check of Mr Rennie's cell was carried out as part of a post-lunch numbers check. This was conducted by Prison Officer SK. Prison Officer SK walked swiftly past a series of cells, including Mr Rennie's cell, pushing against each of the doors as he went. This was captured on CCTV. When Prison Officer SK pushed Mr Rennie's cell door, Mr Rennie responded "Aye, I'm fine."

(36) This check did not comply with SPS's requirements. Prison Officer SK carried it out alone rather than with a second officer. He did not open Mr Rennie's cell door and make a visual check of Mr Rennie.

(37) Prison Officer SK had not received training in relation to the locking/unlocking and numbers checks procedure. He learned the

procedure by watching his colleagues. He was not aware of the requirements for officers to undertake such checks in pairs and to open cell doors and make a visual check of prisoners during the post-lunch numbers check.

(38) Prior to July 2020 it was common practice within HMP Perth for a single prison officer to undertake the post-lunch check and to do so without opening the cell door and making a visual check of the prisoners. The prison officers had not been adequately trained and they were not aware that all numbers checks, including post-lunch numbers checks, should be undertaken by two officers and should involve seeing the face of prisoners as well as obtaining a verbal response from them.

(39) At approximately 14:17 hours, CC, a prisoner within HMP Perth, attended at Mr Rennie's cell having previously arranged to meet at 14:00 hours to play their guitars together. He found the door unlocked but closed. On entering the locus he immediately noticed Mr Rennie hanging from his toilet door with a black shoe lace around his neck. Mr Rennie's bodyweight was slumped forward and his feet were still on the ground.

(40) At 14:18 hours prisoner CC exited the locus and raised the alarm. He waved his hands to attract attention and made a gesture of someone hanging to some of the other prisoners. This was captured on CCTV.

(41) Prisoner Taylor and prisoner AM, both prisoners within HMP Perth, entered the locus and attempted to lift Mr Rennie, supporting his bodyweight. Another prisoner ran towards the officers' station. Prison staff attended a few seconds later and on entering the cell observed Mr Rennie to have a ligature around his neck, which was attached to the top hinge of the toilet door.

(42) At approximately 1419 hours SH, a prisoner, used a razor blade to cut the ligature in order to release Mr Rennie. Mr Rennie was moved to the communal hall area just outside his cell. Further prison staff arrived and directed the other prisoners to return to their own cells. Prisoner CC was visibly upset and was escorted back to his cell by another prisoner and prison officer.

***Medical response***

(43) Prison staff sent out a radio alert for nursing staff to attend a "code blue" and an ambulance was requested. At 14:19:46 hours prison staff administered CPR to Mr Rennie.

(44) At about 14:21 hours nursing staff arrived in C hall and made their way to Mr Rennie's cell. They took it in turn to give Mr Rennie CPR. This was captured on CCTV.

(45) At about 14:26 hours paramedics of the Scottish Ambulance Service were assigned to a "code purple" at HMP Perth, indicating that a person was

in cardiac arrest with CPR ongoing. Paramedics attended at 14:31 hours and were shown to C Hall, HMP Perth. Nurses were administering medical treatment including CPR on Mr Rennie when paramedics arrived. Graeme Brown, Paramedic Team Leader, Scottish Ambulance Service, was the first paramedic to enter the hall at 14:33:40 hours. He observed a deep ligature mark around Mr Rennie's neck. Other paramedics also arrived and they took over the medical response from the prison nursing staff. At no point during their medical interventions did the paramedics get any response or output from Mr Rennie, and he remained asystole.

(46) After a period of approximately 30 minutes Paramedic Brown telephoned D Ronald Cook, Consultant, Ninewells Hospital, Dundee and advised him of the situation. It was agreed that resuscitation was to be discontinued due to the length of time passed without a response. CPR ceased at 15:07 hours.

(47) On 19 July 2020 Mr Rennie's life was formally pronounced extinct at 15:07 hours. A "Pronunciation of Life Extinct" ("PLE") form was completed by Kirsty Anne Hosie, Paramedic Team Leader, Scottish Ambulance Service.

