SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE IN PERTH

[2021] FAI 27

PER-B153-20

DETERMINATION

BY

SHERIFF GILLIAN A WADE QC

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

into the death of

SIMON JAMES STEWART (date of birth 23 March 1988) latterly a prisoner at HMP Perth, Cell 26, level 4, A Hall

Act: Sadiq, Procurator Fiscal Depute
Alt: David Adam Advocate, Tayside Health Board; Ms Lucy Thornton, Scottish Prison Service; Mr Alan Rodger, Scottish Prison Officers Association

Perth 13 April 2021

The Sheriff, having considered all the evidence adduced and the joint minute of agreement,

Determines

1. In terms of section 26(2)(a) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, that Simon James Stewart, hereinafter referred to as "the deceased", born 23 March 1988, sometime residing in, Dundee

and latterly at Cell 15, 4th Floor, B Hall, HMP Perth, 3 Edinburgh Road, Perth, died at Perth Royal Infirmary at 1949 hours on 18 September 2018.

2. In terms of section 26(2)(b) of the said Act, makes no finding, the death not having been the result of an accident.

3. In terms of section 26(2)(c) of the said Act, that the cause of his death was:

I a) Suspension by the neck from Fabric Ligature (Hanging)

4. In terms of section 26(2)(e), that there were no precautions which could reasonably have been taken to prevent the death.

5. Makes no findings in terms of sections 26(2)(d), (f) and (g).

NOTE

Procedural background

[1] The Fatal Accident Inquiry into the death of Simon James Stewart, hereinafter referred to as "the deceased" was held at Perth Sheriff Court on 18 February 2021 using the WebEx Platform as a result of the Coronavirus Pandemic prevalent at the time.

[2] The Crown was represented by Mr Muhammed Sadiq, Procurator Fiscal Depute. Ms Lucy Thornton, represented the Scottish Prison Service, hereinafter referred to as "SPS", Mr Adam, Advocate appeared on behalf of the Tayside Health Board and Mr Alan Rodger appeared on behalf of the Scottish Prison Officers' Association.

[3] Preliminary hearings had taken place on 3 and 16 February 2021 in advance of which a draft of the proposed joint minute upon which parties sought to proceed along with drafts of affidavits were produced. This afforded me an opportunity to consider

matters in advance of the full hearing and refine the areas in relation to which I considered further enquiry was required. Nevertheless, as will be discussed below, it became apparent to me during the course of the inquiry that further oral evidence would be of assistance. Accordingly I was able to have the benefit of further oral testimony from Dr NH to whom I am most grateful as he was called upon at short notice.

The evidence

[4] I was furnished with affidavits from the following witnesses:

i) DW, Lead Nurse for Perth and Kinross Health and Social Care Partnership

ii) MD, Clinical Governance Coordinator for Perth & Kinross Social Care Partnership.

iii) Prison Officer, GB

iv) Dr NH

This evidence can be summarised as follows:

DW

[5] This witness's affidavit was obtained by and on behalf of Tayside Health Board. The witness is a 48 year old nurse who has held the post of Lead Nurse for Perth and Kinross Health and Social care Partnership since 9 December 2020. She was previously a Senior Nurse for Justice Healthcare for a period of 8 months during which time she was

involved in line management and professional leadership of the Nursing and Allied Health Professionals across NHS Tayside Prison Health Care and Custody & Forensic Healthcare Services. She was not personally involved in the care of the deceased but her evidence was led to provide insight into the prison systems and procedures.

[6] She began by providing a comprehensive review of the current Scottish Prison Services' suicide prevention strategy known as Talk to Me "TTM". She explained that this involved a strict regime of assessment of prisoners entering or leaving the prison or being transferred between prisons. The purpose of the assessment is to establish if the prisoner has any thoughts of suicide or self-harm in which case he would be placed on and managed on TTM.

[7] This could include being placed on a regime of periodic checks or constant monitoring. If an individual is made subject to the provisions of TTM a case conference takes place within 24 hours attended by the prisoner, a member of his or her family if possible, a frontline manager and a member of healthcare staff. The witness noted that they endeavour to have a specialist mental health nurse present but that is not always possible due to resources.

[8] The records to which this witness had had access for the purpose of giving her evidence, particularly the Local Adverse Event Review ("LAER") and the Death in Prison learning Audit Review ("DIPLAR") disclose that the deceased was not placed on TTM as there were no concerns which would have indicated this to be appropriate.

[9] When the witness became aware of the death of the deceased a review of his medical records was carried out with a view to the preparation of a Situation

Background Assessment Recommendations ("SBAR") report. This was available to the Inquiry and summarised the immediate response to the death and the care which the deceased received during his time in custody. It did not identify any actions which required to be taken in this instance.

[10] This witness was also the senior nurse in the review team for the LAER which identified nine action points to be taken up following the deceased's death. These were addressed by all parties and agreed in the joint minute. They are enumerated in that section of the determination along with a note of the action which was taken.

[11] Similarly this witness was involved in the preparation of the DIPLAR which is referred to below in more detail.

[12] In her conclusions the witness said that the deceased had a substance misuse problem which, not unusually, went hand in hand with mental health problems but that he did not have a formal mental health diagnosis. For that reason he was not referred to the Mental Health Team on admission and was managed instead by the Substance Misuse Team. However by the time of his death he had been referred to mental health services and was listed for assessment by a mental health nurse on 28 August 2018 but did not attend. He was eventually seen by Dr NH, Consultant Psychiatrist on 3 September 2018 but denied any thoughts of self-harm. She opines that a referral to mental health services on admission is therefore unlikely to have changed the course of events for the deceased.

MD, Clinical Governance Coordinator for Perth & Kinross Social Care Partnership

[13] This witness had been in the organisation for 20 years having extensive academic qualifications in the field. It was his role to collate the information for and then write up the LAER report in consultation with his team. He provided very little additional evidence beyond the mechanism by which the report is put together.

G B, Residential Officer, HMP Perth.

[14] This witness provided an affidavit relating to her interactions with the deceased. On the 18 September 2018 she had been working a long day shift, which begins at 0800 hours and finishes at 2100 hours within A Hall level 3. At the time she was an Operations Officer, but was Acting Residential Officer. The witness knew the deceased as he had been on the flat for a while.

[15] She had just returned from a tea break when staff received a call from a Level 4 Officer who had carried out a numbers check but got no response from deceased and had requested assistance to open his cell.

[16] She was present when the other officer opened the door and when they entered, discovered the deceased unresponsive and hanging from the toilet door with a ligature around his neck. At this point, Officer GB took hold of the body to relieve the strain of the ligature. Officer SK called a code blue on the radio and the witness went for a crash pack returning moments later at which point FLM AB arrived with Officer SK. Officers SK and GB performed CPR briefly until nurses attended. They asked for the defibrillator which the witness provided and the nurses thereafter took over.

[17] The witness described the deceased as "quite quiet". She was sure she had seen him on the day of his death and remembered him coming down for his meal as she was overseeing the pantry.

[18] She described being totally shocked at his death which she had not expected as there were no obvious signs or changes in his presentation. She had thought that he had had engagement with mental health services but could not comment further on that.

[19] She explained that if she was worried about someone being at risk of self-harm or suicide she would place them on Talk to Me but that she had no concerns that the deceased was at risk of self-harm or suicide.

[20] She went on to deal specifically with the issue of observation sheets and clearly evidence some knowledge of their purpose but could not say whether there had been any such sheets for the deceased.

Dr NH

[21] A very extensive affidavit was provided from Dr NH who had been responsible for the care of the deceased's mental health prior to his death. He was able to provide a comprehensive account of the deceased's treatment which can be summarised as follows:

[22] Dr NH was employed by NHS Tayside as a Consultant in Forensic Psychiatry since August 2014. He had extensive and impressive qualifications in the discipline of psychiatry and had accumulated significant experience over his career.

[23] He worked at HMP Perth from 2011 until January 2020 providing a weekly psychiatric clinic. This aspect of his work involved assessing and treating a range of prisoners presenting with mental health problems whilst in custody. He also participated in weekly multidisciplinary team meetings within the prison and provided expert advice in relation to prisoners presenting particular behavioural challenges in the prison environment.

[24] He was instrumental in developing the mental health service within HMP Perth. As part of his role, he regularly arranged for prisoners to be transferred to psychiatric hospitals.

[25] He could recall the deceased's suicide and for the purposes of giving his evidence had refreshed his memory with regard to the productions which had been lodged particularly the medical records, the Local Adverse Event Review (LAER) and the Death in prison Local Adverse Review (DIPLAR). He pointed to an error in the DIPLAR report which suggested that he had seen the deceased on the 3 March 2018. This ought to have read 3 September 2018.

[26] The witness helpfully divided his evidence into chronological chapters which charted the involvement of the deceased with mental health services throughout his period of incarceration.

[27] When the deceased was admitted to prison on 21 June 2018 he was initially managed by the Substance Misuse Team ("SMT") rather than the Mental Health Team ("MHT"). The SMT has its own psychiatrist and many of the nurses would have mental health training, albeit that they were not currently specialising in mental health in their

day-to-day work in the prison. He considered whether with the benefit of hindsight the deceased might have been better managed by the MHT but observed that the two teams worked very closely and any concerns observed by the SMT would have been communicated to the MHT.

