INQUIRY INTO THE DEATH OF APRIL ADAM UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976

DETERMINATION

Of

SHERIFF R E G YOUNGER

Sheriff of Tayside Central and Fife at Stirling

In

Inquiry into the Death of

April Adam (DOB: 16 April 1967) when a Prisoner at

HM Prison, Cornton Vale, Stirling

Or at Stirling Royal Infirmary

In September 2002

Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

And in particular Section 6(1) thereof

STIRLING, 15 December 2003

The Sheriff, having resumed consideration of the evidence and the documents produced and the Submissions of parties all heard over 11 days between 27 October and 12 November 2003 at the Inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("the 1976 Act") into the death of April Adam (DOB: 16 April 1967) in September 2002, *RECORDS* (Firstly and obviously) that April's death has been shocking and very sad for all those touched by it, but in particular for friends and relatives. There has been considerable upset and disapproval expressed in Court during the Inquiry by those attending, and one witness from the prison was unfortunately very upset and distressed as a result of one of these expressions and all that it brought back. In the event all managed to remain at the Inquiry, and I express my appreciation that they did. (Secondly) I consider that the Procurator Fiscal Depute in presenting the evidence and making submissions, and those representing interests at the Inquiry, did so appropriately and well. (Thirdly) I consider that all of those who gave evidence were credible and reliable witnesses, albeit that their interpretations of events, and of rules and systems, and of the best way of helping prisoners in relation to self-harm/suicide, may not always have been identical. (Fourthly) I recognise that those who gave evidence are more expert on the issues than I, having first-hand experience or knowing April well. (Fifthly) It has to be

remembered that Productions 16 and 15 do not pretend to show how all self-harm/suicides can be avoided; but they are an attempt, and an attempt on the evidence at this Inquiry which has had considerable success, to search for and implement the best possible practice in the hope of getting as near as possible to no self-harm/suicides of prisoners. The Conclusion at Page 9 of Production 16 while saying that "suicide is not inevitable" also concedes that "It has to be recognised that not all suicides are preventable". The aim of the Strategy is "In every instance" ..... to ..... "offer prisoners the best possible Standard of Care and help to address his/her needs". (Sixthly) As is obvious from the "his/her" in the preceding quote, the Strategy in Production 16 is nation-wide and not confined to Cornton Vale: on this point it was mentioned at the Inquiry that there is on-going, or is about to be, a national review of the Strategy relating to self-harm/suicides of prisoners. (Seventhly) Nothing in this Determination, however poorly expressed, should be taken as attributing blame for April's death since I do not consider that evidence heard at the Inquiry justifies such attribution or a finding that there is blame. That being my view, the aims have been to seek to establish the facts of and around April's death, to see whether the Strategy, the system, was followed or not, and (by posing questions suggested during the Inquiry) to join in the search for best practice, for the best possible Strategy, in order to make self-harm/suicide of prisoners as rare as possible. Bearing these Recorded points in mind, the Sheriff *DETERMINES* as follows:-

- In relation to Section 6(1)(a) of the 1976 Act ("where and when the death and any accident resulting in the death took place"), April's death occurred at the Intensive Therapy Unit of Stirling Royal Infirmary (to which Infirmary she had been taken from HM Prison, Cornton Vale between 1535 and 1600 hours on 26 September 2002) at about 1630 hours on Sunday 29 September 2002.
- Further in relation to Section 6(1)(a) of the 1976 Act, April was in the Intensive Therapy Unit on 29 September 2002 as indicated in Determination 1 as a result of April hanging herself on Thursday 26 September 2002. Part of the evidence of Dr Bruce Michie, who undertook the Post Mortem Examination and Report Production 18 on April, was that, from information given to him to the effect that immediately after April was found hanging on that day she had no heartbeat or pulse (asystole), was not breathing, and had staring glazed eyes, April was probably "clinically dead" when found hanging. However, no submissions based upon this evidence of Dr Michie or on any other basis was made to the effect that April was already dead by 26 September 2002: and as the Concise Oxford Dictionary defines "clinical death" as "death judged by observation of a person's condition" (and so perhaps a judgement before more detailed examination); as the first definition of death in the Concise Oxford Dictionary is "the final cessation of vital functions in an organism", and in Collins Dictionary is "the permanent end of all functions of life in an organism" (there being no definition in point in the Scottish Contemporary Judicial Dictionary: Stewart); as some of those functions were reactivated in April at the Infirmary on 26 September 2002 with the aid of ventilatory therapy including drugs (Page 7 of Stirling Royal Infirmary Medical Records, Production 17); as those reactivated functions continued in April until 29 September 2002 albeit with the aid of such ventilatory therapy; and as it took the withdrawal of that therapy to stop those functions at the time of death indicated in Determination 1: I consider that Determination 1 should remain and is correct.

- Further, in relation firstly to Section 6(1)(a) of the 1976 Act, secondly to Paragraph 5.47 of Carmichael: Sudden Deaths and Fatal Accident Inquiries:

  Second Edition which, while not directly dealing with self-harm, does refer to "analogous cases" for the proposition that the word "accident" in Section 6(1) of the 1976 Act can include "incident", and thirdly Section 6(1)(b) of the 1976 Act ("the cause or causes of such death and any accident resulting in the death"), April's death, as timed in Determination 1, was caused by the self-harm indicated in Determination 2. I consider that that self-harm was not an accident in its usual sense but was an incident which resulted in April's death and so appropriate to be dealt with by me under Section 6(1). That incident occurred in Room 6 (which April shared in Unit 4 of Younger House at HM Prison, Cornton Vale) between about 1455 hours and 1525 hours on Thursday 26 September 2002.