***Police involvement***

(48) Detective Constable Samantha Wilkie, officer of the Police Service of Scotland, was appointed Crime Scene Manager in relation to the death of Mr Rennie. She attended at HMP Perth at approximately 17:40 hours and observed Mr Rennie's body in situ outside the cell door. She checked for any injuries but found only the ligature mark around his neck. Two packets of guitar strings were observed next to Mr Rennie's acoustic guitar and a pair of black and white trainers, one of which had a missing black lace. The cell toilet door had the head of a floor squeegee (a cleaning implement) hanging on it, with a black shoe lace and a guitar string wrapped around it. Part of the black lace was wedged into the door hinge.

(49) Robert Bishop, Scene Examiner and a member of the Scottish Police Services Authority, Forensic Services, Scene Examination Unit, Dundee also attended and took photographs of the locus and Mr Rennie's body in situ, in the presence of Detective Constable Wilkie.

(50) The body of Mr Rennie was recovered by undertakers from outside cell 4.19 within C Hall, HMP Perth and conveyed to the Police Mortuary, Dundee.

***Post mortem examination and toxicology analyses***

(51) On 21 July 2020 the Crown Office and Procurator Fiscal Service received the death report from the Police Service of Scotland and instructed a post mortem examination to take place, along with toxicology analyses.

(52) On 22 July 2020 a post mortem examination was carried out by Doctor Alan Farnworth, Consultant Forensic Pathologist, Dundee. The results of said examination are recorded in the Post Mortem Examination Report. The medical cause of death was certified as:

I. (a) Hanging.

(53) Toxicology analyses were performed on the bodily fluids of Mr Rennie by Doctors Hazel Torrance and Eleanor Miller, both Forensic Toxicologists, which detected:

a. Buprenorphine, and its metabolite Norbuprenorphine (opiate substitute);

b. Gabapentin (anticonvulsant and analgesic).

(54) The levels of the substances found in the toxicology analyses are considered to be in keeping with Mr Rennie's prescription medication.

***Cause of death***

(55) The cause of Mr Rennie's death was hanging.

***Subsequent action taken by THB and SPS***

(56) Following Mr Rennie's death THB created a standard operating procedure in order to improve joint working between the Substance Use Team and the Mental Health Team. The purpose of the procedure is to improve communication and liaising between these teams within the prison setting.

(57) Since Mr Rennie's death SPS have been required all of their existing prison officers to undergo training on the procedure for locking/unlocking and numbers checks. SPS have also introduced training on the procedure for new staff members and for staff who are transferring to HMP Perth. Training is provided to both operations officers and residential officers. Since April 2024 SPS have also imposed a regime of continuing refresher training on the procedure which all staff are required to undertake annually.

**Analysis and conclusions**

***Introduction***

[13] The Inquiry focussed primarily on two issues.

[14] The first issue was whether Mr Rennie was provided with appropriate care and treatment in the weeks leading up to his death. In particular, a question arose as to whether he should have been identified as being at risk of committing suicide and placed on TTM.

[15] The second issue concerned the procedure for making routine checks on prisoners while they were within their cells. As explained below, it was accepted that a check made shortly prior to the discovery of Mr Rennie's death was not carried out in accordance with SPS's procedure, as it was undertaken by a single officer who did not open the door of Mr Rennie's cell and make a visual check of him. The Inquiry addressed both the immediate question of whether any consequences flowed from the failure to conduct the check correctly, and wider questions of training and instruction that followed on from this.

[16] These issues are discussed separately below.

***Care and treatment provided to Mr Rennie***

[17] I deal first with the question of whether Mr Rennie was provided with adequate care and treatment in the weeks leading up to his death.

[18] In the course of examining the care provided to Mr Rennie I have considered the terms of (i) a timeline of events prepared by witness Tracey Darlington, Staff Nurse, NHS Tayside (Crown Production 5); (ii) internal emails provided by witness Airlie Dewar, Mental Health Senior Charge Nurse, NHS Tayside (Crown Production 6); (iii) a timeline, prepared by Lizeath Margaret Mackenzie, Substance Use Caseworker, detailing her contact with the deceased from 4 February 2020 until his death on 19 July 2020 (Crown Production 16); and (iv) an affidavit of Airlie Rose Dewar, Clinical and Professional Team Manager for Perth and Kinross Adult Community Mental Health Teams, employed by NHS Tayside, dated 8 March 2023 (THB Production 1). I have also

considered a psychiatric Report prepared by Dr Fergus Douds, Consultant Psychiatrist, NHS Forth Valley, dated 13 June 2022 (Crown Production 12).