[28] At the assessment on 3 September 2018 the deceased presented as an "archetypal prisoner". He had a very difficult background and had experienced a lot of trauma in his life. He had significant and ongoing problems with drug and alcohol misuse and had poor mental health. The working diagnosis was that he most likely had paranoid schizophrenia complicated by substance misuse. His handwritten notes which were available to me as a production noted that he could find no clear evidence that the deceased was a risk either to himself or others although there were previous reports of violence towards others.

[29] He went on to say that had he thought the deceased was at increased risk of suicide or self-harm, he would have made him subject to Talk to Me ("TTM"). He went on to explain that TTM is a policy used by the Scottish Prison Service to prevent suicide and self-harm. He explained that if a prisoner is subject to TTM a package of care is put in place to manage the specific risks identified. This can include: putting prisoners in a cell that is anti-ligature (i.e. one that limits the prisoner's access to things they can harm themselves with, such as electrical cords and ligature points); requiring the prisoner to wear only "strong" anti-ligature clothing; and/or putting a prisoner under review so that they are checked at regular intervals (e.g. every 15 minutes). In addition, a case conference is held every couple of days regarding the prisoner's state of mind in view of

deciding whether they need to remain on TTM and, if so, what measures need to be put in place to ensure their safety.

[30] Interestingly he explained that because TTM is very intrusive and prisoners dislike being subjected to it, it can discourage patients from being open and honest with professionals and others for fear of being placed upon it. However he would not hesitate to implement the policy if he considered it necessary which he did not in the case of the deceased. At the end of the assessment Dr NH and the staff Nurse KM discussed and agreed a four point treatment plan with the following components.

1. Psychiatric observations of the deceased to be undertaken by Hall officers.
2. Increase the deceased's dose of quetiapine to 400mg daily.
3. Regular nursing follow up.
4. A follow up appointment in four weeks unless any more immediate concerns came to light. It is recorded that if it was not possible to control the deceased's symptoms in prison, then there was a need to consider whether he should be transferred to hospital for further treatment.

[31] Considering each component part of the plan the witness indicated that in relation to the hall observations the nursing staff would ask the Scottish Prison Service ("SPS") Hall staff to record observations for the deceased and would record whether he displayed any unusual behaviour either on his own or in his interactions with other prisoners and prison staff.

[32] There is a standard document for this purpose which the nursing staff would have passed to SPS staff to record prison officers' observations of the deceased in the Hall. Then, when the nursing staff go to the Hall, for example to administer medication, they could review the document to note any changes in behaviour. This document was developed informally within the HMP Perth MHT to try to improve communication between officers and the team. The forms have a cover letter which explains the types of behaviours that the MHT would like officers to comment on, and officers are asked to note unusual behaviours they might see at different times of the day. This procedure is not something that is covered under any formal SPS or NHS policy but instead is something that was put in place to better capture the views and observations of different officers working with a prisoner across several days. The form is now referred to as a "Behavioural Observation Sheet" since it was considered that the term "*psychiatric*" suggested that it required some form of additional training or expertise which is not the case. The witness explained that the prison officers were often best placed to form a rapport with the prisoners and would therefore be most likely to note behavioural changes over time. The process of completing the behavioural observation sheet helped inform the overall assessment of an individual.

[33] Despite this having been part of the treatment plan the DIPLAR notes that it is "*unclear if the forms were actually provided to the hall as there is no 'sign out' process nor is there a process for confirming that they have been returned to the mental health team*." However on this point the witness opined that, while the observations by Hall officers are important, if they were not carried out, it seems unlikely that this would have made

a difference to the outcome as the deceased was being seen daily by the nursing team to administer his medication. If they, or the Hall staff, had any serious concerns about the deceased this would have been flagged up over and above the standard forms.

[34] Turning then to the issue of the deceased's quetiapine dosage it was noted that the deceased had previously been prescribed 700mg of quetiapine. However, as a result of what appeared to be an error he had been liberated in August 2017, on a reduced dosage of 200mg, prescribed by his GP in the community. This was not reviewed by community mental health services. Therefore, he remained on this dosage until the prison team noted the error and his dosage was increased to 400mg during the appointment on 3 September 2018.

[35] Quetiapine is an antipsychotic medication commonly used for the treatment of illnesses like schizophrenia. It can be used to suppress psychotic symptoms. The difference between 700mg and 200mg is significant. 700mg is a fairly high dosage; 200mg is unlikely to be sufficient to suppress psychotic symptoms in most individuals. Accordingly a sudden drop in his quetiapine dosage in August 2017 is concerning. However the witness did not know how relevant it is to the deceased's suicide given he was on this reduced dosage for a considerable period of time (around a year) prior to this. It is of note that the deceased did not raise any particular concerns in relation to psychosis when he was admitted to prison on 21 June 2018 on a dosage of 200mg. This suggests he had been coping, at that time, on a 200mg dosage. When at liberty the deceased lived a chaotic lifestyle which included alcohol and drug misuse. The witness

explained that trying to separate behaviours caused by mental health issues (such as psychosis) from those caused by drug misuse in this context is almost impossible.

[36] The doctor explained that at the assessment on 3 September 2018 he formed the impression that the deceased was likely to be experiencing a psychotic episode. He concluded that 200mg was not a sufficient dose to suppress this. He considered an immediate increase in the dosage to 700mg to be too much of a jump and could have been associated with significant short term side effects. 400mg is a reasonable dosage and should have had some effect.

[37] The witness referred to his note that the deceased "*somewhat reluctantly agreed to an increase in the dose of his quetiapine. He did not appear to be convinced that this was necessary at this time*." The discharge summary report which was produced by the Crown records that on 5 September 2018 "*Administration NOS. Advised by team today that Simon has refused in increased dose of quetiapine - MHT made aware and email sent to Dr H with information by KM MHN*." On 10 September 2018, it is recorded on the discharge summary report (Crown production 6, page 188) that: "*Consultation. Further email sent to mental health re: simon's refusal of quetiapine (nocte)*." The witness could not recall these emails and as his email address had changed he could not now look back to see whether this had been followed up.

[38] However in his letter to the chief executive on 21 September 2018 he is noted as having written "*He continued to be followed up by mental health nurses and substance misuses nurses leading up to his death. There was concern about his noncompliance with medication which led to his case being discussed at the prison mental health team. A plan was made to bring*

forward his next appointment with me; it had not been considered that he required immediate transfer to hospital or that his risk of suicide was increasing."

[39] Beyond what was written in the letter the witness could not recall the specifics of any discussion about the deceased at the team meetings but made clear that had he thought there was any increased risk of suicide he would have placed the deceased on TTM and arranged to see him as quickly as possible.

[40] With regard to his non-compliance with the medication regime the doctor pointed out that it was not uncommon for prisoners to refuse to take their medication and that in its self would not inform a further assessment unless accompanied by displays of concerning behaviour or symptoms. While the witness would have been reassured by the fact that the deceased had been taking his medication as prescribed there was nothing about the reported psychotic symptoms that pointed towards suicide being a likely outcome, and therefore it is not clear that potentially better control of such symptoms through an increased dose of quetiapine would have had any impact on his suicide risk. The witness said fairly that that is not to say that it might not have had an impact: His position was that it is quite impossible to know.

[41] The witness gave evidence to the effect that even if the deceased had been taking the quetiapine as prescribed, he may still have died by suicide. Suicidal behaviours can be triggered by a range of factors, and mental illness is only one such potential trigger. As the deceased did not present as suicidal and he opined that we cannot know what ultimately caused him to kill himself and any attempt at trying to quantify the

significance of his non-compliance with quetiapine on his risk of suicide would be so speculative as to be of little or no value.

[42] The third aspect of the treatment plan was the regular follow up nursing. The witness could not recall that discussion specifically but thought it would have been along the lines that nursing staff should be keeping an eye on the deceased. It was his evidence that the vast majority of patients with mental health issues in prison (including those with associated risks of self-harm and suicide) are managed entirely by mental health nurses. The nurses in the MHT were very experienced mental health professionals. They are very familiar and comfortable with making decisions about managing the day to day risk that a patient may present. While the doctor would generally have been content for the nursing staff to have used their own judgment regarding how regular their contact with the deceased should have been, on reflection, he felt he could have been clearer in what he meant by "regular" nursing follow up and stipulated the frequency within my letter.

[43] Finally the witness assessed that a follow up assessment in about 4 weeks would have been reasonable and proportionate to the level of risk present at the initial interview. That was largely on the basis that the deceased would have had daily contact with the nurses who would be able to flag up any concerns.

[44] Finally while generally commending the mental health team of which he was of course part he indicated that as a generality the caseload with which they require to work is very high and resources are stretched. This was reflected upon in the LAER.