- Further in relation to Section 6(1)(b) of the 1976 Act ("the cause or causes of such death and any accident resulting in the death"), the cause of April's death without which she would not have died at the time indicated in Determination 1, was April's self-harm by hanging herself by her neck (under reference to Determinations 2 and 3) from a sheet, knotted both around her neck and to the top bunk in her shared room referred to in Determination 3. Her hanging had the effect of depriving her brain of oxygen for at least about 5 minutes causing her irreparable brain damage; she was probably so hanging for at least about 20 minutes since her heart beat, pulse and breathing had stopped, and her eyes were glazed and staring, all by the time at which April was found hanging. By the time that she was found hanging April was beyond responding so as to sustain any vital functions without continuing ventilatory therapy, and even with that therapy beyond responding so as to reach a state of consciousness or semi-consciousness.
- Further in relation to Section 6(1)(b) of the 1976 Act ("the cause or causes of such death and any accident resulting in the death"), while no Death Certificate has been lodged, it has been proved that the causes of April's death were certified as "I(a) Hanging by Neck, II Colitis". It seems from inference from the evidence that colitis (inflammation of the colon) was included as a cause of April's death as a result of colitis being found to be present during the post mortem examination, since colitis is a condition whose symptoms can lower a patient's mood, and since if colitis did result in low mood it could cause or contribute to suicidal ideation. It was not proved in evidence that April felt symptoms from colitis leading to low mood, and as there was also evidence that colitis was certified as a cause of death since it was helpful for Government or Medical Statistics that it should be recorded when found at a post mortem examination (which nevertheless seems to me to be at best a very doubtful reason for finding colitis to be a cause of death), I determine that colitis has not been shown at this Inquiry to have been a cause of April's death (although it could if presenting symptoms before April's hanging which lead to low mood be a cause of self-harm by hanging which resulted in April's death under reference to Determination 7(i)).
- Further in relation to Section 6(1)(b) of the 1976 Act ("the cause or causes of such death and any accident resulting in the death"), it is probable that April's death was precipitated by withdrawal of "ventilatory therapy" at 1610 hours on

Sunday 29 September 2002 (Production 17, Page 15), but that therapy was only withdrawn with consent based on medical advice after it was clear that continuing resuscitation would not result in the return of meaningful brain or bodily functions for April. That withdrawal has not been suggested to be a cause of death by any party and I do not consider it to have been a cause of April's death which by the time of that withdrawal was regarded as, and was, inevitable.

- Further in relation to Section 6(1)(b) of the 1976 Act ("the cause or causes of such death and any accident resulting in the death"), which includes in this Inquiry the cause or causes of the incident of self-harm, of April's hanging, April (of whom there is a small photograph attached to Page 26 of the Scottish Prison Service Healthcare Records Production 3) gave no indication of the purpose of her self-harm whether by leaving a note or making threats in advance. Further, there is nothing to indicate whether this incident of self-harm by hanging was a determined suicide attempt, or was a risky attempt to cry for help which was a possibility which seemed to underlie some of the questions asked. Whichever it was, the cause may have been any one or more of April's problems, worries or feelings at the time, some of which at least I am able to draw from the evidence, Productions and Submissions:-

(a)A vulnerable prisoner. Although April had been remanded in Cornton Vale for about a week in September 2001 before being granted bail, on 19 September 2002 she was sentenced to her first period of imprisonment at the age of 35. Her sentence was one of 4 years' imprisonment from the High Court in Glasgow. For whatever reason, it is clear from the pre-sentence Social Enquiry Report Production 9 both that April did not accept the terms of her conviction which was after trial, and that April had not expected to receive the length of sentence that was pronounced and had been hoping for a non-custodial sentence. There was ample evidence that on arrival at Cornton Vale and for some time after arrival, running perhaps into some days, April appeared to be stunned by what had happened to her and not to have fully taken on board what had happened (under reference as example to the entry wrongly dated 20 September 2001 instead of 20 September 2002 in Production 6). Her vulnerability in this respect seemed from the evidence to be quite extreme, and although I do not have sufficient knowledge or experience to know how unusual April's vulnerability was in comparison to that of other arrivals at Cornton Vale it was clear from the evidence that her vulnerability was concerning to those who received her at Cornton Vale.

(b)History and thoughts of self-harm. From the bottom of Page 5 of the pre-sentence Social Enquiry Report Production 9, it is clear that the High Court knew when sentencing that April was thought to be at risk of being suicidal if in receipt of a custodial sentence; and that information was relayed and made clear to Cornton Vale through the note at the bottom of the Extract Sentence and Warrant, Production 2. There was also evidence (under reference in particular to the evidence of Doreen Evans a previous partner of April's and her best friend and given as her next-of-kin in the Admission Interview Production 8, nurse Hart's Admission Profile at Photocopy Page 6 of Production 3, nurse Duffy's Pre-Case Conference Report on 20 September 2002 at Photocopy Page 8 of Production 4, and Dr Sayer's Assessment, Photocopy Page 9 of Production 4) that April had made attempts at deliberate self-harm/suicide prior to 19 September 2002, one of which attempts was by means of taking her partner's methadone recently (probably in June 2002), with scars indicative of deliberate self-harm on her arm or arms, and with some mention that

April had had thoughts of hanging herself. She also indicated in her Admission Interview Production 8 Page 2 that she had been bereaved recently by the suicide of one friend (and the murder of another). The attempted suicide of her partner referred to under (d) may have encouraged or re-activated so called "suicidal ideation" in April when taken along with the contents of this paragraph.