[19] It is clear from the evidence that there were concerns about Mr Rennie's mental state in the weeks that preceded his death. During this period Mr Rennie had a series of consultations with members of the Substance Misuse Team and the Mental Health Team within HMP Perth. He was referred for a GP assessment and to the Mental Health Team.

[20] On several occasions consideration was given to placing Mr Rennie on TTM, but this was not instigated prior to his death. Had TTM been initiated, an assessment of Mr Rennie would have been undertaken. If he had been deemed to be at risk of committing suicide, a tailored care plan would have been devised and implemented, with a view to reducing the risk. By way of example, this might have involved moving Mr Rennie to a safer cell or ensuring that he had a greater level of interaction with staff.

[21] Should Mr Rennie have been placed on TTM at any point before his death? The question of whether MR Rennie was having suicidal thoughts appears to have been raised at a number of points during June and July 2020. In particular, on 30 June 2020 Charlotte Gilmour of Phoenix Futures raised a concern regarding a dip in Mr Rennie's mood and the possibility that he might be experiencing suicidal ideation. This prompted Staff Nurse Tracey Darlington to assess Mr Rennie. She recorded that he did not express suicidal ideas during their discussion and she concluded that there was no apparent risk, while identifying that he might require to be placed on TTM following an imminent court hearing. On 1 July 2020 Substance Misuse Caseworker Liz Mackenzie

noted that Mr Rennie was quite low in mood and anxious about the forthcoming hearing. During her discussion with Mr Rennie he admitted having contemplated suicide, but said that he had changed his mind after having spoken to Ms Gilmour. He said that he needed to deal with his emotional issues and advised that speaking to staff helped him with this. Ms Mackenzie saw Mr Rennie again the following day. By this stage he had had his court hearing and the news had been good, but he was "still very low in mood." He denied having suicidal thoughts and said that he would reach out to staff if he had such thoughts. When Ms Mackenzie next saw Mr Rennie on 8 July he appeared to be better than he had been. He spoke of having applied for a pass-man job in order to occupy his time and of having had supportive calls with his aunt.

[22] On 16 July Mr Rennie was seen once again by Ms Mackenzie, who noted that he was "a bit flat at beginning of meeting but started to improve as time passed." They discussed various aspects of Mr Rennie's treatment, including the possibility of increasing his opiate substitution treatment and of antidepressants being prescribed. Mr Rennie spoke of the need to address his underlying mental health problems. Ms Mackenzie did not expressly document whether Mr Rennie had suicidal ideation, but described him as "reflective at times but planning for his future also." She concluded that no concerns had been raised at the consultation and that she would see Mr Rennie again in a couple of weeks.

[23] Mr Rennie's final interaction with a health care professional was on 17 July, when he was seen by Staff Nurse Darlington. During this consultation Mr Rennie disclosed that on 30 June he had attempted to make a noose. He said that had he not

spoken to Charlotte Gilmour he "would be dead today." He reported a rapid lowering of mood and said that he could become quite low, experiencing dark thoughts, quite quickly. He also said that following an increase in his opiate substitute medication his anxiety levels were reduced, which had in turn helped him to sleep better and reduced the risk that he might seek illicit substances. He was still requesting antidepressants. In the records, Nurse Darlington did not document whether Mr Rennie had ongoing suicidal thoughts, but in the chronology that she has prepared for the present proceedings, Nurse Darlington notes that she had a conversation with Mr Rennie about his current mood, during which no concerns were indicated and he denied suicidal ideation. It was agreed that she would email the mental health team to indicate that Mr Rennie wished involvement from them or a psychiatrist and that she would discuss with them the possibility of a short antidepressant course being prescribed to Mr Rennie.