[45] Having reviewed the notes and records and with the benefit of hindsight the witness concluded that there was nothing which he would have done differently in this case. He concluded that he did not believe that was there anything that he or the MHT could have reasonably done to prevent the deceased's suicide. He added that often the people who die through suicide in prison do not present with any thoughts of suicide or self-harm. They are typically the people are considered to be at low risk of suicide as, if the risk was higher measures would have been taken to manage the risk. His view is that we will never know what caused the deceased to take his own life. There may have been factors other than mental illness. As noted in the DIPLAR, he had had recent contact with his mother and the suggestion was that this had a negative impact on him; there had been a number of suicides in his peer group over the years; and he had no funds in his PPC (Prisoner Payment Cash account) in the month prior to his death. The feedback from his peers was that he was unusually positive on the day prior to his death. There is anecdotal evidence that people planning to kill themselves can sometimes appear more cheerful than normal shortly before their deaths. People have speculated that this may be because the individual has reconciled themselves to a solution to managing their longer term distress. Of course, it is not unusual for people to have good days even when they are in prison. It would be quite appropriate for professionals working with someone presenting in this way to conclude that they were getting better and that the risk was reducing. Indeed this would almost certainly be the correct interpretation in the vast majority of occasions that it might be seen. It is extremely difficult to see how the observation that someone seems unusually positive

could be used meaningfully to reduce suicide rates in prison, much as it would be very good to identify any means of addressing the tragedy of prison suicide.

[46] Despite the very comprehensive nature of the affidavit and the fact that none of the parties had intimated a desire to challenge or cross examine the witness on any part of it I had some concerns about various aspects of the treatment the deceased had received between the 3 September 2018 and the date of his death.

[47] Fortunately the witness was available and amenable to providing supplementary oral evidence to assist the court and in addition to his affidavit gave oral testimony.

Oral evidence of Dr NH

[48] On questioning by Mr Adam the witness largely reiterated what was contained in his affidavit. However at the end of his oral evidence I had some very serious concerns that certain areas had perhaps been glossed over and sought to clarify the extent to which the four point treatment plan which had been drawn up by the witness and his team had in fact been implemented.

[49] On further examination it is clear that the main focus of the witness's concerns was whether the deceased had been ill enough to warrant a transfer to hospital. His immediate concern, quite understandably, was not with an acute risk of suicide.

[50] It was clear that in relation to the proposal that hall observations of the deceased be undertaken this did not occur. It was agreed that no observation sheets could be found and as the witness GB, who purported to be working on the hall in which the deceased was housed could not speak to any such sheets it would be quite reasonable

for me to conclude on the balance of probabilities that this part of the plan was not implemented. It may well be that this witness did not actually know that this was so as later comments would seem to suggest that he thought this was being attended to. However the fact remains that between the 3 September 2018 and the date of his death no formal observations of the deceased's behaviour had taken place.

[51] The next issue upon which I sought further clarification was that of the quetiapine dosage which had been reduced in error while the deceased had been in the community. The dosage ought to have been 700mg which the witness described as a "fairly high dosage". However in the community he had been receiving only 200mg which is not sufficient to suppress the psychotic episodes which it was suspected the deceased was experiencing.

[52] On review on 3 September his dosage was increased to 400mg but, as is common with patients suffering mental illness, he was not consistently taking his medication. It appears that a number of emails were sent to Dr NH regarding this non-compliance but he could not recall having received any of them. Accordingly the second point in the action plan could not be said to have been followed through and despite attempts to alert Dr NH to this nothing was done. Accordingly it likely that the deceased was continuing to experiencing psychotic episodes at the time of his death although there is nothing which could specifically link this to his suicide. It was conceded that those with mental health issues are often at greater risk of suicide or self-harm but it could not be said that failure to take anti-psychotic medication would of itself lead to suicide.

[53] The third point on the action plan was regular follow up by mental health nurses. I put it to the witness that in fact there had been no formal follow up by nursing staff between the 3 September 2018 and his death. The doctor was understandably defensive and may have been unaware that this was the case but indicated that as the deceased would have had to attend for his opiate substitute which was administered in person he would have daily contact with nursing staff. Nonetheless I do not think that is what the action point really envisaged and again it can be concluded that this action point was not implemented.

[54] Finally the witness was asked about the intention to have a follow up appointment with the deceased within 4 weeks or earlier if more immediate concerns came to light. However the records clearly show that no follow up appointment had been arranged. This would be of less concern had it not been stated in Dr NH's letter of 21 September 2018 that "He *continued to be followed up by mental health nurses and substance misuse nurses leading up to his death. There was concern about his non compliance with medication which led to his case being discussed at the prison mental health team. A plan was made to bring forward his next appointment with me; it had not been considered that he required immediate transfer to hospital or that his risk of suicide was increasing*".

[55] Clearly that is not an entirely accurate representation of the facts. There had been no follow up by any nurses between 3 and 18 September 2018 and if there was a plan to bring forward his appointment that is certainly not documented anywhere and had certainly not been intimated to the deceased. Indeed it is most unlikely that there was such a plan or if there was it had certainly not been acted upon. Furthermore the

reason for bringing forward the appointment from the original 4 week period was to deal with "more immediate concerns" if they came to light. If the witness is correct and the appointment had been brought forward that would suggest that there were indeed concerns about a deterioration in his mental health, which ran contrary to his evidence in chief.

[56] In short, as the witness ultimately conceded, although a four point plan had been put in place no part of that plan had been properly implemented by the time of the deceased's death by which time he had not been formally observed for behavioural changes, had been significantly under medicated and had not received any mental health nursing input despite the Mental Welfare Commission having been told the contrary.

[57] I rather suspect that Dr NH was not personally aware of the failures to adhere to his plan and it seems he cannot recall seeing the emails about the medication. He remained adamant that the fact that the deceased was not medicated could not be causally associated with his death.

[58] I had considerable sympathy for this witness who is clearly passionate about his role and is doing what he can to help devise and develop better methods by which to identify patients who are at greater risk of taking their own lives. I am in no doubt that overall the level of input provided is of a high quality but ultimately is resource led and depends on implementation of any plan which is put in place.

Joint minute of agreement

[59] In addition to the oral and affidavit evidence parties had entered into an extensive joint minute which addressed a number of factual matters and allowed me to make the majority of the findings upon which my final determination is based.

[60] SIMON JAMES STEWART ("the deceased") was born on 23 March 1988. His last known address was in Dundee.

[61] Prior to December 2016, the Scottish Prison Service Suicide Risk Management Strategy was named ACT 2 Care ("ACT"). 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" ("TTM"), the Prevention of Suicide in Prison Strategy.

[62] As part of TTM, all prisoners are assessed upon admission or re-admission to the establishment. In addition, any individual working with a prisoner may initiate a TTM assessment should they have concerns about a prisoner at any time. It is not restricted to when a prisoner enters or re-enters an establishment. Staff are trained on "cues and clues" and precipitating factors and are alive to prisoners' moods changing when, for example, their circumstances change.

[63] The deceased had a lengthy record of previous criminal convictions. He had been remanded in custody on numerous occasions throughout his life. His SPS Previous convictions report is produced at pages 84 to 104 of Crown Production 4.

[64] In or around 2016, Dr F C, a Consultant Psychiatrist specialising in addictions, suspected that the deceased suffered from schizophrenia. The deceased's symptoms included delusions that he was missing ribs, had been microchipped and that he had been hypnotised by mental health professionals who then sought to control his actions. The deceased's treating clinicians continued to suspect that he suffered from schizophrenia until his death. Reference to Dr FC's treatment of the deceased can be found within (i) a letter from Dr G C, ST4 in Forensic Psychiatry of Rohallion Secure Care Clinic to the Prison Medical Officer of HMP Perth, dated 26 June 2017 and produced at pages 160 to 162 of Crown Production 6 and (ii) a letter from Dr G C to the Prison Medical Officer of HMP Perth, dated 22 February 2017 and produced at pages 174 to 177 of Crown Production 6.

[65] Dr G C prescribed the deceased quetiapine at that time. Quetiapine is an antipsychotic medication. It is commonly used for the treatment of schizophrenia. It can be used to suppress psychotic symptoms.

[66] On 23 June 2017, while the deceased was in custody at HMP Perth, Dr G GC consulted with him. Dr GC increased the deceased's prescribed dose of quetiapine from 600mg to 700mg due to the severity of his symptoms. The entry within the deceased's prison medical records for his consultation with the deceased is produced within Crown Production 6 at page 193.

[67] The deceased remained on 700mg of quetiapine until 18 August 2017, when it was reduced to 200mg. The entry within the deceased's prison medical records

evidencing this reduction in his dosage is produced within Crown Production 6 at page 209.

[68] The deceased was then released from custody on or around 25 August 2017.

[69] The deceased was remanded in custody at HMP Perth on 13 June 2018. On his admission to HMP Perth he was assessed as part of the TTM process. It was concluded that the deceased did not represent a risk of self-harm or suicide. The TTM Reception Risk Assessment ("RRA") completed with respect to the deceased on this date is produced at pages 1152 to 1154 of Crown Production 9.

[70] The deceased was liberated from custody at HMP Perth on 20 June 2018.

[71] On 21 June 2018, the deceased appeared on Petition at Dundee Sheriff Court charged with Theft by Housebreaking, Assault & Robbery, a contravention of section 24 of the Electricity Act 1989 and culpable and reckless conduct. He was remanded in custody to HMP Perth. An extract of the warrant to imprison the deceased is produced at pages 63 of Crown Production 4.

[72] On his admission to HMP Perth on 21 June 2018, the deceased was assessed as part of the TTM process. It was concluded that the deceased did not represent a risk of self-harm or suicide. The TTM RRA completed with respect to the deceased on this date is produced at pages 80 to 81 of Crown Production 4.