(c) Drug/Alcohol Problems. While April had had drugs problems previously, by the time of her arrival at Cornton Vale these were not current in a major way. She may have been taking some of her then partner's Valium/Diazepam (a well known tranquilliser and relaxant), and (under reference to her Admission Profile Photocopy Page 6, Production 3) had been prescribed at some time Amitriptylene (an anti-depressant and mild tranquilliser) to help her to cope both with worry and low mood pre-trial. But April's main substance problem at the time of her admission was not drugs but alcohol: she seems from the evidence to have had a habit of consuming about 15 cans of lager and/or some spirits daily for some time prior to sentence (including some alcohol on the day of sentence), a quantity which was likely to lead to overt or covert problems of withdrawal with the sudden non-availability of alcohol on imprisonment. Much or all of this was recognised on April's arrival at Cornton Vale under reference to her Admission Profile Photocopy Page 6 of the SPS Health Records Production 3, and April was set to receive 30 milligrammes of Valium/Diazepam daily to help with such withdrawal consequences, with a planned reduction of that to 20 milligrammes on 23 September 2002 and to 15 milligrammes on 26 September 2002 (her prescription sheet at Photocopy Page 26 of Production 3).

(d)Family Problems. April's then current partner Tracey Clunie had attempted suicide a few days prior to April being sentenced (under reference for example to Dr Sayer's Assessment at Photocopy Page 9 of Production 4) and their relationship of somewhere between 4 and 10 months' duration was to some extent in doubt. It is apparent that Irene Roseveir's Note in the daily log Production 5 for 24 September 2002 at 9.30 pm shows continuing difficulties with April's then partner, although the transcript of a telephone call Production 14 on 26 September 2002 at 12.43 pm may indicate some resolution of that current partner difficulty. Further, April was estranged from all members of her natural family (except for her centenarian grandmother) because of their disapproval of one or more of April's previous female partners rather than because of April's sexual orientation in general. And as regards her centenarian grandmother who had had much to do with April's upbringing, April was worried lest the grandmother found out about her present sentence and about her sexual orientation since April did not wish her grandmother to have such discoveries which might lead in one so old to damage to health as well as distress. This grandmother concern was a real concern for April, and the doubts about the future of her current relationship (bearing in mind the length of her sentence) were in probability also worrying April.

(e)The Complainer in the Charges for which April was sentenced. April expressed worries about the presence of friends of her former partner Rhona Cassie in Cornton Vale one of whom she named as being (she thought) in Peebles Block at Cornton Vale, under reference in particular to the Information and Intelligence Report Production 10. This was also a real worry to April.

(f)April's tenancy. For at least part of the time that April was on bail and so for up to about a year since she was charged there had been various delays of her trial which had increased April's worry, and April had been prevented by a bail condition from living in her own tenancy, apparently since there was fear that Rhona Cassie, the Complainer already mentioned, would confront April there. These delays of April's trial had therefore the result of prolonging her absence from her tenancy, and the thought of probably losing her tenancy and of having no-one to assist her in Cornton Vale in relation to trying to prevent that, was a considerable worry to April.

(g)April a loner? April's previous partner Doreen Evans said in evidence that April had been an outgoing attractive person but that since being charged with the offences for which she was convicted she had understandably become increasingly withdrawn and isolated. Following that up, on 20 September 2002 April indicated to nurse Duffy (under reference to Photocopy Page 8 of Production 4) that she was "not really a people person prefers to be on her own", and on the same day, according to Production 5 the Daily Log, April stated to a Social Worker Michael Stewart (who did not give evidence but Production 5 was available as the Daily Log to others dealing with April) that April "felt like her agoraphobia was returning at present". Perhaps in retrospect these indications soon after April's arrival, particularly if April became isolated subsequently, could have been taken as warnings of there possibly being more to worry about and watchful for in such isolation than natural distress at the length of her first sentence. Further it is clear that April did not attend either Case Conference (on 20 & 23 September 2002) despite invitation if not attempts at persuasion, although many prisoners fail to so attend, finding such one to three meetings uncomfortable. From perhaps 24 September 2002 April was spending much time in her room (although she seems to have attended part of an induction course), lying on her bed with her face to the wall, apparently not eating much, and sleeping a lot, and refusing to go on a work party when required on 26 September 2002 for which she was put on Report to the Governor, under reference to Productions 6 (last entry) 11 and 12. On the other hand there is also evidence which I accept that it is not unusual for prisoners beginning a lengthy sentence to behave in much the same way as April behaved simply from the distress of their lengthy sentence rather than from being suicidal, and that fact might mean that the giving of space to such a prisoner was more appropriate than thinking in terms of suicide risk. There is in addition evidence that April had more than one phone call with each of Doreen Evans referred to in (b) and Tracey Clunie referred to in (d) and probably at least attempted other phone calls under reference to Production 13. Further, by the time of her self-harm April in probability had a visit arranged for the following day under reference to the telephone call related in Production 14 and in (d), and to some evidence that Tracey Clunie turned up for a visit on 27 September 2002 since she had not been told of April's self-harm: it may be that April while wanting to see her partner Tracey was doubtful if she could cope with that visit. There is no suggestion that April had any other visitor at Cornton Vale.