[24] In his report, Mr Douds, Consultant Psychiatrist considers this series of consultations and concludes that Mr Rennie was provided with appropriate care and treatment. He highlights that the notes of the consultations on 16 and 17 July did not include a record of whether Mr Rennie was experiencing suicidal ideation, but he accepts that this is something that the professionals involved would have considered, along with the accompanying question of whether Mr Rennie should have been placed on TTM, given that Mr Rennie had presented with low mood. Mr Douds explains that the question of whether a prisoner should be placed on TTM is a matter of judgment for

the person making the assessment and he makes no criticism of the assessments that were made at the various consultations that took place.

[25] Mr Douds' analysis appears to me to be cogent and I am prepared to accept it. Moreover, what emerges from the various medical entries is that the healthcare professionals involved, Ms Mackenzie and Nurse Darlington, made a series of careful assessments of Mr Rennie's mental state during the weeks before his death, with the aim of providing him with appropriate care and support. In the course of this they repeatedly considered whether he was at imminent risk of committing suicide. Where they reached a negative conclusion they did so for ostensibly logical reasons. Mr Rennie denied having current suicidal thoughts at a number of consultations. The credibility of these denials was bolstered by the fact that at times Mr Rennie would talk openly about having previously had such thoughts, as he did most notably on 17 July. At points he also talked about the future – eg at the consultations on 16 and 17 July. At other times the surrounding circumstances supported the conclusion that he did not pose an imminent risk of suicide, such as on 30 June when Nurse Darlington recorded that SPS staff had not had any concerns about Mr Rennie in the course of their interactions with him. More broadly, in all of the consultations Mr Rennie appears to have engaged positively in a dialogue about his mental state, the current arrangements for his treatment and the way forward.

[26] While the professionals involved did not initiate TTM, they identified various non-emergency treatment options: in particular, prescribing Mr Rennie with antidepressants, initially via a GP appointment; and referring him either to a

psychiatrist or back to the Mental Health Team. Mr Douds provides the opinion that these were reasonable steps to have taken, as no imminent risk of suicide had been identified.

[27] Against this background, I do not think that it can be said that at any point in the weeks running up to Mr Rennie's death the healthcare professionals who were assessing him ought to have identified an immediate risk and placed him on TTM. Instead, Mr Rennie appears to have been provided with appropriate care and support during this period.

[28] Before I leave the subject of Mr Rennie's treatment, I must address a related issue which Dr Douds raises in his report. Two different teams were involved in providing Mr Rennie with care and treatment: the Substance Misuse Team and the Mental Health Team. Dr Douds observes that there were shortcomings in the communication and liaison between the members of these teams. This appears to have manifested itself in a delay in arranging a multi-disciplinary team meeting which did not take place before Mr Rennie's death, despite the need for this having been identified; and also in the form of a delay in a referral reaching Nurse Darlington between 7 July and the date of Mr Rennie's death.

[29] Given that Mr Rennie was provided with appropriate treatment throughout the first half of July 2020 and, in particular, having regard to the fact that he was assessed by healthcare professionals on 16 and 17 July, I do not think that these delays, or any underlying issue of communication between the teams involved, had any detrimental consequences for Mr Rennie. But it is appropriate to record that in response to

Dr Douds' observations, THB has created a standard operating procedure in order to improve joint working between teams within the prison setting (production 2 of THB).

[30] In conclusion, as Mr Rennie was provided with appropriate care and treatment prior to his death, I make no findings regarding this issue in terms of section 26(2) of the 2016 Act.

***The post-lunch check***

[31] I turn next to consider the last check that was carried out prior to the discovery of Mr Rennie's death, and the issues arising from the manner in which the check was carried out. As I have already mentioned, at the time of this check the correct procedure was not followed.

**Locking/unlocking and numbers checks procedure**

[32] The SPS lodged three documents which set out the procedure for making regular checks of prisoners within their cells, during the course of the day: Governors and Managers Action Policy ("GMA") 004A/19, dated 22 January 2019 (SPS production 2); GMA 016A/16, dated 28 March 2016 (SPS production 3); and Standard Operating Procedure for HMP Perth in relation to "Residential Numbers Checks", dated July 2022 (SPS Production 4).

