SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT PERTH

[2018] FAI 21

PER-B10-18

DETERMINATION

BY

SHERIFF GILLIAN A WADE QC

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

into the death of

JOHN WILLIAM MONTEATH
(4 June 1991)

PERTH 5 June 2018,

The sheriff, having considered the application, the evidence presented, the joint minute, the productions used in evidence and the submissions made:-

FINDS AND DETERMINES under section 26 of the Inquiries into Fatal Accidents And Sudden Deaths etc. (Scotland) Act 2016:

(1) In terms of subsection (2)(a) that John William Monteath, whose date of birth was 4 June 1991, died at 1610 hours on 28 December 2015 at Perth Royal Infirmary;

(2) In terms of subsection (2)(c) that the cause of his death was suspension by the neck by ligature (hanging);

(3) In terms of subsection (2)(e) that there were no precautions which could reasonably have been taken and which, had they been taken, might realistically have resulted in his death being avoided;

(4) In terms of subsection (2)(g) that there are no other facts which are relevant to the circumstances of his death.

NOTE

[1] This fatal accident inquiry ("the Inquiry") was convened to enquire into the circumstances of the death of John William Monteath ('Mr Monteath '). His date of birth was 4 June 1991.

[2] The deceased was a convicted prisoner having been convicted of assault to injury on 19 June 2015. He was sentenced to 2 years, 7 months and 20 days imprisonment. Shortly prior to his death he was incarcerated at Cell 11, Flat 4, B Hall, HMP Perth, Edinburgh Road, Perth. His earliest date of liberation was 3rd October 2017.

[3] He died on 28 December 2015 at Perth Royal Infirmary.

[4] The holding of the Inquiry is mandatory under and in terms of section 2 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act") because his death occurred in Scotland and at the time of his death he was in the legal custody of the Scottish Prison Service within a prison.

[5] Other than the Procurator Fiscal, the participants in the Inquiry were Tayside Health Board, the Scottish Prison Service, the Prison Officers Association and members of the deceased's family, principally represented by the next of kin, Rachel Somerville. All parties were legally represented.

[6] The Inquiry heard from 6 witnesses, namely

1. Reverend Kenneth Russell, the prison chaplain
2. Dr Mark Anthony Wallace, the General Practitioner
3. Elaine Armstrong, the mental health nurse who attended the deceased
4. DC Stanley Gilroy
5. Natalie Campbell, Prison Officer
6. Hazel Donaldson, mental health nurse

[7] The parties had also entered into an extensive joint minute of admissions which greatly reduced the requirement for oral evidence and agreed a number of the salient facts.

[8] Shortly prior to his death the deceased had been the sole occupant of Cell 11, Flat 4, B Hall, HMP Perth, Edinburgh Road, Perth. It was agreed that there were no special risks indicators attached to the deceased by the prison and as such he was not subject to any special measures.

[9] About 1810 hours Saturday 26 December 2015 prison officer Laura Barnett was within the office in B-Hall along with prison officer Natalie Campbell. At this time they received a call from the deceased's cell. The deceased asked to speak to any staff who knew him. Laura Barnett offered to go and see him or have a manager do this but he declined and said he was 'fine'. Natalie Campbell overheard this and as she was familiar with deceased she, along with Laura Barnett went to see him. They checked the handover sheet at his cell and noted that there were no issues regarding the deceased during the day. They found the deceased sitting on his bed reading a book. He was also noted to have a sheet of paper in front of him on which he appeared to have been writing. When spoken to he was smiling, joking and generally presented well. Natalie Campbell asked the deceased why he wanted to see someone and he replied something similar to "ACH IT'S NOTHING, DON'T WORRY ABOUT IT" and "CHRISTMAS IN THE JAIL IS SHITE". The conversation lasted a few minutes and concluded with the deceased saying he was fine.