(h)Vegetarian. April was a vegetarian as stated at the time of her Admission Interview, Production 8 Page 2. She complained about her preference for that type of food not being allowed for and possibly also that a prisoner who was serving the food did not wish to provide her with such meals. Two of the prison staff (Irene Roseveir and Louise Hanson) who were in contact with April did however provide

April on their own initiative with snack meals suitable for a vegetarian when aware that she had missed a meal or meals but it is unknown whether April ate such meals.

(i)Colitis. Determination 5 refers to the fact that on Post Mortem examination April was found to have had colitis and that this may have lowered her mood. There is no way of knowing whether this colitis is a relevant consideration or not. As already explained it could have served to lower April's mood if she was feeling its symptoms.

(j)Room-mate. April had met, and had apparently got on with, Antoinette (Tony) Quinn (who did not give evidence) at Cornton Vale when she had been remanded there in 2001 as indicated in (a) and as appears from the 8.45 pm entry for 20 September 2002 in Production 5. Further Tony was "pleasant and supportive and knows April is struggling" according to Irene Roseveir in her note of 24 September 2002 in Production 5. Tony should therefore have been a good choice as room-mate for April. However by 25 September 2002 at 8.45 (presumably) pm (Production 5) April was quiet and not eating and was asking for a room on her own. Was this because she did not wish company and/or wanted time and space for planned self-harm as her refusal to go on the work party, referred to under (g), could also suggest?

- Date of Liberation. As is obvious, for a first time prisoner of 35 like April with an earliest date of liberation (under reference to Photocopy Page 6 of Production 3) of September 2004, the time ahead in custody probably felt to April so long that it was the same for her as if no end to her sentence had been fixed.

I can only state that the cause or causes of the incident of April's self-harm referred to in Determinations 2 and 3 cannot on the evidence be definitely determined. I do however consider that it is probable that one some or all of the problems worries and feelings detailed under (a) to (k) above caused or contributed to April's decision to self-harm, whether that self-harm was an attempt at suicide or a cry for help which on the evidence I cannot determine.

8.In relation to Section 6(1)(c) of the 1976 Act ("the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided"), the only submission came from Mr Findlay Solicitor on behalf of April's relatives. His submission was that all prisoners, or in any event all prisoners placed on the Scottish Prison Service Suicide Risk Management Strategy (under reference to the Act and Care Document Production 16) such as April, should be warned of the risks of self-harming (and there is under "key issues in communication" at Page 13 of Production 16 a point which starts "Emphasise to prisoners the dangers of self-harm ....."; and under Suicide Standards: Context at page 23 Point 2.1 there is "Information for prisoners in respect of suicide awareness should be provided as a standard part of the induction process"); and in particular he suggested that prisoners should be warned that hanging may result in incapacity/unconsciousness very quickly with irreversible brain damage happening quickly, and with all brain functions usually becoming irretrievable after about 5 minutes of hanging. Under reference to the first two sentences of Determination 7 there is no evidence or inference from evidence that I can find or recall that April by hanging herself may have had the intention of achieving self-harm short of death. It would in my opinion

only be such self-harm short of death which would be relevant to such a warning since without the warning someone like April might have been caught out by the speed of incapacity/unconsciousness from hanging if she was not wishing to die. April left no note as to her intentions and one explanation of that could I suppose be that she left no note because she was not expecting to die: but I consider that to rely on that explanation would be to speculate rather than to infer. At the risk of further speculation there has been no evidence at this Inquiry that any object was near her feet when she was found hanging on to which she could have stepped so as to remove the pressure of the noose, or any other evidence that I can think of on which to base an inference as to April's intention. If April's intention, or the intention of any other prisoner, was to kill herself rather than to self-harm short of death, such a warning of the possible short time to incapacity/unconsciousness from hanging would seem more likely (at least to a non-expert like me) to encourage a suicide attempt than to prevent it: and it is obvious that prisoners intending self-harm short of death cannot be selected in advance to receive the warning while excluding those seeking death. I cannot therefore infer that such a warning precaution might have prevented April's death since, if such a warning could ever be appropriate, that would only be upon April's intention being to self-harm short of death which intention has not been proved directly or by inference and which intention could not have been known in advance anyway. I do not therefore make a Determination that this suggested warning to April was a precaution whereby April's hanging and/or death might have been avoided; I do however consider that whether such a warning that hanging may result in incapacity/unconsciousness very quickly should be given to prisoners at risk is a fact relevant to the circumstances of April's death (since questions at the Inquiry suggested (a) that April may have been unaware how quick the effects of hanging may be, and (b) that April may have been attempting self-harm short of suicide), and so this suggested warning is revisited in view of Section 6(1)(e) of the 1976 Act in Determination 12(a).