[73] When assessed on admission by Nurse J B of HMP Perth's healthcare team, the deceased denied having any mental health concerns. He tested positive for benzodiazepines. The deceased was not currently prescribed such medication. He was assessed as alcohol dependant. As a result, he was referred to the Substance Misuse

Team ("SMT"). He was prescribed a detoxification programme. Reference to the deceased being prescribed a detoxification programme can be found at section 9 on page 1143 of Crown Production 8, the report produced following the Local Adverse Event Review ("LAER") regarding the death of the deceased. The entry within the deceased's prison medical records for his admission consultation with Nurse JB was produced within Crown Production 6 at page 189.

[74] The deceased was allocated Cell 26, Level 4 of HMP Perth's "A" Hall. On admission, the deceased shared a cell with another prisoner.

[75] On 22 June 2018, Pharmacy Technician LG carried out a medication reconciliation for the deceased. This involved preparing a list of medications that the deceased would receive while in custody, the relevant dosage of each medication and the frequency that each medication was to be taken. At that time his prescription included 200mg of quetiapine. This had been the dosage of quetiapine the deceased had been prescribed in the community since he was released from custody on 25 August 2017.

[76] On 22 June 2018, the deceased consulted with Dr MW, the prison Medical Officer. During his consultation with Dr MW, the deceased stated that he had no issues for Dr MW. The medications detailed on the Medicines Reconciliation Form prepared by Pharmacy Technician LG were subsequently prescribed by Dr MW following his consultation with the deceased.

[77] The deceased received his prescribed medications in the Hall on at least a daily basis. This would involve a nurse coming from the prison clinic to the Hall, providing

the deceased with the medication and the nurse then observing the deceased take the medication. The nurse would then record whether the medication had been taken, or refused, by the deceased on a Recording Sheet for Prescription Administration. This would be dated, initialled, and where apocopate commented on by the dispensing nurse.

[78] These Recording Sheets formed part of the deceased's prison medical records. The Recording Sheets for Prescription Administration for 22 June 2018 until his death on 18 September 2018 were available as productions.

[79] On his re-admission to HMP Perth on 27, and 29 June, 9 10 and 13 July 2018, the deceased was assessed as part of the TTM process. It was concluded that the deceased did not represent a risk of self-harm or suicide.

[80] On 23 July 2018, the deceased self–referred to the prison clinic's Mental Health Team ("MHT"). He noted that he needed a "medical marker" as his mental health was not too good and he had been up for days.

[81] In the summer and autumn of 2018, the MHT team that served HMP Perth comprised of a consultant forensic psychiatrist (Dr NH), a forensic psychologist (Dr K S) and four mental health nurses (Senior Charge Nurse AD and Nurses MC, EM and KM). The MHT team also served HMP Castle Huntly. Three of the nurses were based permanently at HMP Perth, with one nurse covering HMP Castle Huntly. The total caseload of the team was approximately 120 patients at that time.

[82] During the summer and autumn of 2018, where the MHT needed to transfer a patient to a secure psychiatric unit for treatment, the approximate waiting time for a bed was seven to 14 days.

[83] On 27 July 2018, the deceased was discussed at the Mental Health Multidisciplinary Team meeting following his self-referral. It was decided that as he was currently in the care of the SMT and his main problem was lack of sleep, he would continue to be managed by the SMT. If there were any concerns, the deceased was to be re-referred to the MHT.

[84] As of 30 July 2018, the deceased had no available funds in his prisoner's personal account. There were no funds deposited into his account prior to, or on, 18 September 2018.

[85] On his re-admission to HMP Perth on 14 August 2018, the deceased was assessed as part of the TTM process. It was concluded that the deceased did not represent a risk of self-harm or suicide.

[86] On 17 August 2018, the deceased was discussed at the MHT Multidisciplinary Team meeting as he refusing to take his prescribed dose of quetiapine. It was agreed at that time that the deceased would be seen by the MHT nursing staff before the next psychiatrist's clinic.

[87] On 27 August 2018, at approximately 0930 hours, SPS staff contacted the prison clinic to raise concerns about the deceased's mental health. He was withdrawn, not sleeping, his mood was low and he had poor hygiene. The deceased's cellmate added

that the deceased appeared to be paranoid. The deceased told him that he believed that people wished to harm him and that there was urine running down the walls.

[88] Following the call made by SPS staff, the MHT sought to review the deceased in the Hall. Prior to consulting with the deceased, Mental Health Nurse MC reviewed the deceased's medical records. On considering his history, Nurse MC formed the view that the reduction in the deceased's prescribed dosage of quetiapine to 200mg in August 2017 may have been an error.

[89] At approximately 1115 hours, the deceased was assessed in the Hall by Nurse MC and a psychologist, Dr KS. At consultation, the deceased's mood was low. He was distracted, guarded, and uncomfortable and wanted to leave the room before the end of the consultation. Nurse MC and Dr KS were unable to ask the deceased about suicidality as he wished to leave the room.

[90] Following the consultation, the deceased was given a "single cell" marker. This was due to him having a previous record of violence towards a cellmate on the SPS Prison Record (PR2) system. PR2 is the SPS "Prison Record" system which stores information regarding prisoners electronically. The deceased was also put on psychiatric observations in the Hall, listed for psychiatric assessment and listed for MHT assessment in the health centre on 28 August 2018. The deceased stated he would "consider" attending the latter assessment. Nurse MC and Dr KS shared their concerns with the Hall's First Line Manager, BM, and the other prison staff in the Hall.

[91] Psychiatric observations of a prisoner are carried out in the Hall by prison officers. They are carried out at the request of mental health nurses. In 2018, prison staff

were provided with a Psychiatric Observations Cover Sheet and Psychiatric Observations Sheet. The Psychiatric Observations Cover Sheet detailed the types of behaviour the prison officers were expected to record in the Psychiatric Observations Sheet for the period of time that the prisoner remained subject to psychiatric observations.

[92] Once a Psychiatric Observations Sheet was completed, it would be kept in a tray within the Hall office. The completed Sheets would either be (i) collected by a mental health nurse, or (ii) delivered to the prison clinic by a prison officer after a period of seven days.

[93] The entries on the completed Psychiatric Observations Sheets would then be considered by the prisoner's treating mental health nurse. Their contents assist in building a picture of the patient's day to day behaviours. Where anything of concern was noted, this would for part of the assessment of the patient and would be discussed by the MHT.

[94] Thereafter, the clinic's administration team would scan the Psychiatric Observations Sheets for a patient. The electronic copy would then be saved to the Docman section of their Vision record. The Sheets would be scanned whether they were blank or partially or fully completed. A blank Psychiatric Observation sheet for a patient was still regarded as significant.

[95] Psychiatric Observations were not governed by any written policy or procedure.

[96] The deceased refused to attend his appointment with the MHT on 28 August 2018. The deceased's refusal to attend is recorded within his prison medical records.

[97] On 29 August 2018, the deceased was reviewed in the Hall by Mental Health Nurse EM. When assessed, the deceased was euthymic in mood although eye contact was limited. He continued to appear guarded. He was slightly distracted at times but did not appear to be responding to unseen stimuli. The deceased stated that he did not attend his appointment on 28 August 2018 as "everyone gets a bit depressed when they first come in here" and that he was "fine now".

[98] When Nurse EM asked the deceased about his medication, he stated that he asked for his quetiapine to be reduced because it caused him to stay awake all night. The deceased stated that he did not want to be seen in the prison clinic or have a psychiatric review. Nurse EM advised the deceased to consider being reviewed.

[99] SPS staff reported to Nurse EM that the deceased's presentation had improved slightly since he was reviewed on 27 August 2018. His mood was also said to be brighter. Nurse EM recorded that MHT staff were to continue liaising with the Hall staff regarding the deceased and that his presentation should continue to be monitored. She listed the deceased for psychiatric review. The entry within the deceased's prison medical records for the 29 August 2018 mental health review is produced within Crown Production 6 at page 188.

[100] On 3 September 2018, the deceased was discussed at the MHT Multidisciplinary Team meeting. He was listed for psychiatric assessment by Dr NH, Consultant Forensic Psychiatrist that day. The minutes of that meeting (as redacted) were produced.

[101] That afternoon, the deceased was reviewed in the Hall by Dr NH in the presence of Mental Health Nurse KM. When asked by Dr NH if he had any suicidal thoughts or

any thoughts of harming himself or others, the deceased denied such thoughts. Dr NH could not find clear evidence that the deceased presented a risk to himself or others.

[102] Following his assessment of the deceased, Dr NH prescribed a four-part treatment plan for the deceased. This involved the following:

(i) Hall officers undertaking psychiatric observations of the deceased.

(ii) Increasing the deceased's dose of quetiapine to 400mg daily.

(iii) Regular nursing follow up.

(iv) A follow up appointment with Dr NH four weeks later unless any more immediate concerns came to light. Dr NH recorded that if it was not possible to control the deceased's symptoms in prison, then there was a need to consider whether the deceased needed to be transferred to hospital for further treatment.