[33] It is unnecessary to narrate the contents of these documents in detail, but for present purposes it is noteworthy that the procedure for which they provide is known as the locking/unlocking and numbers checks procedure. Under this procedure regular

checks must be undertaken by two officers, who are required to ensure that they account for each prisoner. There is a specific requirement that the officers should unlock each cell door in order to see the face of and obtain a response from the prisoner: in other words, there is both an oral and a visual element to a correctly carried out check. The officers are required to engage in a dialogue with prisoners in what is described as a pro-social manner. It is stated explicitly that these measures are designed to reduce the risk of suicide and to identify any person with a deteriorating health condition.

**19 July 2020: The date of Mr Rennie's death**

[34] Mr Rennie was found hanging from his toilet door at 14:17 on Sunday 19 July 2020. He was pronounced dead at 15:07. The last check to be conducted before this was the post-lunch check. It carried out at 13:29 by Prison Officer SK. The check has been captured on CCTV, which shows Prison Officer SK walking past a series of cells, including that of Mr Rennie. He pushes against the door of each cell door as he passes it.

[35] Prison Officer SK swore an affidavit as well as giving parole evidence to the Inquiry. On his account, at the time of the check he rattled the door of each of the cells, and obtained a verbal response from the occupants. He said that when he rattled Mr Rennie's door, Mr Rennie had responded "Aye, I'm fine."

[36] Statements were also available from three prisoners: CC, SH and AM. It was agreed that I should treat these statements as equivalent to the parole evidence of these witnesses. All three witnesses state that prison officers would normally lift the cell hatch

and obtain a verbal response (as opposed to opening the door, as the GMA required), but that this was not done at the time of the check in question. In addition, SH and AM state that while their doors were rattled, no verbal response was sought from them.

[37] As will be apparent from this summary, on 19 July 2020 the post-lunch numbers check did not comply with the requirements in that (a) it was undertaken by only one officer; and (b) no attempt was made to open the cell-door and make a visual check of the prisoners in their cells, including Mr Rennie.

[38] What is also striking about the CCTV footage is the speed at which the officer can be seen moving along the hall, past each individual cell. Any scope for more than the most cursory of verbal exchange with each prisoner must have been minimal; and would have fallen far short of a dialogue of the sort that the GMA envisages. On one view, the footage might be taken as being consistent with the accounts of the prisoners, to the effect that not even a verbal response was sought from them. However, Prison Officer SK was clear in his evidence that he received a reply from Mr Rennie. Prison Officer SK seemed to me to be a candid and straightforward witness and, on balance, I am prepared to accept his evidence on this point, notwithstanding the speed at which the check was conducted.

**Training**

[39] The manner in which the post-lunch check was undertaken on 19 June 2020 raises the questions of what training Prison Officer SK had received and, more generally,

of what arrangements SPS had in place for training officers to perform checks and for ensuring that the officers complied with their training.

[40] Prison Officer SK's evidence was that he did not receive formal training in relation to numbers checks prior to June 2020. He explained that he had been appointed as an operations officer. He had attended an 11-week training course for this role in around November 2019. The course had not included training on locking/unlocking and numbers checks procedure. Shortly after taking up his post as an operations manager Prison Officer SK had been promoted to the post of residential officer. In this role he was responsible for undertaking such checks. Again, he received no formal training, but instead learned on the job by shadowing more experienced officers. Prison Officer SK said that at the time he had understood that he required only to obtain a verbal response from the prisoners, and he had not been told that checks must be undertaken by two officers. Later in his evidence, however, he acknowledged that officers usually did the checks in pairs and that they would see the prisoners as well as obtaining a verbal response from them. SPS did not challenge Prison Officer SK's evidence on these points, nor did they lead evidence to contradict his account of having received no training.

[41] The Inquiry also heard evidence from Prison Officer PM, who had worked in HMP Perth since taking up employment with the SPS in 1999. Prison Officer PM did not recall having been trained in locking/unlocking and numbers checks procedure either during his original training course in 1999 or at any time prior to July 2020. He said that at that time his understanding had been that the post-lunch check involved obtaining a verbal response from prisoners by shouting through the cell doors to them. If a prisoner

replied there would be no need to make a visual check, though it would be necessary to do so if there was no response. Prison Officer PM said that it was common practice for the first officer back from lunch to undertake the post-lunch numbers check alone. The position had changed in around 2020, when he and his colleagues had been given training in relation to the locking/unlocking and numbers checks procedure. He was uncertain as to how this training had been given – ie whether this was done on a training day or whether the officers had simply been handed over training documentation and invited to read and sign it. In any case, the officers had started working in pairs and making sure that they opened the doors of cells in order so see the prisoners and obtained a verbal response from them.