9.Under reference to Section 6(1)(d) of the 1976 Act ("the defects, if any, in any system of working which contributed to the death or any accident resulting in the death"), Mr Findlay, Solicitor for the relatives of April, made several submissions (the only participant to make submissions in reliance on this sub-section) on behalf of the relatives of April, which submissions I have to some extent re-grouped into three main groups. The first of these groups concerns the Case Conferences held in relation to April at Cornton Vale Prison. On arrival April was "placed on the Act", that is was assessed as a prisoner at risk of self-harm/suicide: she was therefore to be dealt with in light of the Scottish Prison Service Suicide Risk Management Strategy Act and Care Document Production 16 ("the Act" on which April was placed), as further explained in the related Suicide Risk Management Staff Handout Production 15, which Productions 15 and 16 show the "system of working" insofar as written for "at risk" prisoners during April's time at Cornton Vale in September 2002. There is no satisfactory substitute to reading the whole documents, but they may not be readily available to some readers and so I refer to relevant parts of them now.

Direct references seeking to explain the system of Case Conferences in Production 16 are, as far as I can see, as follows:-

- At Page 1 "Case Conferences and Care Plans are the means by which support is organised and reflect the prisoners' needs" (in the context that

"Residential teams manage the care process with specialist providers in partnership and support", "Multi-disciplinary working and sharing of information are essential", and "Decisions about at-risk prisoners should be made by teams not individuals").

- At Page 2 "The Strategy focuses on care plans and Case Conferences and subsequent care plans organised by residential staff and suggested by specialist teams".
- At Page 9 "Care will be delivered by multi-disciplinary teams, working together through case conferencing and care plans to help and support prisoners to address their problems".
- At Page 10 "Where possible, a Case Conference is held immediately, or within 24 hours, attended by the most appropriate members of staff", that is after a prisoner is considered to be at risk of suicide or self-harm and so placed on "the Act"; and "The case is reviewed at least 72 hours after the initial Case Conference and as often as is felt necessary thereafter", the "at least" meaning by inference from evidence heard at the Inquiry "within", that being confirmed also by "case review within 72 hours" on the flow chart at Page 11 (and also on Page 2 of Production 15).
- Also at Page 10 "The Case Conference determines the level of risk, ie high or low" when assessing a prisoner assessed as at risk of self-harm/suicide.
- At Page 18 one of 23 "key issues in Regime Provision" is "Invite family members to attend Case Conferences" (which was not possible for April under reference to Determination 7(d) unless Doreen Evans referred to in Determination 7(b) as stated next-of-kin should have been invited in place of family).
- At Page 19 "with the consent of the prisoner the Samaritans may be invited to attend Case Conferences....." . This is not a point which arises on the evidence in April's case.
- The standards to be achieved at Audit when there is a perceived risk of suicide are stated as regards Case Conferences at Page 26 Point 4.5 and from Point 4.8 to Page 27 Point 4.16 inclusive. These points are all starred and so are core standards and so priorities under reference to Page 20. The points made are: that where concern has been expressed about a prisoner's well-being there should be a Case Conference at the earliest opportunity; that a co-ordinator is needed in each hall/unit to manage the Case Conference process: the second audit question under "teamwork" at Page 31 also mentions this and may raise in its first part an appropriate question from this Inquiry, that is "Are residential Co-ordinators properly prepared .....?" ie as to who is to chair a Case Conference, as to attempting to achieve (if appropriate) some continuity of participation in Case Conferences, as to the extent, if any, to which attendance by the prisoner at her Case Conference should be encouraged, as to who should speak for her and report the outcome to her if she does not attend; that there should be minimum number designated for a Case Conference (which, although there seems to be no minimum in writing, from the evidence seems to have been as regards this Inquiry at least 3 which from the bullet point on the right of Page 3 of Production 15 beginning "The supervisor/co-ordinator arranges ..." is the minimum in one sort of first Case Conference); that there is need unless there are specific reasons to the contrary to invite attendance by the prisoner at her Case Conferences (which provision

should perhaps be read along with 2 points in particular under "key issues in communication" at Page 13: "Discuss with the care team and prisoner how information about them can be passed on" and "Try to encourage the prisoner to accept support. A feeling of coercion or losing control can make things worse"); that there is need to update the prisoner's care plan at each Case Conference; that removal of a prisoner from the Act strategy has to be decided by a Case Conference; that where a Case Conference which is needed cannot be held immediately there must be a risk assessment made and a safe environment (presumably meaning an environment in which the means to self-harm are not available insofar as that it is possible) provided until the Case Conference which must be within 24 hours; and that if a pre-Case Conference Nursing Assessment is not available a safe environment must be provided by the Case Conference.

- There is also an audit framework of 5 points as regards Case Conferences at Page 32 which are checks rather than part of the way to operate Case Conferences and confirm rather than add to the strategy indicated in the previous points.

The Suicide Risk Management Staff Handout Production 15 as well as repeating points from Production 16 adds to Production 16 in my opinion as follows:-

- At Page 1 it clarifies the second passage quoted from Page 10 of Production 16 by stating that the level of risk of a prisoner self-harming ("High", "Low", or "No apparent risk") is to be decided at a Case Conference on information available at the time of that Case Conference.
- At Page 2 decisions at Case Conferences of level of risk are not by majority: such decisions must be the highest risk thought appropriate by any participator in the Case Conference.