[103] Dr NH's handwritten notes from the consultation on 3 September 2018 and his letter to HMP Perth's medical officer following the consultation, dated 11 September 2018 were produced as was his letter regarding his involvement in the deceased's care sent to Mr Colin McKay, Chief Executive of the Mental Welfare Commission for Scotland, dated 21 September 2018.

[104] Following the consultation, Dr NH updated the dosage of quetiapine that the deceased was to receive on the deceased's Prescription Sheet. Nurse KM delivered Psychiatric Observations Sheets to the Hall for the deceased. The Observation Sheets are used only to assist the healthcare staff at any further appointments with psychiatry. The Observation Sheets, at that time and now, are used to note behaviours. The observations were not a replacement for TTM. If at any stage staff trained on TTM, such as SPS

officers or healthcare staff, felt the deceased was at risk of self-harm or suicide, the TTM strategy would have been initiated.

[105] On 5 September 2018, the deceased refused his increased dose of quetiapine. The MHT were advised and Nurse KM emailed Dr NH to advise him of the position. Nurse KM entered a corresponding entry into the deceased's medical records.

[106] On 10 September 2018, an email was sent to the MHT by SMT Nurse RH regarding the deceased's refusal of quetiapine. Nurse RH entered a corresponding entry into the deceased's medical records.

[107] That day, the deceased's refusal of quetiapine was discussed by the MHT at their Multidisciplinary Team meeting. A plan was implemented to bring forward his next appointment with Dr NH. However, it was not considered that the deceased required an immediate transfer to hospital or that his risk of suicide was increasing. The MHT also decided that the deceased's compliance with his medication regime should continue to be monitored. The decision was taken to keep the deceased on psychiatric observations in the Hall to gather evidence about his current mental state. Finally, the MHT's nursing staff were to obtain further information on the deceased's past offending and his current charge. The minutes from the MHT Multidisciplinary meeting on 10 September 2018 (as redacted) are produced as Tayside Health Board Production 8. The terms of what was discussed at the meeting are also referred to in Dr NH's letter to Mr Colin McKay, Chief Executive of the Mental Welfare Commission Scotland of 21 September 2018.

[108] On 14 September 2018, the deceased consulted with social worker G WK. The purpose of their consultation was to prepare a "Progress Review Report" for court. In her report, Ms GWK noted "At interview [the deceased] looked well. He states he has been eating well, not supplementing his prescribed medication and feels a lot better. He tells me he continues to be prescribed Amitriptyline but his antipsychotic medication has been stopped. His prescription of opiate substitute medication Subtex *(sic)* continues."

[109] As at 18 September 2018, the deceased had never been assessed as being at risk under TTM since it was introduced by the SPS. The deceased was last managed under ACT in 2011.

[110] Prison Officer LS was on duty on the fourth floor of "A" Hall during the afternoon and evening 18 September 2018. She started work at 1230 hours that day. She had no concerns regarding the deceased or any other prisoner on the fourth floor of "A" Hall.

[111] Around 1630 hours, the deceased was let out of his cell together with the other inmates of the fourth floor of "A" Hall to collect his dinner from the pantry. He returned to his cell around 1640 hours.

[112] Prison Officer GB saw the deceased in the pantry on 18 September 2018 when he attended for his meal. Officer GB had no concerns regarding the deceased at this time. SPS Production 11 is the Affidavit of GB, Residential Officer at HMP Perth.

[113] Around 1735 hours, prison staff checked that prisoners were all locked within their cells on the fourth floor prior to taking their break. At this time Officer SK checked

on the deceased. She opened the door of his cell and saw that the deceased had finished his dinner and was sat in his cell, safe and well. Thereafter, she locked the door of his cell. Officer SK and her colleagues on duty in the Hall at the time then went for their hour-long meal break.

[114] Around 1845 hours, prison staff returned to check on all of the prisoners. As the Hall was now "locked down", the check was carried out by looking through the cell hatch only.

[115] On checking deceased's cell, Officer SK could not see the deceased within his cell. The cell was in darkness. She turned the light in his cell on but she could still not see the deceased. She chapped on the cell door but received no response. She assumed that he was in the toilet out of view. Officer SK continued to check other prisoners, with the intention of returning to deceased's cell to check on him.

[116] Around 1852 hours, Officer SK returned to deceased's cell and again looked through the cell hatch. Office SK then called her colleague, Officer GB, who was working on the third floor of A Hall.

[117] Officer GB accompanied by Officer MG then attended the deceased cell. They, along with Officer SK, went into the cell. On entering, they found the deceased hanging by his neck on what appeared to be a torn piece of green material that was attached to the back of the toilet door.

[118] Around 1853 hours, the deceased was brought down and Officer SK put out a "code blue" on her radio. A "code blue" is an emergency call seeking medical assistance.

[119] Around 1855 hours, Nurses HD, WH, PO and CP left the prison clinic and attended the deceased's cell to assist in response to the "code blue". On their arrival they observed that the deceased had visible bruising and swelling around his neck. They also found no pulse on examination of the deceased.

[120] CPR was initially performed on the deceased by Officers GB and SK. The nursing staff took over on their arrival. The nursing staff also attached a defibrillator to the deceased. This analysed the deceased five times, but at no point did it advise shocking the deceased.

[121] Around 18:56 hours an ambulance was called. At 19:08 hours a single crew paramedic arrived at the prison and was escorted to the deceased's cell. This was followed around 1915 hours by a double crewed emergency ambulance. The paramedics from the ambulance were escorted to the deceased's cell.

[122] Around 1927 hours the ambulance left the prison with the deceased on board undergoing treatment. About 1935 hours, the deceased was admitted to Perth Royal Infirmary and was examined by Dr TM. Test results from arterial blood gas showed that the deceased's blood oxygen level was incompatible with life. A decision was made to cease further resuscitation attempts in light of its futility. There were no signs of output and deceased was pronounced dead at 1949 hours.

[123] Around 1950 hours, Police Scotland were informed of the incident by HMP Perth.

[124] The deceased's body was removed from Perth Royal Infirmary and lodged at Police Mortuary, Dundee.

[125] On 21 September 2018, at the instance of the Procurator Fiscal, Dundee, Dr David William Sadler, carried out an autopsy examination on the body of the deceased and certified the cause of his death as:

a) Suspension by the neck from Fabric Ligature (Hanging)

[126] In view of the deceased's history of Hepatitis C and the associated risk this posed at autopsy, an internal examination of the deceased was not performed. The examination of the body revealed a prominent irregular ligature mark encircling the deceased's neck which came to a point of suspension behind his left ear. The ligature mark was broad and irregular. This was in keeping with the application of a broad fabric ligature. There were old injection sinuses within both groins and there were no injuries to the body to give any cause of concern or suggestive of an assault. The absence of petechial haemorrhages within the skin over the deceased's face and eyes suggested rapid occlusion of the carotid arteries by ligature pressure. This would be associated with rapid loss of consciousness within a matter of seconds and death within a few minutes.

[127] The results of said examination are accurately recorded in the Post Mortem Examination Report dated 8 November 2018, which was produced as Crown Production 2.

[128] Toxicological analyses were performed on the body fluids of the deceased by Lauren O'Conner, Forensic Toxicologist at the University of Glasgow. These detected therapeutic levels of medications prescribed to the deceased, amitriptyline (an antidepressant) and buprenorphine (an opioid analgesic) and its metabolite in urine.

[129] The results of said analyses are accurately recorded in the Toxicology Report dated 7 November 2018.

[130] Tayside Health Board Production 2 is the Situation Background Assessment Recommendations ("SBAR") report produced regarding the circumstances surrounding the death of the deceased.

[131] The SBAR report was produced on 20 September 2018 by Senior Nurse DW, then Head of Nursing for Prisoner Health Care at HMP Perth.

[132] Ms DW first became aware of the deceased's death on 19 September 2018. On being notified of a death of a prisoner, Ms DW's first duty is to review their medical records. Thereafter, Ms DW prepares the SBAR report.

[133] SBAR is an acronym for "Situation Background Assessment Recommendation". SBAR reports are a mechanism used throughout the NHS to provide a framework for communication between healthcare teams and/or to present the clinical conditions of a patient.

[134] In the context of a death in custody, the SBAR report summarises the immediate response to the death and the care delivered to the patient during their time in custody. It also identifies if any immediate actions need to be taken by the prison clinic. In the deceased's case, Ms DW did not identify the need for any such actions.

[135] On completion, the SBAR report was submitted by Ms DW to the Chief Officer and other senior healthcare staff of the Perth & Kinross Health & Social Care Partnership.

[136] Ms DW also logged the circumstances of the deceased's death on to the NHS adverse incident electronic recording system, DATIX.

[137] Crown Production 8 is the report produced following the Local Adverse Event Review ("LAER") regarding the circumstances surrounding the death of the deceased. The review took place on 11 October 2018. The LAER report is dated 17 December 2018 and was led by MD, Clinical Governance Coordinator of Perth & Kinross Health & Social Care Partnership. The LAER was instructed by Tayside Health Board and was contributed to by their staff alone.

[138] Nine action points arose from the LAER. The points raised, and actions subsequently taken were as follows:

(i) "To clarify the patient's date of birth and update the DATIX adverse event record accordingly." This was completed and the deceased's records were updated.