[42] Prison Officer PM struck me as a straightforward witness who was doing his best to assist the court. His evidence was not challenged in cross examination by SPS. I had no difficulty in finding him credible and reliable. I accepted his evidence regarding the operation of numbers checks in practice, including his description of what he called "common practice" in relation to post-lunch checks prior to July 2020.

[43] SPS lodged an affidavit for Andrew Hodge, Governor of HMP Perth, in which he acknowledged that the correct procedure had not been followed at the time of the post-lunch check on the day of Mr Rennie's death. Mr Hodge explained that following Mr Rennie's death he introduced refresher training in relation to the procedure for locking/unlocking and numbers checks. He referred to a power point presentation which sets out the correct procedure (SPS production 7), although he explained that during the time of Covid-19 restrictions training could not be delivered to groups of

officers: instead, individual officers had been required to attend their First Line Manager's office in order to read through the presentation and to sign a form, confirming that they had done so.

[44] SPS also provided an affidavit for Jane Brown, Learning and Development Manager at HMP Perth, in which she explained the current arrangements in place for training. She said that training is now delivered to both new recruits and transfers to HMP Perth. Both operational and residential staff receive a session on numbers checks training which lasts 90 minutes. The training confirms that both officers must see the face of the prisoner and hear his verbal response.

[45] [46] SPS lodged an affidavit for Barry John Davidson, head of Finance and Compliance at HMP Perth, dated 19 April 2024. Mr Davidson confirmed that GMA 016A (the document that sets out the procedure for locking and unlocking prisoners, as mentioned earlier) was previously made available to staff by being placed within the Governor Order Book, which was placed on a wooden pedestal that was situated at the front of the house. The current arrangement is that GMA's are uploaded onto SPS's internal internet service, Share Point. If a new GMA is uploaded, a link to Share Point is sent to staff members via email. Mr Davidson acknowledged that Share Point is not always easily accessible to officers, as it is accessed via a PC and there is only one PC on each residential hall. Mr Davidson explained that staff members are delegated the responsibility of reading any new GMA, policy, or procedure that the Governor should issue.

[46] Finally, in the course of making submissions the agent for SPS advised me that since April 2024 all officers have started to receive mandatory annual refresher training on the locking/unlocking and numbers checks procedure.

**Analysis**

[47] What conclusions can be drawn from this evidence?

[48] First, the post-lunch numbers check did not comply with the requirements, as it was undertaken by only one officer, who obtained a verbal response from Mr Rennie but did not open Mr Rennie's cell door in order to make a visual check of him.

[49] Second, the officer in question, Prison Officer SK, had not received training on the locking/unlocking and numbers checks procedure.

[50] Third, Prison Officer SK seems not to have been unique: Prison Officer PM, who was a more experienced officer, could not recall having received training on these procedures and had incorrectly understood that the post-lunch check could be undertaken by a single officer and involved no more than obtaining an oral response from the prisoners. He described this as common practice. This is suggestive of a general failure on the part of SPS to ensure that the officers were trained in and complied with the procedure for locking/unlocking and numbers checks, in particular, the post-lunch check.

[51] Fourth, subsequently SPS have acted to remedy the position. All of their staff have been required to undergo training on the locking/unlocking and numbers checks procedure. SPS have also introduced training on the procedure for new staff members

and for staff who are transferring to HMP Perth. A feature of the circumstances with which this Inquiry is concerned is that Prison Officer SK had been promoted from an operations post to a residential post. According to SPS, the position today is that both operations officers and residential officers receive training on the procedure. In addition, a regime of obligatory annual refresher training on the procedure is now in place.

**Statutory findings**

[52] Against this background it is necessary to determine whether any findings should be made in terms of section 26(2)(e), (f) and (g) of the 2016 Act.