It is against this background of a written system in Productions 16 and 15 that Mr Findlay suggested defects in relation to the system of Case Conferencing. He suggested that there was no real attempt to secure April's attendance at the second Case Conference on 23 September 2002; that the person (Prison Officer James Alexander Stewart) who in the event chaired that second Case Conference had only met April prior to it by chance and not as the result of a laid down system; that although there is provision in Production 16 at Page 26 Point 4.8 that there is need for a co-ordinator of Case Conferences in each area, it is not clear what the role of that person is to be and in particular who is to chair the Case Conference and who if anyone is to inform the prisoner of its outcome; that in relation to April the Nurse's assessment at the Case Conference on 23 September 2002 had been inadequate; and that there was no part of the system which required consistent continuing participation by one or more members from one Case Conference to the next, the only member common to April's Case Conferences having been the same Prison Officer James Stewart who was unknown to April before her first Case Conference and who was only seen by April by chance prior to the second Case Conference as already indicated (these duties having fallen to Prison Officer Stewart within the only 3 months that he had served at Cornton Vale).

As regards the submissions about the system of Case Conferencing, I do not consider that there was direct evidence, or evidence from which I could infer, that

any defect in that system contributed to April's death or to her self-harm by hanging which led to her death. April's deterioration leading to her wish to self-harm seems to have occurred less than obviously, and in probability only took hold after the second Case Conference which occurred 3 days before her death. The critical point is however that Residential Officer Irene Roseveir, by keeping her eyes open without involvement in the Case Conference system which was in use for April, sussed out that April might not be coping and so referred her to the Mental Health Team (under reference to her entry at 9.30 pm (2130 hours) on 24 September 2002 in Production 5 and her Mental Health Referral at Page 3 of Production 3). This Roseveir Referral resulted in Practitioner Nurse Owen Masterson visiting April in her room to carry out a Mental Health Assessment between 1230 and 1245 hours on 26 September 2002, when April declined to see him until she had got up and washed and dressed, to which request by April (it was accepted) Mr Masterson rightly agreed. As he was at the end of his shift Mr Masterson passed on the Roseveir Referral to Practitioner Nurse Debra Dunnachie, and the Joint Minute of Admissions details how it came about that despite planning to visit April on the afternoon of 26 September 2002 Miss Dunnachie did not so visit prior to April's self-harm by hanging on that afternoon. I conclude that any defects in the system of Case Conferencing do not fall within my remit in terms of Section 6(1)(d) of the 1976 Act having not been shown to have contributed to April's death or to the prior incident of self-harm in the way required by that sub-section.

Despite not falling within Section 6(1)(d) as indicated I do consider that any defects in the Case Conferencing system are facts relevant to the circumstances of April's death under reference to Section 6(1)(e) of the 1976 Act: April was, at the time of her death, subject to that system (another Case Conference having been arranged for 30 September 2002), which system was part of the effort to reduce substantially self-harm by prisoners like April. I therefore refer back to this Determination in Determinations 12(b), (c), (d) and (e).

- Under reference again to Section 6(1)(d) of the 1976 Act ("the defects, if any, in any system of working which contributed to the death or any accident resulting in the death"), Mr Findlay's second group of submissions for the relatives (of the 3 such groups anticipated in the first sentence of Determination 9) related to Observations of prisoners. Again there is no substitute for reading the whole documents, but direct references in Production 16 which seek to explain the system of Observations of prisoners are, as far as I can see, as follows:-
    - At Page 1 under "Key Principles of the Act Model" the second last principle is "The care of prisoners who are at risk must involve supportive relationships and regimes which are interactive and appropriate, not just observation, important though this is", while at Page 2 under "Key Issues in Care" the second is "Care of prisoners at risk must involve active supportive contact, not just observation"; and at Page 17 "Hall staff must take on a contact or support role .....".
    - At Page 3 under "Key Issues on Assessment" it is stated that at Reception there is only a one-off snapshot of a prisoner, and that "because a prisoner's situation may change it is vital for staff to look for signs of increased risk throughout the period of custody", and at Page 15 it is indicated that "It is important to look for signs of poor coping which seems to be associated with self-harm .....".

- At Page 27 under "suicide Standards ..... Facilities" Point 4.18 (which is starred and so is a core standard and a priority under reference to Page 20) is "Twenty-four hour care is considered to be best practice". This standard point for Audit (also included as the first point under "Facilities" at Page 32) was hardly mentioned during the Inquiry, but its meaning, and the reason that it was hardly mentioned, are made clearer in Production 15 as indicated later.
- At Page 27, Point 4.19 (which is also starred and so a core standard and priority under reference to Page 20) indicates that those in "safe" cells "must be observed every 15 minutes", this corresponding to the evidence that such facilities were for those assessed as high risk of self-harm/suicide. April was so assessed and so accommodated until her first Case Conference on 20 September 2002.