[10] About 2020 hours same date Laura Barnett carried out another check on the deceased. On arrival at his cell, she could hear music from within the cell but on knocking at the door and shouting through same, she received no reply. She looked through the observation hatch but could not see into the cell due to the toilet door being pulled over in an apparent deliberate attempt to obscure the view. Officer Barnett called for assistance as

she was not authorised to enter the cell. About 5 minutes later Natalie Campbell arrived along with Prison officer Steven Shillan. Officer Campbell shouted on the deceased but there was still no answer. They were joined shortly afterwards by Prison Manager, Brian Sharp and with his permission they unlocked and entered the cell. They found the deceased alone on his bed lying face down with a green sheet tied around his neck and attached to the bedframe at the bottom of the bed. Brian Sharp immediately snapped the ligature around the deceased's neck and requested a first aid kit. He and Steven Shillan turned the deceased onto his back and commenced CPR. Whilst doing this said witnesses noticed an orange coloured liquid coming from his nose and mouth. Ryan Hartridge also attended and assisted with cleaning the deceased's nose and mouth of the discharge. The deceased did not respond to the CPR.

[11] An ambulance was called and two double-crewed units attended. The deceased was removed from the prison and conveyed to Perth Royal Infirmary. On arrival, Consultant Anaesthetist Rhona Younger oversaw his initial treatment before he was transferred to the Intensive Therapy Unit (ITU).

[12] About 2230 hours, same date, the matter was reported to the Police. The Police were advised that the deceased was being intubated, and had suffered a brain injury. However the extent of this was unknown and he was to be monitored overnight. During 27 December 2015 the deceased continued to show no brain activity. However he was able to breathe on his own to some extent.

[13] About 1845 hours on the same date Detective Sergeant Lamont attended at HMP Perth in his capacity as Scene Manager along with Detective Constable Watson, Scene Examiner Megan Bassett and search trained officers' Constables Stephen Harley, Colin McDonald and Stuart Roy.

[14] Crown production number 3 is a book of photographs taken on 27 December 2015 at the locus by Megan Bassett, Scene Examiner and a member of the Scottish Police Services Authority, Forensic Services, Scene Examination, Dundee. The said book of photographs contains the following:

a) Views from communal floor into cell, and around same, including the ensuite toilet.

b) Views within the cell showing the bed and other personal effects.

[15] The locus was searched and a number of items were recovered including a quantity of letters, prescribed medications, two apparent ligatures and a piece of paper with writing thereon which is possibly a 'tick list' and a burnt tin foil consistent with heroin having been smoked on the foil.

[16] The deceased's condition deteriorated and about 1610 hours on Monday 28 December 2015 he was pronounced dead by Consultant anaesthetist Gordon Forbes. However the deceased was kept on life support systems in order to facilitate organ donation.

[17] During the morning of Wednesday 30 December 2015, the organs of deceased were harvested and life support systems were shut down.

[18] About 1450 hours, same date, Detective Constables Lowndes and Morrison conveyed deceased from Perth Royal Infirmary to the Police Mortuary Dundee to await his Post Mortem.

[19] On 31 December 2015 Dr David Sadler, Forensic Pathologist, carried out a post mortem examination of the body of the said John William Monteath and certified the cause of his death as: 1(a) HANGING.

[20] The results of said examination are accurately recorded in the Post Mortem Report dated 31 December 2015 (Crown Production number 1) and the contents of said report were agreed to be true and accurate.

[21] Toxicology analyses were performed on hospital admission samples with negative results. The results of said analyses are accurately recorded in the Toxicology Report dated 1 February 2016 (Crown Production number 2) and the contents of said report were agreed to be true and accurate.

[22] On 8 May 2015 the deceased was seen within the prison by Dr Wallace as he was deemed to be at risk of self-harming due to having cut his neck on 7 May 2015 in prison. It appeared to have been a minor injury only and the deceased stated that he did it because he was 'bored'. The wound was treated with steri-strips. The deceased appeared to have had a history of depression even prior to coming into prison in February 2015.

[23] In May 2015 the deceased was put on AT RISK due to his self-harm. He was checked every 15 minutes and placed in an anti-harm cell. On 15 May 2015, the deceased was taken off AT RISK as he appeared mentally well and there were no other concerns at that time. He was seen by the Mental Health Team on a regular basis and there were no concerns about his mental health. He was seen regularly every 1 to 2 months, the last time being 17 December 2015.