***Section 26(2)(e)***

[53] I shall deal first with section 26(2)(e), which is concerned with precautions that might have been taken. The legislation requires the court to apply a two-part test, first, identifying any precautions which could reasonably have been taken; and second, determining whether any such precaution might realistically have resulted in the death being avoided. Both of these requirements must be satisfied before the court may make a finding under section 26(2)(e). Insofar as the first part of the test is concerned, the term "reasonably" relates to the reasonableness of taking precautions rather than to the foreseeability of the death or accident.

[54] The correct approach to be taken to second part of the test was authoritatively laid down by Sheriff Kearney in his determination following the Inquiry into the Death of James McAlpine (Glasgow, 17 January 1986):

> "the phrase 'might have been ' avoided is a wide one … it means less than 'would on the balance of possibilities have avoided' and rather direct one's mind in the direction of lively possibilities."

Similarly, in the Inquiry into the Death of Kathryn Beattie (Glasgow, 4 July 2014) Sheriff Ruxton observed:

> "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."

[55] In light of this, the following questions fall to be answered: (i) would it have been a reasonable precaution to ensure that all prison officers at HMP Perth who were tasked with undertaking numbers checks were adequately trained and complied with their training? (ii) is there a lively possibility that Mr Rennie's death might have been prevented if this precaution had been taken?

[56] The first of these questions may readily be answered in the affirmative. Part of the point of undertaking regular visual and verbal checks of prisoners is to reduce the risk of suicide. Self-evidently it would have been a reasonable precaution to have ensured that the officers understood and complied with the procedure that SPS had devised for this purpose.

[57] But the second question is more difficult. The factual background was that Mr Rennie had had contact with mental health professionals and substance misuse workers in the weeks that preceded his death, as discussed above. But while the

possibility of initiating TTM had been raised at various points, the view had been taken that this was unnecessary. It is of particular moment that Mr Rennie was not considered to be at risk of committing suicide when he was assessed during the 72-hour period prior to his death, on 16 and 17 July 2020. On the morning of 19 July 2020 Prison Officer SK recalled seeing Mr Rennie at the lock-up at around 11:42. According to Prison Officer SK, Mr Rennie was fine and was quite excited about the prospect of getting a guitar lesson. Accordingly, prior to the post-lunch check there were no pressing indicators that he was at imminent risk of suicide. I proceed on the basis that at 13:29 Mr Rennie was still alive, as I have accepted that he responded to Prison Officer SK during the post-lunch numbers check. Mr Rennie was discovered to have hanged himself at 14:17.

[58] What would have happened if the 13:29 check had been carried out properly, with two officers opening the door, seeing Mr Rennie's face and engaging in a dialogue with him? Would it have been apparent that something was wrong? Was Mr Rennie in a state of distress at the time and would something in his demeanour have betrayed this? Was he taking practical steps that would have come to light? Would anything observable have caused the officers to intervene? If so, what steps would have been taken? Would TTM have been initiated? Would he then have been assessed as being at risk of committing suicide? What form of care plan would have been implemented? Would Mr Rennie's death have been prevented?

[59] These questions may be salient but they are ultimately elusive as the evidence provides no answers to them. In view of the imponderables it is not possible to say

what would have transpired if the post-lunch check had been carried out properly. Critically, there is no way of knowing how Mr Rennie would have presented. This amounts to an unbridgeable evidential gap which cannot be crossed, as it would have to be, before it could reasonably be concluded that Mr Rennie's death might have been avoided. Accordingly, I shall make no finding under section 26(2)(e).

***Section 26(2)(f)***

[60] I turn next to section 26(2)(f) which requires the court to identify any defects in any system of working which contributed to the death. In order to make a finding under section 26(2)(f) the court must not only be satisfied of the existence of a defect in a system of working, but must also find, on the balance of probabilities, that the defect contributed to the death. It will be noticed that the latter of these requirements is more onerous than the "lively possibility" test, discussed immediately above, under section 26(2)(e).

[61] It might be said that the fact that the post-lunch check was not conducted in accordance with SPS's requirements on 19 July 2020 was indicative of a defect in the system of working. Moreover, Prison Officer PM's evidence that it was common practice for post-lunch checks to be carried out in this way suggests that what was done was indicative of a general and systemic failure on the part of SPS to ensure that the correct procedure was followed.