The nature of these sometimes oblique or doubtful references to Observations in Production 16 tie-in well with the evidence of Susan Brookes, Governor of Cornton Vale, and Heather Keir, Head of Care at Cornton Vale, both of whom as I understood them were keen on Observations of a frequent and informal nature by all of those in contact with prisoners in an endeavour to build relationships with prisoners, but were less enthusiastic about the more old-fashioned within fixed time limits sort of Observations of prisoners with their main (or at least a main) purpose being to see that prisoners appear to be refraining from self-harm. In Production 16 there is only mention (as far as I can see at Page 27 Point 4.19 already referred to) of such old-fashioned Observations, and that mention is only in relation to High Risk prisoners having to be observed every 15 minutes. However, such old-fashioned observations were from the evidence at this Inquiry still in use not only for high risk prisoners, but also for those assessed as low risk as is shown by April's experience (15 minutes for the first day after her Admission when assessed as high risk, 30 minutes after the first Case Conference when assessed as low risk, and 60 minutes after the second Case Conference when assessed as less, but still low, risk).

The difference of emphasis between informal frequent contact with prisoners and more old-fashioned "Observations" is perhaps more balanced when the Management Strategy Production 16 and Staff Handout Production 15 are read in tandem that is together but with Production 16 leading. Production 15 seems to me to supplement Production 16 as regards Observations as follows:-

- In the third paragraph under "definitions" on Page 1 the need for individualised care is emphasised, declaring that the previous categories of supervision of prisoners "will now no longer exist".
- From Pages 1 to 2 the categories of prisoners at risk of self-harm suicide are stated as High Risk and Low Risk with the remainder in a category of "no apparent risk", so that April was High Risk when on 15 minute observations, and Low Risk to differing degrees when on 30 minute and later 60 minute Observations.
- I have already pointed out that at Page 27 of Production 16 "Twenty-four hour care is considered to be best practice". This becomes "24 hour support is recommended as best practice for those at high risk" at Page 3 right column Production 15. There are several further references to similar thoughts in Production 15. At Page 2 there is reference to one sort of safe

environment being "a local facility with 24 hour contact", at Page 3 this 24 hour contact is explained as "at least in sight at all times", and "24 hour visual contact". There is a suggestion at the bottom of the left column on Page 3 which follows on from a reference to "24 hour visual contact" that "a ward/dormitory type environment may be preferable ....". Just above that it is pointed out that this 24 hour "best practice" will depend on local facilities being available, and so the reason for near silence about that "best practice" at this Inquiry was obviously because there is no such facility at Cornton Vale. It must be remembered that Productions 16 and 15 show a plan for the country and not just a plan for Cornton Vale. But the importance of this 24 hour "best practice" is that it shows that whether it is called "care" or "support" or "contact" its aim if introduced would be insofar as possible constant observation of high risk prisoners in order to make high risk prisoner self-harm less likely: why else would there be "24 hour visual contact", "at least in sight at all times" and the suggestion that "a ward/dormitory type environment may be preferable"? And since such longer periods of Observation are (or were in 2002) still used for Low Risk, it is not surprising that those doing the Observation considered that its purpose, or a purpose of it, was to check for self-harm and to make self-harm more difficult since they had presumably read Production 15.

- Production 15 confirms the importance of Observations directly as well as by inference as already indicated. At the bottom of Page 1 left column among other aspects of care which staff are allowed to specify there is included "How often each prisoner will be observed". And at the top of Page 3 right column it is stated "For all prisoners there are no set levels of observation. In each case the Case Conference will decide the level of observation appropriate for each prisoner. This might range from a designated person making checks at regular intervals to a requirement that staff are simply made aware of the need for extra support. If checks are made it is best that the intervals can be varied e.g. 'twice every hour'. This helps to prevent prisoners timing a suicide attempt .....". It is clear I consider that "a designated person making checks at regular intervals" remains one means of observation which staff could specify; and, since it is considered "this" (i.e. varied intervals of observations) "helps to prevent prisoners timing a suicide attempt", Observation is (or was in September 2002) still seen as one tool to deter self-harm.

It is against this background of a written system in Productions 16 and 15 that Mr Findlay suggested defects in relation to the system for observing prisoners. He submitted that there is muddle in relation to what such Observation means. He divided Observations into Observation with the object of building relationships and gaining the confidence of prisoners since the best way of knowing of possible self-harm is from the mouth of the prisoner, and Observation (sometimes referred to as "Obs.") of the more old-fashioned sort, that is with its main object to minimise the risk of self-harm by regular sightings of the prisoner. He submitted as an example of a confusion in the system of Observations, that while the Governor and Head of Care thought Observations as they have developed were there mainly to help the creation of trust between staff and prisoners, those at the coal face such as Prison Officer Mark Skinner thought that their purpose was more to check that the prisoner was not engaged in self-harm. As a consequence of this confusion resulting in differing views of the purpose of Observation, or in any event for some such reason, Mr Findlay

submitted that the system of Observation had failed April in 3 ways. Firstly he submitted that staff had not been proactive and communicative enough with April with the consequence that the care and support which she needed did not materialise; he submitted that had the sort of contact with April envisaged by the Governor and Head of Care been provided for April her deterioration should have been obvious to staff. Secondly Mr Findlay submitted that there was breakdown of the system of Observations as a preventative measure for April since April was on 60 minute observation and Louise Hanson last visited April (who was locked in her room) at 1415 hours on 26 September 2002 and went off duty at about 1515 hours without visiting her again, with the next known visit being by Prison Officer Mark Skinner at about 1525 hours when he found April hanging. And Thirdly Mr Findlay submitted that a system of recording of Observations when a prisoner is on time-limited Observations would encourage compliance with such time-limited Observations, as would "a designated person making checks at regular intervals", since one person would then take on board that he or she alone was responsible both for making such time-limited Observations and for recording them.