[24] The deceased's last visit to the medical suite within the prison was on 17 December 2015 when he was seen by a nurse, Elaine Armstrong. At this time the deceased stated he felt depressed due to his physical health which possibly related to his recurring backache. Up until then the deceased had been receiving support from the Mental Health team due to his history of depression; however on 17 December 2015 he stated to staff he no longer required this support and as such he was discharged from it.

[25] Crown Production number 4 is a Death in Custody Folder prepared by Scottish Prison Service. The folder contains a Disc which is a recording of telephone calls made by the now deceased to his mother Pauline McKay, his partner Rachel Sommerville and Linda Tarbett.

[26] Crown Production number 5 contains the Scottish Prison Service Health records pertaining to the deceased, John Monteath also noted as John Monteith.

[27] Crown Production number 20 is the ACT 2 Care document prepared by the Scottish Prison Service. The ACT 2 Care ("ACT") document is the Scottish Prison Service Suicide Risk Management Strategy which was in place at the time of the deceased's death. ACT was introduced by the Scottish Prison Service in its most recent form in 2005, with a version of the strategy having been in place since 1998. ACT stands for Assessment Context Teamwork. On 5 December 2016, ACT 2 Care was replaced by a revised strategy known as "Talk to Me, the Prevention of Suicide in Prison Strategy."

[28] Crown Productions number 6-13 & 15 are notes and letters written by the deceased to various persons.

[29] Production number 1 lodged in the second list of productions on behalf of the next of kin is a report prepared by Forensic Psychologist Vicky Orme on 1 December 2012. The said report was requested by the Court for a Court hearing of 5 November 2012. The said report is a forensic Psychology report in relation to the deceased. No other report was prepared by Vicky Orme in respect of the deceased.

[30] The witnesses adduced by the Crown were all credible and reliable and indeed their credibility was not challenged to any extent. The Reverend Kenneth Russell had clearly formed a strong bond with the deceased and was offering him counselling as well as the opportunity to talk. He was clear that the deceased had been referred to him by his personal

manager, Jim Daly, on the basis it was considered that the Reverend Russell might be able to assist with issues relating to a bereavement which the deceased had suffered during his childhood.

[31] Reverend Russell told the inquiry that the deceased had reported to him that his childhood friend and he had been in the company of an older boy who had encouraged them to walk across a glass roof. The deceased's friend had followed the older boy's instructions and had fallen through the roof to his death. The deceased had experienced feelings of guilt and blame because he felt he had not done enough to protect his friend and discourage him from complying with the older boy. The deceased associated his behaviour in later life with this incident. He had resolved that he would not let a friend down again but had come to realise that this meant that he was exploited by his friends who would contact him to deal with situations as he was now considered a "hard man". The consequence of this was that he had been unable to avoid getting himself into trouble.

[32] Reverend Russell was aware that the deceased had self-harmed on a previous occasion. It appeared that the incident of self-harm occurred shortly after the deceased had had his first meeting with Reverend Russell. This caused Reverend Russell some concern to the extent that he discussed the matter with his counselling supervisor to determine whether there was anything he ought to have done differently in relation to the counselling he was providing. Reverend Russell had discussed the reasons behind the deceased's attempted suicide with him and was assured by the deceased that they did not relate to the matters in relation to which he was obtaining counselling, namely the death of his childhood friend. On the contrary the deceased said that he had had a difficult conversation with his partner due to perceptions of infidelity which were not unusual within the prison population.

Although Reverend Russell could not initially remember the name of the deceased partner he was later prompted to recall that her name was Rachel.

[33] The Reverend Russell recounted that the second last occasion on which he had seen the deceased was at a case management conference where the discussion centred round a potential move to the open estate. The deceased had indicated at that case conference that he would prefer to remain in the closed estate because he felt that he was benefiting from the input provided by the Reverend Russell. At this stage the deceased was meeting with Reverend Russell on a fortnightly basis. In consequence at a further meeting with the deceased, Reverend Russell discussed refocusing their counselling sessions in order that the maximum benefit could be achieved from them. He was clear that the deceased was looking into the New Year and expected to carry on the counselling sessions in the future. At his last meeting he had no concerns about the deceased.