[62] But I am not persuaded that this can be said to have contributed to Mr Rennie's death, on the balance of probabilities. This is for the same reason that I have been

unable to find that there is a lively possibility that Mr Rennie's death might have been prevented had the post-lunch check been carried out properly: it is impossible to know what, if anything, would have come to light if the check had been properly carried out, with two officers engaging in a dialogue with Mr Rennie through an open door.

***Section 26(2)(g)***

[63] The next issue for determination is whether a finding should be made regarding any other facts that are relevant to the circumstances of the death, in terms of section 26(2)(g). On this issue the Crown and SPS advanced competing submissions.

[64] The Crown submitted that it would be open to the court to make findings under this provision that (a) the numbers checks policy was not complied with at the time of the post-lunch check; and (b) the officers had not been adequately trained and did not properly understand the policy.

[65] Conversely, SPS submitted that findings could only properly be made under section 26(2)(g) of facts that were "relevant to the circumstances of the death." The fact that evidence might have had been led at the Inquiry did not mean that it related to the circumstances of the death. While it was accepted that the Inquiry had heard evidence that Prison Officer SK had not conducted the post-lunch check in line with the procedure that was in place at the time, and that he appeared to have been unaware of the terms of the numbers check policy, these circumstances were unrelated to Mr Rennie's death.

[66] In my opinion, the submissions of the Crown are to be preferred. At the stage of assessing whether a finding should be made under section 26(2)(g) the court does not require to be satisfied that the facts in question are causally connected to the death: the question for determination is whether those facts are relevant to the circumstances of the death. The occurrence of a suicide within a prison will inevitably prompt the questions: what procedures were in place to reduce the risk of suicide and were those procedures followed? The answers to these questions will invariably be facts which are relevant to the circumstances of the death for the purposes of the legislation, as they concern measures that were intended to address precisely the risk that has materialised.

[67] In this case I consider it to be relevant to the circumstances of Mr Rennie's death that (i) he post-lunch numbers check that was carried out at 13:29, shortly prior to the discovery of Mr Rennie's death, deviated from the locking/unlocking and numbers check procedure, as it was carried out by a single officer who did not open the cell door in order to make a visual check of Mr Rennie; (ii) the officer who conducted it had not been trained in the procedure; (iii) it was common practice within HMP Perth for a single prison officer to undertake the post-lunch check and for no visual check of the prisoners to be made; and (iv) the prison officers had not been adequately trained and were not aware that all numbers checks, including post-lunch checks, should be undertaken by two officers and should involve opening cell doors, seeing the face of prisoners and obtaining a verbal response from them.

[68] Accordingly, I have made findings under section 26(2)(g), as set out at the start of this Determination.

**Recommendation**

[69] The final issue that it is necessary to address is whether any recommendation should be made to SPS. Reading the terms of section 26(1)(b) and section 26(4) together, it would be open to me to make a recommendation as regards the taking of any reasonable precautions, the making of improvements to any system of working, the introduction of a system of working or the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

[70] In this Inquiry I have found that the post-lunch check carried out prior to Mr Rennie's death did not comply with SPS's procedure for locking/unlocking and making numbers checks; and that both the prison officer who conducted it and his colleagues at HMP Perth had not been adequately trained in those procedures and did not properly understand them. Given that part of the purpose of having the procedure is to reduce the risk of suicides, it can reasonably be concluded that other deaths might realistically be prevented in similar circumstances if SPS were to take steps to ensure that the prison officers understand and comply with it.

[71] Is it necessary to make a recommendation to achieve this end? I do not think so. This is because the problem appears to have been addressed satisfactorily by SPS. As set out above, they have provided existing staff with refresher training on the locking/unlocking and numbers checks procedure, introduced training on the procedure for new recruits and for transfers to HMP Perth, whether they are to take up operational or residential posts, and they have implemented a regime of mandatory annual refresher

training for all staff. It is to be hoped that these measures will serve to ensure that in future prison officers will understand and comply with the locking/unlocking and numbers checks procedure.

[72] Accordingly, I make no recommendation.

**Conclusion**

[73] All that remains is for me to express my sincere condolences to Mr Rennie's family.