(ii) "To source the SPS "Talk to me" suicide prevention documentation for this patient and add any relevant information will be added into this LAER summary as an addendum. "This was completed by the date the report of the LAER was produced. The report states "COMPLETE - Document completed at point of admission clearly stating that patient had not reported suicidal thoughts." Reference is made to the deceased's TTM documentation condescended upon above.

(iii) "Further discuss within the Mental Health MDT how patients can be [sic] seen more quickly for Mental Health assessment, and link in the Quality Network standards regarding Mental Health assessments."

The MHT now monitor waiting times. The senior charge nurse for the MHT submits information to Head of Nursing for Prisoner Health Care regarding waiting times on a monthly basis. That information is then inputted on to a performance dashboard that is considered at the prison clinic's monthly Business & Clinical Governance meeting. Waiting times relate to the clinical governance of the prison clinic. The aim of monitoring waiting times is to reduce them. Waiting times are under constant review. If waiting times increase, this is discussed at the monthly meeting. A recovery plan to reduce the waiting times would be agreed where possible. If not, the waiting times would be flagged as a risk to the organisation.

(iv) "Further discuss within the Mental Health MDT how to capture key information regarding patients gained during informal interactions (e.g. during medicines administration). It is suggested that any important information be discussed during the Mental Health MDT meeting, and have it recorded in the note of this meeting."

When informal information is picked up, nursing staff are recommended to record and share that information by noting an entry on the prisoner's VISION medical records or by way of an email. Informal information is also shared at the weekly MHT meetings. These weekly meetings are run by the mental health

nurses and consultant psychiatrists. Discussions in relation to a prisoner are recorded in a patient's VISION medical records.

VISION is the computer system used by the NHS throughout Scotland to store prisoners' medical records electronically.

(v) "To work to further improve the quality and level of detail within the admission assessments undertaken." The review group heard during the LAER that it can be challenging to have time for staff to fully read through a patient's record and background history during the admission assessment. An Admission Data Form was introduced in October 2018. It is used to highlight what services people will need at point of admission to HMP Perth. It aims to picks up things like addiction problems, whether assistance is needed to stop smoking, and mental health conditions. It is intended to provide a quick "tick box" assessment to see which teams within the prison clinic should assess the individual. A new admission with a "tick" for mental health issues is referred on to the MHT to be reviewed. The Form is currently in use and is produced as Tayside Health Board Production 3.

(vi) "To undertake planned training regarding risk assessment guidance (TAG). Training is planned for the team w/b 15 Oct." Prior to the deceased's death, the senior members of the MHT (Dr NH, Dr KS and Senior Charge Nurse AD) had identified the need for a risk assessment tool to assist with their treatment of patients as a matter of generality. TTM was the specific risk

assessment and management tool used in relation to the management of patient's risk of self-harm and suicide.

The senior members of the MHT reviewed a number different of risk assessment tools available to mental health professionals. They came to the conclusion that the Threshold Assessment Grid ("TAG") tool may be appropriate to use within the prison environment.

MHT staff familiarisation training with the TAG tool took place during October 2018. However, when the MHT started to use the tool in practice, they found it was unsuitable.

The main reason that the tool was found to be unsuitable was due to the length of time a TAG assessment took to complete. A typical MHT assessment of a patient lasts 45 minutes. It was found that a TAG assessment alone could take 30 minutes to complete. Furthermore, in order to complete a TAG assessment fully, significant clinical and forensic information needed to be ingathered. This required access to both (i) a patient's medical records and (ii) a patient's prisoner record on PR2. Computers with access to PR2 are not available in treatment rooms in the HMP Perth clinic or in the Halls. MHT staff only have access to one shared computer with access to PR2 in the office area of the clinic.

Thus, it became apparent to the senior members of the MHT that use of the TAG tool was impractical in the prison environment given the time and resource issues encountered.

Attempts were made until the summer of 2019 to use the TAG tool with specific patient groups. However, as practical use of the system proved unachievable, the decision was taken by Senior Nurse DW and Senior Charge Nurse AD to cease using the tool.

At the current time, TTM remains the specific risk assessment and management tool used in relation to the management of patient's risk of self-harm and suicide. Patients general level of risk is assessed and managed through their clinical interaction with members of MHT staff, discussions with prison staff about a patient's presentation, the use of Behavioural Observations, assessment of a patient's presentation and treatment by their assigned MHT professionals, discussion of complex cases at MHT Multidisciplinary Team meetings and by referring complex cases for psychological or psychiatric treatment where appropriate.

(vii) "Obtain the SPS documentation used when the patient was under "Psychiatric Observation" in the halls and add any relevant information will be added into this LAER summary as an addendum."

Tayside Health Board have been unable to locate the Psychiatric Observations Sheets completed in relation to the deceased for the period 27 August to 18 September 2018.

(viii) "Clarify if the patient had been appointed to be seen by the Mental Health team after the 3rd Sept and the appointment had been cancelled."

This issue was reviewed, and it was ascertained that no appointment had been planned or was cancelled.

(ix) "Establish a process whereby if a patient is referred to the Mental Health Team, a request should be made for a copy of the SPS 'Talk to me document'". All patients being actively managed on TTM have their TTM assessment reviewed when they have an appointment with a member of the MHT. There is no access to a patient's historic ACT or TTM documentation as this is stored in hard copy by the SPS. It is not available on PR2.

[139] Crown Production 10 is the report produced following the Death in Prison Learning, Audit & Review ("DIPLAR") regarding the circumstances surrounding the death of the deceased. The review took place on 27 November 2018. The DIPLAR was instructed by the SPS and contributed to by staff employed by both the SPS and Tayside Health Board. The report was signed off for the SPS by R McR, Deputy Governor of HMP Perth on 28 May 2019. It was signed off for Tayside Health Board by Ms DW on 6 June 2018.

[140] At the DIPLAR, the prison Chaplain, HS, reported that the deceased's peers had noticed his mental health decline prior to his death, but that on the day he took his own life he seemed "unusually positive and happy". Mr HS also noted that there had been a number of suicides in the deceased's peer group in the years prior to his death.

[141] It was also reported at the DIPLAR that the deceased had recently had contact with his mother and that this had a negative impact on him.

[142] The two action points arising from the DIPLAR both needed to be addressed by Tayside Health Board. Ms DW was given the responsibility of progressing these points. The points raised, and actions subsequently taken were as follows:

(i) "Consultant Psychiatrist will recommend frequency of nursing contact with patients."

The MHT mental health nurses and consultant psychiatrist reviewed this action point. They agreed that it should be the nursing team who determine the frequency of review and not the consultant psychiatrists. This is now the current practice.

(ii) "New Admissions document introduced to allow easy of [sic] flagging individuals with mental health conditions."

An Admission Data Form was introduced in October 2018. Reference is made to paragraph 85(v) above.

[143] The system of Psychiatric Observations described at paragraphs 34 to 38 above was modified in October 2019. The Psychiatric Observations Cover Sheet and Psychiatric Observations Sheet were replaced by the Behavioural Observations Cover Sheet and Behavioural Observations Sheet produced as Tayside Health Board Production 6(i) and (ii). The Behavioural Observations Cover Sheet details a series of examples of the types of behaviours that the MHT wish prison staff to record on the Behavioural Observations Sheet. These examples were listed following discussions between MHT staff and prison staff. Their purpose is to assist prison staff with the completion of the Behavioural Observations Sheet. In addition, examples of completed

Behavioural Observations Sheets are provided by the MHT to prison to demonstrate how to complete the sheets correctly. These examples are produced as Tayside Health Board Production 9. It is also now the responsibility of the patient's mental health nurse to ensure that the completed Behavioural Observations Sheet/s are either collected or returned to the MHT within seven days and subsequently saved to the patient's Docman file.

[144] The number of healthcare professionals that work as part of MHT at HMP Perth remains as narrated at paragraph 25 above. Its patient caseload also remains similar. However, only Senior Charge Nurse AD continues to practice at HMP Perth. The waiting time for transferring a patient to a secure psychiatric unit for treatment remains between 7 to 14 days.

[145] A number of documents were produced for the Inquiry and were agreed to be true and accurate. These included:

- the Intimation of Death from the Registrar,
- the Death in Custody Folder regarding the deceased. It was prepared by the SPS.
- a book of photographs taken on 19 September 2018 at the locus by EB, Scene Examiner and a member of the Scottish Police Services Authority, Forensic Services, Scene Examination, Dundee.
- the deceased's NHS Tayside Medical Records.
- the deceased's SPS Healthcare Records.
- TTM RRAs for the deceased.

- the Talk to Me Strategy.
- Talk to Me Guidance Parts 1 and 2 relevant to the deceased's death.
- GMA016A/16 which relates to the requirements for locking and unlocking periods within SPS establishments.
- GMA50A/15 which was the ligature procedure in place at the time of the deceased's death.
- GMA0001A/20 which is the revised ligature procedure in place across SPS establishments from 15 January 2020.
- a letter from Dr NH, Consultant Forensic Psychiatrist, NHS Tayside, to HMP Perth, dated 11 September 2018.
- a blank Admission Data Form, which was introduced in October 2018.
- a letter from Dr NH, Consultant Forensic Psychiatrist, NHS Tayside, to Mr Colin McKay, Chief Executive of the Mental Welfare Commission Scotland dated 21 September 2018.
- the handwritten notes of Dr NH, Consultant Forensic Psychiatrist, NHS Tayside regarding his consultation with the deceased on 3 September 2018.
- Samples of (i) the Behavioural Observations Cover Sheet and (ii) the Behavioural Observations Sheet currently used by healthcare and prison staff at HMP Perth.
- the minutes (as redacted) of the MHT Multidisciplinary Team meeting that took place on 3 September 2018.