[34] Reverend Russell became aware of the deceased's attempted suicide on 27 December 2015 when he attended at Perth prison in order to carry out Sunday worship. He was advised that the deceased was at that time in the intensive care unit at Perth Royal Infirmary. He made arrangements to attend at the hospital with the permission of the family and thereafter engaged with the family until the deceased finally passed away. The family, particularly the deceased's mother, asked the Reverend Russell to officiate at the deceased's funeral.

[35] Reverend Russell was familiar with the ACT 2 Care suicide prevention strategy and had had previous experience of placing prisoners under its supervision. He indicated that in the event that any prisoner made a remark to him which caused concern he would make clear that he had a duty to keep that prisoner safe and that he would discuss the matter with the hall manager in the presence of the prisoner himself. The prisoner would be aware that

this might mean that he was being placed on ACT and in the past this course of action had caused the Reverend Russell to fall out with another inmate. However he was clear that if he had had any concerns about the deceased this is the course which he would have taken.

[36] The inquiry then heard evidence from Dr Wallace who had seen the deceased on a number of occasions during his time in custody but did not recall him personally. He had not been involved in his mental health treatment and indicated that it would not have been the usual practice for him or any of his colleagues to have attended case management conferences.

[37] He indicated that he had been involved with the deceased in May 2015 after the incident of self-harm. He was taken to Crown production number 5 where there were entries on 8 May and 8 July 2015 indicating that the deceased had had contact with him.

[38] He was able to explain in detail the procedures under the ACT 2 care suicide prevention strategy. He explained that when people are in prison and identified as a risk of self-harm or suicide they would have been put on the existing suicide prevention strategy which provided various degrees of supervision. The highest level of supervision is known as 15/15. In addition those at highest risk are placed in what is known as a C4 cell where they are not allowed any items which could constitute ligatures or any sharp objects. Accordingly the opportunity to self-harm would be minimised. It was confirmed that following the self-harm incident in May the deceased had been placed on ACT at the highest level of supervision.

[39] He was taken to the ACT document itself which constituted Crown production number 20 and to a reference on 7 May made at 18:10 hours. It was observed by Dr Wallace that this had been completed on the hall because it had been completed by officers. At page 430 he had noted that the deceased's mood was hard to judge and that it appeared to be his

thinking that the self-harming incident would be a way of "getting revenge" at his girlfriend with whom he had recently had a difficult telephone conversation.

[40] In his police statement Dr Wallace had said that there was no indication that the deceased would be inclined to commit suicide. While Dr Wallace could not remember having said that he confirmed that if he had told the police that at the time that would have been the truth.

[41] When taken to the appropriate records Dr Wallace was able to confirm that the deceased was receiving an antidepressant medication and a painkiller.

[42] The next witness to give evidence to the inquiry was Elaine Armstrong who was a forensic community mental health nurse and had been working within the mental health team at Perth prison at the time of the deceased's incarceration. She had a good knowledge and recollection of the deceased. She was able to confirm that the first time she had seen the deceased he had cuts to his neck which she knew had arisen from an attempt at self-harm. He was on ACT supervision at that time and she had agreed to keep him subject to that supervision. She confirmed that the deceased himself would have been involved in that decision making process. She noted that on 15 May 2015 he was taken off ACT as he was apparently mentally well. Thereafter he was seen by the mental health team on a regular basis. She recalled that she had had three or four meetings with the deceased.

[43] She recounted that when she had first met with the deceased they had agreed on a plan because he wished to address his anger and wanted strategies to manage his emotions. In order to facilitate this Elaine Armstrong gave the deceased 'homework' which he completed and brought back to a subsequent meeting. She was pleased and hoped that they were going to carry on with the work which they had begun. Unfortunately at the next meeting the deceased presented as unhappy because of the care he was receiving in relation

to his physical health problems. The witness could not remember precisely what the physical problems were but believed it was a bowel problem. As a result of his disquiet she agreed to sit in on GP appointments and as a consequence he was referred to Perth Royal Infirmary. The deceased had been sceptical as to whether such a referral had in fact been made and Ms Armstrong double checked and confirmed that it had "gone through".

[44] On the next two occasions when Ms Armstrong met with the deceased he presented as angry and continued to complain about the care he was receiving from the GPs. Despite Ms Armstrong making clear that she could do nothing more with regard to his complaints in relation to the doctors he persisted with his anger and would not engage with the work she was attempting to carry out to address coping mechanisms. As a result the meetings which she had with him lasted 2 to 3 minutes. However she had no particular concerns about his mental health or any suicidal ideation because he had future plans. He had told her that he wanted to go to college and to support his partner about whom he talked a great deal. Ms Armstrong did not feel the need to refer him to a psychiatrist because he did not have a mental illness.

[45] Accordingly despite a positive start he refused to engage further with her in relation to his mental health issues. He remained disgruntled and was "ranting and shouting" regarding the physical health care which he was getting. He stated that he did not want support from mental health services. No other professional working within the mental health team had been able to engage him previously and as a result of the deceased's rejection of assistance from Ms Armstrong she discharged him from her care in the knowledge that he was continuing to see Reverend Russell.

[46] In cross-examination she was taken back to the entries which had been made following meetings between the mental health team and the deceased on 11 and 15 May

2015. In particular reference was made to an assessment which had been made in 2012 by Vicky Orme who is a consultant forensic psychologist. She had been instructed to prepare a risk assessment report following the deceased's conviction.

[47] Interestingly Ms Armstrong indicated that it was her view that the deceased may have benefited from a referral to a clinical psychologist but there was no clinical psychologist attached to the prison. She had attempted on various occasions to engage clinical psychologists from out with the prison setting but none were available to provide the sort of assistance she envisaged would assist prisoners such as the deceased. She believed that he may have benefited from the intervention of a clinical psychologist because of the past trauma which he visited over and over again. He considered that a lot of the anger he had at others was linked to the fact that he blamed himself for the death of his childhood friend. She confirmed that anger and blame could be linked to suicide. At the time she was dealing with the deceased she had not been aware of the content of the report by Vicky Orme. However she had now had an opportunity to read it. She confirmed that the individual portrayed in the report reflected the deceased and that she agreed with the description of him.

[48] She was specifically asked whether, having seen this report, there was anything which she could have done in terms of further referrals or assessments which might have affected the situation or prevented the deceased's death. She answered that question in the negative and said that she could have done no more in the environment within which she was working. The issue appeared to be that there were no clinical psychologists available to provide therapies although there are forensic psychologists who will provide therapies in relation to offending behaviour. She stated that at the time there was no pathway for

referring in or out of the prison. However she added that this had now changed but that was not further explored with her.

[49] She added that if he were at liberty he would have been able to access clinical psychological services through the adult psychological therapies services but clearly this would involve his engagement with those services. The report from Vicky Orme made it clear that he had been offered these services in 2010 and had failed to take them up or engage meaningfully. While she thought that he required additional clinical psychological input she pointed out that she did not think that this would have had any effect on his treatment because a) he had not engaged with services in 2010 and b) by 2015 was refusing to engage with her to work on his anger management issues and would not engage with the rest of the mental health team.

[50] Of course Elaine Armstrong was not the only mental health nurse who had treated or had involvement with the deceased and the court heard later (on 29 May 2018) from nurse Hazel Donaldson who had been working within the prison system at the time of the deceased's incarceration. She was considerably less experienced than Nurse Armstrong but had met with the deceased in the immediate aftermath of the self-harming in May 2015. She was the author of the entry in the medical records dated 8 May 2015 which was scrutinised in some detail.