- the minutes (as redacted) of the MHT Multidisciplinary Team meeting that took place on 10 September 2018.
- examples of completed Behavioural Observations Sheets provided by the MHT to members of prison staff.

Submissions

[146] Following the conclusion of the evidence I afforded parties an opportunity to prepare written submissions in advance of a further hearing which took place on 22 March 2021.

[147] I was furnished with very full submissions from all parties which invited me to return formal findings only. Each set of submissions referred to appropriate and relevant authority and statutory provisions, and provided a summary of the evidence relevant to their respective positions.

[148] I do not propose to summarise these submissions in any detail but thank parties for their diligent and comprehensive efforts in this regard.

Discussion and determination

The legal framework

[149] The legal framework against which I am constrained to make my determination is found in *section 26(1) of the 2016 Act*, in terms of which I am required to make a determination setting out:

a) my findings as to the circumstances mentioned in *section 26(2);* and

b) such recommendations (if any) as to any of the matters referred to in *section 26(4)* as considered appropriate.

[150] The circumstances mentioned in *section 26(2) of the 2016 Act* are as follows:

a) When and where the death occurred;

b) When and where any accident resulting in the death occurred;

c) The cause or causes of the death;

d) The cause or causes of any accident resulting in the death;

e) Any precautions which –

i) Could reasonably have been taken, and

ii) Had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided;

f) Any defects in any system of working which contributed to the death or any accident resulting in the death;

g) Any other facts which are relevant to the circumstances of the death.

[151] With regard to any recommendations, the matters referred to in *section 26(4)* are as follows: a) The taking of reasonable precautions; b) The making of improvements to any system of working; c) The introduction of a system of working; d) The taking of any other steps; which might realistically have prevented other deaths in similar circumstances.

[152] In terms of section *26(2)(a) and (c)*, namely where and when the death occurred and the cause of death, parties are in agreement and I have no difficulty in making the findings suggested in paragraphs 66 and 69 of the joint minute, namely that the

deceased", born 23 March 1988, sometime residing in Dundee and latterly at Cell 15, 4th Floor, B Hall, HMP Perth, 3 Edinburgh Road, Perth, died at Perth Royal Infirmary at 1949 hours on 18 September 2018 and that the cause of his death was suspension by the neck from a fabric ligature (hanging).

[153] However sections *26(2)(e),(f) and (g)* merit further consideration of the evidence.

[154] In his submissions, counsel for the Tayside NHS Trust appears to make much of the fact that at the preliminary hearings in this case no issues were identified by the parties and there was no notice of matters which were likely to be in dispute. What he fails to note was that I indicated at the first preliminary hearing that I was not content with either the terms of the joint minute or the content of the material lodged at that stage. It was for that reason there was a further preliminary hearing. On this occasion I did not provide a note of the matters which I wished to have investigated as I have done in relation to numerous other such inquiries as I would have hoped that my comments would have been taken on board by those appearing at the full inquiry. Indeed the joint minute which was finally produced bore no relation to the original draft, its content had been far more considered and greatly expanded.

[155] At the risk of repeating myself I would stress that a fatal accident inquiry is not simply an opportunity for a Sheriff to endorse the findings of the DIPLAR or the LAER and more often than not issues arise in the course of the Inquiry which it is quite proper for the Sheriff to explore fully to ensure that the statutory requirements for the determination are met.

[156] *Section 26(2)(e)* requires me to consider whether there are any precautions which could reasonably have been taken, and had they been taken, might realistically have resulted in the death being avoided.

[157] In this regard I am urged to have regard to Lord Armstrong's comments in *Sutherland* v *Lord Advocate* 2017 SLT 333 which, although dealing with the legislative predecessor to the current section, was in broadly similar terms.

[158] While I accept what is submitted as a generality, it should be borne in mind that Lord Armstrong was considering specifically issues of clinical decision making or judgement where there was more than one option available and it may subsequently transpire that the option taken was not the optimum one.

[159] In some cases care may have to be taken not to conflate issues of professional negligence and the tests which arise in such cases with the identification of reasonable precautions which might realistically have prevented the particular death or similar deaths in the future.

[160] In this case the deceased was someone who was no stranger to the prison system. While in custody previously his mental health and substance misuse issues had been identified and treated. Accordingly on being received into the prison system again his presenting conditions were known and he was immediately placed in the care of the substance misuse team. Although Dr NH questions whether that was the best choice with the benefit of hindsight it does not appear to me that there was any objective reason why that was an inappropriate team to deal with someone who had long standing

substance misuse issues and received an in person prescription of an opiate substitute bringing him into contact with nursing staff daily.

[161] Those arrangements sat alongside the TTM suicide prevention strategy which enabled anyone with concerns to bring those to the attention of medical staff.

[162] Again we know that these measures worked to the extent that by 27 August 2018 the deceased was presenting as withdrawn, not sleeping, of low mood and deteriorating hygiene. His cellmate reported signs of paranoia and perhaps hallucination. It was at that point that a review of the deceased's notes identified that there had been an error in the community prescription of the deceased's anti-psychotic medication quetiapine and it was probable that for the best part of a year he had been under medicated.

[163] However one must also take into consideration the evidence of Dr NH to the effect that the deceased's compliance with any regime over that period is likely to have been poor due to his chaotic life style and ongoing use of illicit substances.

[164] Nevertheless it is clear that as a result of the intervention of the mental health team the deceased was on the radar of prison mental health team professionals. He was made subject to psychiatric observations and despite a reluctance to engage and attend appointments with mental health professionals he was reviewed daily and by the 3 September 2018, which was really the first opportunity for assessment by a psychiatrist, he underwent a thorough assessment as a result of which he was not identified as a risk of harm to himself or others. It was at that point that the four part plan of which we heard a great deal was drawn up.

[165] To this point it is clear that the reasonable precautions to prevent suicide in prison were being implemented and the deceased had not fallen through any systemic gaps.

[166] I am in agreement with the comments of Sheriff Braid, as he then was, in Fatal Accident Inquiry into the death of Marion Bellfield 2011 FAI 21 at paragraph 41 as quoted in the submissions on behalf of the Health Board where he says,

> *"A fatal accident inquiry cannot prescribe how doctors or nurses should exercise their judgement. Put another way, the true precaution which ought to be taken in any given case may simply be a requirement that a patient is seen by a suitably skilled doctor, rather than how the doctor exercises his skill and judgement thereafter".*

[167] However what he, like Lord Armstrong, was seeking to do was to draw a distinction between the remit of the Sheriff in a fatal accident inquiry when contrasted with tests for clinical negligence.

[168] I have made it clear that I do not consider that an issue of clinical negligence arises in this case. Not only was the deceased brought to the attention of health care professionals but he was seen, assessed and an appropriate treatment plan was drawn up within a matter of days from concerns first being brought to light.

[169] In this case the real focus came to be what happened next. The spotlight must fall on the period between 3 September 2018 and the deceased's death on 18 September 2018.

[170] As a result of a combination of concessions made in the joint minute and further questioning of Dr NH by parties and by the Court it became apparent that despite best intentions the follow up of the four point plan was deficient or indeed non-existent.

[171] In the first place it is important to note that while I am now considering the situation after the event and with the benefit of hindsight, Dr NH and his team were approaching the matter from a wholly different perspective at the time. Their main concern was to assess whether the deceased was in need of immediate transfer to hospital or whether they could continue to treat him in the prison.

[172] I have no evidence to suggest that Dr NH was in any way wrong in his clinical judgement that an immediate transfer to hospital was not indicated. Similarly, as I have said I have no evidence to suggest that the treatment plan was other than appropriate. Even if that were not the case the *dicta* to which I have referred make clear that that is not the concern of the inquiry which has the role of first identifying whether reasonable precautions were taken and then assessing whether the taking of such precautions would have avoided the death.

[173] In a sense having determined that "reasonable precautions" in the form of health care intervention were indeed taken I may not need to go any further but I have considered whether implementation of the four points in the treatment plan were also part of the "reasonable precautions" which might have prevented the death.

[174] This leads into issues of causation because even if all of the points on the treatment plan were implemented in full there would have to be evidence that the taking of such measures would realistically have prevented the death.

[175] The first part of the plan was to maintain psychiatric observations on the hall. It was a matter of concession that despite a thorough search no observation sheets pertaining to the deceased for the period between 3 and 18 September 2018 were found.

While I was invited to draw certain inferences from the words used in the minutes of that meeting I am not at all persuaded that this part of the plan was followed up in any meaningful way. It may well be the case that the deceased was being informally observed but the whole point of the observation sheets is to allow prison staff to present a a more comprehensive picture to health care professionals who only see the prisoner at intervals and for appointments. If the observation sheets are worth having then they should be completed and kept in a suitably accessible form. If it is truly the case that they do not add very much, as was argued in defence of their non-availability then one has to question why the health service bother with them in the first place.