[51] That entry was a mental health assessment which took place on the same day as a case conference in relation to the suicide prevention strategy. At the time the deceased was subject to the highest level of observations. When asked about the reasons for his self-harm on that occasion he stated that his girlfriend had cheated upon him and that is why he cut his neck. He identified that he pulled at coping and referred to the psychological assessment carried out by Vicky Orme. He indicated that he had been diagnosed with 'a split

personality, obsessive-compulsive disorder, post-traumatic stress disorder, anxiety and depression.' The note indicated that the validity of this statement would require to be looked at before the next case conference which was to be held on Monday, 11 May 2015. The note also records that by that time the deceased was denying any further thoughts of suicide or self-harm and was blasé about the seriousness of the recent incident. He presented as chatty and pleasant during the first part of the case conference but became verbally abusive when the multidisciplinary team agreed that he should remain subject to the high risk observations in the safe cell. At this time he became abusive and in no uncertain terms told the team to get out of the cell.

[52] At the next case conference on 11 May 2015 the deceased's mood seemed much improved and he was happy with the outcome of the meeting. As already noted he was removed from ACT on 15 May 2015.

[53] In the course of her evidence Hazel Donaldson indicated that she had reported the outcome of the initial case conference to her superiors and had understood that they would follow up the investigations into the report by Vicky Orme. It is clear that that did not occur. However if one actually looks at the report it is clear that its content does not accord with the conditions self-reported by the deceased. In any event there were numerous follow-up appointments which took place after the incidents in May. The report was of course prepared as a risk assessment to consider the role of drug and alcohol abuse in the deceased's offending behaviour. The report was, by 2015, some three years old. In addition it noted that the deceased had entrenched antisocial violent attitudes which caused concern. There was a strong recommendation that he should engage in and complete the violence program prior to further community access and, so far as further psychological therapy was concerned, the report indicated that such treatment would require that level of stability and

a change of attitude which as at 2012 had not been achieved. Accordingly having regard to the actual content of the report it is difficult to see what benefit it would have provided professionals dealing with the deceased in 2015. I shall return to this issue in relation to the submissions which were made regarding recommendations.

[54] The inquiry also heard evidence from Natalie Campbell who was one of the prison officers on duty the evening the deceased took his life. She was an impressive witness in many ways and had clearly formed a good association with the deceased. She was visibly upset when giving her evidence and spoke of the deceased in affectionate terms. She described him as someone with whom she could have "banter". She explained that as a pass man he had achieved a level of trust within the prison environment. She described him as a popular individual and someone with whom she could have a chat. She explained that when he was upset that would be obvious by his demeanour and that on this particular occasion she had no concerns whatsoever. She described the conversation in which he said that the jail was "shite" at Christmas and she frankly agreed with that assessment stating that no one wanted to be locked up and away from their family at Christmas time. She was fully aware of the suicide prevention strategy which was in place and would have had no hesitation in placing the deceased upon that had she had any concerns whatsoever. The deceased had written her a letter apologising for the fact that she would have found him dead. The letter was perhaps somewhat ambiguous in its terms as it apologised for not having told her the truth. It is not entirely clear what the deceased meant by that and it does not seem appropriate to speculate. However it is probable that he was referring to the fact that shortly before he was found he had indicated to her that he was fine.

[55] She indicated that she would have looked for a lack of eye contact or disarray within the prison cell as a clue that all was not well with the deceased. On the contrary he seemed

chatty and was laughing and joking with her shortly before the events which led to his death.

[56] It was very clear from all the witnesses with whom the deceased had had recent interaction that there was no reason for them to suspect that he intended to take his life. All of the individuals be it prison officers, nursing staff, doctors, and the Reverend Russell were fully trained on the suicide prevention strategy in operation and would have had no qualms whatsoever about taking action under that strategy if they had any cause for concern. It was clearly a shock to the witnesses, particularly Reverend Russell and Natalie Campbell, that events took the course which they did. All witnesses talked about the deceased making plans for the future which is inconsistent with suicidal ideation. I therefore have no hesitation in concluding that there were no outward signs that the deceased intended to embark upon this path in the days or hours immediately preceding his death.

[57] The main focus of the inquiry came to be whether there could have been any interventions which might have prevented the ultimate outcome for the deceased. There is no doubt that neither the Reverend Russell nor the GPs with whom the deceased had contact had any cause for concern in the months between May 2015 and December 2015 following the first incident of self-harm. The deceased had been removed from ACT on 15 May 2015 and it had not been considered necessary to invoke further methods of supervision.

[58] The deceased did not present as someone who had a mental illness such as would be diagnosed by a psychiatrist but there were clearly issues of anger management and low mood which were already being addressed by the administration of an antidepressant and by the offer of assistance from the mental health team to develop coping strategies to deal with anger. The deceased had refused to take up psychological services in the past, despite

those having been on offer, and by 2015 was again refusing to undertake the work which Elaine Armstrong considered would be of assistance to him. Accordingly although it may be that clinical psychologists were not available to short-term prisoners in 2015 there is no evidence to suggest that such an intervention would have made any difference in this particular case given the fact that the deceased would not have cooperated with such services in any event.

[59] The nature and content of the letters left by this deceased concentrate on his perceived difficulties in his personal relationships. The letters read out to the court were distressing, not least for his partner who was present in court. At the time of his death the thoughts of the deceased were clearly very focused on his relationship with his partner, which he rightly or wrongly perceived to be in jeopardy. This was not an issue which he was discussing with any of the professionals involved with him at the time and there were no signs that his mental health had deteriorated significantly in consequence of any concerns he had in his personal life.

[60] In submissions the Crown invited me to make the formal findings required of me but to make no other findings in relation to section 26(e) or (g). Most of the parties aligned themselves with this position with the exception of the solicitor for the next of kin who asked me to make recommendations in relation to two matters namely i) the availability of clinical psychologists within the prison setting, and ii) the passing on of information between nursing staff to ensure that all material facts are known to those treating prisoners such as the deceased.

[61] I am invited to comment upon the availability of clinical psychologists within the custodial setting. In general it would appear that while there may have been no access to such services for short-term prisoners in 2015 the witness who spoke to this deficiency also

stated that she believed that that position had now changed. I was not provided with any further information which would entitle me to make any recommendations as to the nature and extent of services which ought to be provided within the custodial setting. There are forensic psychologists who can deliver many of the therapies which clinical psychologists provide albeit the latter operate out with the forensic arena.

[62] Furthermore with regards to this particular death I am not satisfied that the absence of any such service would have it made any material difference to the outcome for the deceased. While it was Elaine Armstrong's hope that such services could be provided she was clear that by December 2015 the deceased had refused to avail himself of the services which the mental health team could provide and had disengaged from the work which she had commenced with him. This is a matter of regret as coping strategies might have assisted the deceased in the long term but it is clear from the material before me that the perceptions which led him to adopt the course which he did were not related simply to anger management issues or to the death of his childhood friend. At the time of his death the deceased was far more focused on his personal life and was not sharing those concerns with professionals working with him.

[63] Significantly it was a matter of great surprise to Reverend Russell that the deceased had attempted to take his own life as he had had no concerns in relation to such ideation at his last meeting with the deceased.

[64] I am also asked to make recommendations in relation to the failure of nursing staff to follow up the enquiries into the content of Vicky Orme's 2012 report. The statutory requirement in terms of subsection (2)(e) is that I should address whether there were any precautions which could reasonably have been taken and which, had they been taken, might realistically have resulted in his death being avoided. The agent for the next of kin quite

properly conceded that neither the issue of provision of clinical psychologists nor the failure to follow up the content of the earlier psychological report could satisfy this test. There was no evidence led before me which identified how the input of a clinical psychologist could have assisted any of the issues facing the deceased. He did not have a mental illness and as such a clinical psychologist would have no diagnosis with which to work. In any event the deceased was not prepared to engage with the mental health services which were available let alone those which are not.