[176] The second point on the treatment plan was to increase the deceased's antipsychotic medication to 400mg daily. The dosage had erroneously been dropped to 200mg but medical opinion was that 700mg, which is quite a high dosage, would have been a more appropriate therapeutic level for the deceased. As a result it was considered likely that by the time of his death the deceased was experiencing some psychotic symptoms but that does not equate to suicidal thoughts. Matters are somewhat compounded by the fact that the deceased was not taking his medication at all and this was known to the mental health team.

[177] At first blush this would seem to be a serious matter and Dr NH conceded that he was concerned about that but following discussions with the Multidisciplinary team on 10 September 2018 did not consider that he was at any greater risk of suicide or self-harm.

[178] Of course a prisoner cannot be forced to take his medication if he chooses not to do so. The issue would have been whether his failure to engage with the drug regime prescribed for him had caused his mental health to deteriorate to the point where, from the medical perspective, he ought to have been admitted to hospital.

[179] Of course Dr NH believed that observations of the patient would have been ongoing for about a week by then and no such deterioration was reported to him. Neither was there any voiced concern about suicide or self-harm. Furthermore Dr NH believed that there was regular nurse follow up taking place in terms of point three of his plan. On that basis he exercised his clinical judgement by deciding not to admit the deceased to hospital.

[180] Even with the benefit of hindsight it would be mere conjecture or speculation to suggest that had he known that there had been no in Hall observations recording the deceased's presentation or formal nursing follow up he would have made a different decision.

[181] On the contrary when the deceased was seen by a social worker on the 14 September 2018, to prepare a progress review for court she noted that the deceased looked well and "was feeling better". She clearly did not identify any outward sign of a deterioration although she was told that his anti-psychotic medication had been "stopped" which was not the truth.

[182] Far from suggesting that Dr NH would have admitted the deceased to hospital if he had known the whole picture as at 10 September 2018 this would tend to indicate that

the opposite is true and there was no immediate cause for admission for a man who was in the sights of the mental health team and could be managed within the prison.

[183] Furthermore there is evidence from two officers who interacted with the deceased very close to the time of his death and they observed nothing of concern.

[184] The final point in the treatment plan was to arrange a follow up meeting with Dr NH in four weeks and earlier if concerns came to light. In his oral evidence Dr NH conceded that the deceased's failure to take his medication was a concern which would have merited accelerating the appointment. He seemed rather surprised that no follow up appointment had been scheduled. However any such appointment would have to have been after the 10 September 2018 and is not likely to have taken place in the interval between that and the deceased taking his own life as there is only one clinic a week at which Dr NH attends.

[185] It is a matter of regret that none of the four points in the treatment plan was implemented between 3 September 2018 and 18 September 2018. It is further a matter of concern that the position was not accurately spelt out in the letter from Dr NH to the Chief Executive of the Mental Welfare Commission for Scotland dated 21 September 2018.

[186] In that letter it is stated that the deceased "*continued to be followed up by mental health nurses and substance misuse nurses leading up to his death*." We know that he did not see a mental health nurse after the 3 September 2018. In addition it is stated, "*A plan was made to bring forward his next appointment with me*." In fact there was no appointment planned at all and certainly not a plan to bring any such appointment forward.

[187] That leads back to the question of causation. Again I am referred to authority by counsel for the Health Board who cited Sheriff William Holligan, *Fatal Accident Inquiry into the death of John Kelly, unreported, 11 March 2004, Glasgow Sheriff Court.*

[188] Under reference to the 1976 Act he said,

> "*One of the purposes of an inquiry is to investigate matters so as to avoid a repetition of the accident. Causation does have a role…In my opinion, the provisions of ss. 6(1)(c) and (d) [of the 1976 Act] fall to be applied objectively and with the benefit of hindsight. Section 6(1)(e) gives some support to this interpretation. There might be circumstances that might be relevant to the death but might not have been established to have a causal link*".

[189] That appears to be relevant to this case. Looking at the facts objectively and with the benefit of hindsight it is clear that the mental health team was engaged, that in itself being a "reasonable precaution". I question whether on the basis of the existing authorities I need go further and say that the measures identified in the treatment plan might also be seen as reasonable precautions or whether those are in the nature of a clinical judgement but it seems to me that there is little sense in putting a plan in place and then failing to implement it.

[190] However, for the reasons discussed I am not of the view that the evidence discloses any causative link between the failure to adhere to the plan and the deceased's death. While observations would have been helpful in an ongoing clinical assessment this inquiry has evidence from which I can reasonably infer that the deceased's presentation was not deteriorating in the days immediately before his death as two prison officers and a social worker were seen to note. There is no reason to conclude that other independent observers would have formed a different view.

[191] The deceased was known not to be taking his medication but it is likely, based on his history, that he had been either under medicated or indeed not medicated at all for some time. Although those with mental health problems are known to be at greater risk of suicide or self-harm Dr NH was at pains to point out that a psychotic illness does not of itself indicate a risk of suicide sufficient to warrant hospital admission. There was no evidence that the deceased was suffering auditory or visual hallucinations which might encourage self-harm and again to conclude otherwise is speculation.

[192] The absence of nursing follow up and a plan to bring forward the appointment with Dr NH is again of concern. The very fact that Dr NH wrote to the mental Welfare Commission expressing the view that the appointment should have been brought forward does infer that he considered the deceased's condition may require to be monitored and his failure to comply with medication was a particular problem. However the appointment would have been most likely to be brought forward to the next clinic when Dr NH attended the prison and would have been after the deceased's death. Even if the appointment had taken place in the days prior to his suicide it is far from clear that the outcome would have been different.

[193] Turning to *section 26(2) (f)* ,which requires me to identify any defects in any system of working which contributed to the death, I would reiterate that no causative link can be made between the death and any failure to implement the treatment plan.

[194] In any event the TTM suicide strategy operated alongside the various elements and if there had been a marked deterioration in the deceased's presentation that would

have been likely to have been picked up by the substance misuse team, the prison officers or the social worker who had contact with him.

[195] *Section 26(2) (g)* covers any other facts which are relevant to the circumstances of the death. I am invited not to make any findings under this subsection by all parties. The submissions of on behalf of the Health Board highlight that DIPLAR and Local Adverse Event Review ("LAER") that followed the deceased's death identified certain actions points which needed to be addressed by the Board.

[196] While those actions points related to matters relevant to the deceased's death and his treatment by the Health Board generally, and the HMP Perth MHT specifically I accept that they were not directly relevant to the circumstances surrounding the deceased's death in the sense of having a causative bearing, and in respect that all of the action points identified were acted upon appropriately I do not consider it necessary to make any finding under this section.

[197] Turning finally to my discretion to make recommendations as to "*the prevention of similar deaths in the future*" in terms of *section 26(4)* I am obliged to consider a) The taking of reasonable precautions; b) The making of improvements to any system of working; c) The introduction of a system of working; d) The taking of any other steps; which might realistically have prevented other deaths in similar circumstances.

[198] I have already addressed the issue of "reasonable precautions" and am of the view that the TTM strategy together with the provision of a mental health team which saw the deceased within days of concerns being raised meets the requirement of

reasonable precautions very fully. I would have no recommendations to make in this regard.

[199] I have already examined the system of working and do not consider any innovations to that that would have met the threshold of having a "real or likely possibility" of preventing deaths in similar circumstances in the future. However that is not to say that the existing system could not be implemented more stringently and no doubt measures will be taken in future to better ensure that treatment plans are followed up. If there had been nursing checks and observation sheets completed I might well have been able to go further than saying that there is no evidence to establish a causative link between these issues and the deceased's death and would instead have been able to point to conclusive evidence that despite rigorous follow up the death could not have been avoided. That is a simple question of emphasis and one which I am sure will have been taken on board.

[200] In the course of the evidence witnesses touched tangentially on the attempts which are ongoing to devise a more reliable risk assessment tool to identify prisoners at greater risk of self-harm or suicide. This was discussed at point (vi) of the LAER. The reasons why the TAG tool was considered unsuitable are rehearsed above. I accepted Dr NH's evidence that no system can ever be fool proof and acknowledge the efforts his team are making to try to achieve a more appropriate tool.

[201] As the doctor identified, these matters are very much resource dependent and it is of course vital that the compliment of mental health staff, both doctors and nurses, is

maintained within the prison estate where it is known that there are large numbers of people with susceptibilities and vulnerabilities for a whole host of reasons.

Conclusion

[202] For the reasons outlined above I shall make formal findings only in relation to this mater.

[203] I have observed that there is always room for improvement and there are always lessons to be learnt. That is clearly so in this case and the diligent LAER and DIPLAR reports have identified where weakness might be said to have arisen.

[204] I am satisfied that the TTM strategy had worked to identify that the deceased may be in need of input from the mental health team and that he received that care timeously. The fact that he did not engage or comply with the regime did not help those who were doing their best to assist him.

[205] In short looking at the evidence as a whole I do not consider that there were any further reasonable precautions which if taken would have had a realistic prospect of preventing this death.

[206] Finally but importantly on my own behalf and on behalf of the parties I wish once again to extend condolences to the family and friends of the deceased for their sad loss.