[65] In terms of subsection (2)(g) I require to be satisfied that there are no other facts which are relevant to the circumstances of his death. I was invited to make recommendations in relation to follow-up of information provided at mental health assessments. I am not persuaded that this is a systemic failure. Information was provided and the deceased's condition was thereafter monitored by way of follow-up appointments. The information provided by the deceased to nurse Donaldson was not in fact accurate and given that other professionals were working with the deceased they were better placed to assess his mental health at the material time. I am not of the view that the evidence shows that access to the risk assessment report would have assisted the treating professionals in 2015.

[66] In light of all the evidence led at the Inquiry all parties invited me to make what are usually called formal determinations. The procurator fiscal invited me to make findings under section 26(2)(a) and (c) only: namely, that John William Monteath, whose date of birth was 4 June 1991, died at 1610 hours on 28 December 2015 at Perth Royal Infirmary and, in terms of subsection (2)(c), that the cause of his death was hanging; I am satisfied to the required legal standard, that being on the balance of probabilities, that the evidence requires me to make those findings under those two paragraphs.

[67] However section 26(1) of the Act imposes a mandatory duty on the sheriff to give proper consideration as to whether the evidence permits or requires any further Findings as to the circumstances mentioned in subsection (2) and such recommendations (if any) as to any of the matters mentioned in subsection (4) as I consider appropriate.

[68] With regard to the circumstances mentioned in subsection (2) paragraphs (b), (d) and (f) deal with circumstances which are irrelevant to this Inquiry. That leaves paragraphs (e) and (g). For present purposes (e) is concerned with any precautions which could reasonably have been taken, and had they been taken, might realistically have resulted in the death being avoided and (g) with any other facts which are relevant to the circumstances of his death.

[69] The central issue of the Inquiry was whether the vulnerabilities of the deceased were such that the possibility of him self harming or attempting suicide could have been identified at an earlier stage and whether sufficient had been done to obviate this risk.

[70] I have concluded that the evidence neither permits nor requires me to make a Finding that there was any precaution of the kind with which the subsection is concerned which could have been taken and which would have made any realistic difference in this case.

[71] The only criticism, if that is the correct term, which was voiced was the lack of availability of clinical psychologists within the custodial setting in 2015 but that appears to have been remedied in any event. So far as the deceased was concerned it is unlikely that had such services had been offered he would have availed himself of them and even if he had availed himself of services of a clinical psychologist to address the issues identified by Miss Armstrong that would not necessarily have assisted in addressing the issues which were at the forefront of the deceased's mind when he took steps to end his life. Accordingly

there were no precautions falling within paragraph (e) which could reasonably have been taken, and had they been taken, might realistically have resulted in his death being avoided.

[72] Turning to paragraph (g), I am not satisfied that the evidence supports making a positive finding under its terms. The paragraph concerns itself with facts not otherwise dealt with under any of the other paragraphs of the subsection which are relevant to the circumstances of the death in question. I am not persuaded that the evidence supports the proposed finding in relation to the follow up procedures as being relevant to the deceased's death. Just as there was no evidence about precisely what clinical psychologists could offer short-term prisoners and how that would have assisted in this or any other case, there was no evidence to suggest that the availability of the 2012 risk assessment report would have altered the treatment offered to the deceased throughout the following three years.

[73] Having agreed with the submissions that I make findings under paragraphs (a) and (c) I am of the opinion that the terms of section 26(1) of the Act entitle me to make a finding in respect of each of paragraphs 9(e) and (g) if I consider it right to do so, even if it is only a negative finding to the effect that there are no precautions under paragraph (e) or no other facts under paragraph (g) which could have prevented the death of the deceased. That should serve to make clear to those who have an interest in the determination that these matters have been taken into account and a considered decision taken on them. For these reasons I have made positive findings under paragraphs (a) and (c) and negative findings under paragraphs (e) and (g).

[74] It remains for me to express my deepest condolences to the next of kin who attended for and participated in the proceedings. Much of the evidence was distressing in its nature and must have been difficult for the relatives, particularly Rachel Somerville, to listen to and absorb. While I have no formal recommendations to make in this particular inquiry I trust

that the next of kin will receive some comfort not only from the fondness with which many of the witnesses spoke about him, but also from the fact that the circumstances surrounding Mr Monteath's untimely death have received proper consideration.