As regards these submissions by Mr Findlay about the system of Observations I do not consider firstly that any failure in the system of care and support as the purpose of such Observation has been proved to have failed April. That she was not coping was sussed-out by Residential Officer Irene Roseveir, and I refer to Determination 9 for details of that Roseveir Mental Health Referral and the circumstances which caused (very sadly) the assessment resulting from the Referral not to be undertaken in time to prevent April's self-harm. Further, I do not consider secondly that it was proved at the Inquiry that the probabilities from the evidence heard thereat are that the requirement for 60 minute Observations was not followed between 1415 and 1525 hours on 26 September 2002 for April. From my Notes Prison Officer Louise Hanson's evidence was that before going off duty at about 1515 hours she handed her duties over verbally to George Phillips (who is on the witness list as an "Estate's Officer") and to a Janet (Jan) Harrower (who is not on the witness list but who was a Prison or Residential Officer), neither of whom have given evidence at the Inquiry. While therefore both the Prison Officers Mark Skinner and Louise Hanson had not visited April in the 70 minutes between 1415 and 1525 hours (Mr Skinner having drawn from what Louise Hanson said about putting April on Governor's Report that she had last seen April at about 1430 hours), both George Phillips and Janet Harrower were also available to have done a visit, and were perhaps more likely to do so than Mr Skinner if Miss Hanson is correct that she handed over her duties to one or both of them. Having said all that any lack of 60 minute Observation covering the time of April's hanging determined in Determination 3 as between 1455 and 1525 hours could be important, bearing in mind that any such visit to interrupt the fatal, or totally disabling, consequences of hanging would have had to have occurred within the time after initial hanging indicated in Determination 4. And lastly as regards Mr Findlay's submissions relating to Observations I do not consider on the evidence heard that written recording of Observations or a specified person to carry them out have been shown by evidence at the Inquiry to be necessary parts of such a system of Observations. In Cornton Vale those on duty at relevant Observation times in relation to a particular prisoner can be ascertained and their evidence as regards such Observations or lack of them can be lead and judged. There was evidence at the Inquiry that such a system would be cumbersome and might well result in those doing the Observations being more concerned to see that the appropriate box was

ticked than in checking or passing time with the prisoner. A designated person to carry out Observations would mean less chance for the prisoner to select a Prison Officer with whom she felt confident to discuss any problems. On the evidence that I heard I consider that it remains speculation and so less than probable that the lack of a designated person to fulfil a 60 minute Observation regime was a defect in the system of Observations. If it turns out however that none of the 4 staff available to visit April at some time between 1415 and 1515 hours (Skinner, Hanson, Phillips and Harrower), did visit in those 60 minutes, the lack of a designated visitor (and perhaps the lack of recording of fixed time Observations) might thereby become apparent as a defect or defects in the system so requiring some thought by those who have expertise (which I do not have) in safeguarding prisoners.

I do not consider therefore that on the evidence heard at the Inquiry the defects of system in relation to Observations alleged by Mr Findlay can be said to have contributed to April's death or to her self-harm by hanging. It follows that such alleged defects are not to be considered on the basis of Section 6(1)(d) of the 1976 Act. I do however consider that such alleged defects in the Observation system are facts relevant to the circumstances of April's death (since she was on 60 minute observations at the time of the incident which lead to her death) under reference to Section 6(1)(e) of the 1976 Act. I therefore refer back to this Determination in Determinations 12(f) and (g).

11.Under reference again to Section 6(1)(d) of the 1976 Act ("the defects, if any, in any system of working which contributed to the death or any accident resulting in the death"), Mr Findlay's third group of submissions for the relatives (of the 3 such groups anticipated in the first sentence of Determination 9) related to the Code Blue Procedure, that is the arrangements in place when an alarm is broadcast by telephone to those required to react to such an emergency. A Code Blue alarm indicates to the receiver of it that there is an incident involving difficulty in breathing, in April's case from hanging. The submission made by Mr Findlay was that the evidence heard at the Inquiry discloses doubt as to whether the person on the gate at Cornton Vale (who was one of those who would receive a Code Blue alarm) should order an ambulance immediately, or should await confirmation that an ambulance was needed from a nurse attending the prisoner prior to ordering such an ambulance. April's self-harm might have had significance since while Prison Officer Mark Skinner who found April hanging gave evidence that he put out a Code Blue alarm at about 1525 hours, the evidence of the Ambulance Technician Alison Arnott under reference to Page 18 of Stirling Royal Infirmary Medical Records was that the call for the ambulance was timed as reaching ambulance control at 1531 hours on 26 September 2002, an apparent delay from the start of the Code Blue alarm of approximately 6 minutes. Something of course might depend upon synchronisation or lack of it between Mr Skinner's watch and ambulance control time. But in view of my finding in the last sentence of Determination 4 that by the time that April was found hanging (at 1525 hours) she "was beyond responding so as to sustain any vital functions without continuing ventilatory therapy, and even with therapy beyond responding so as to reach a state of consciousness or semi-consciousness", I do not consider that a delay of 6 minutes (if there was such a delay) from the time April was found until the time that an ambulance was called contributed to April's death or to the incident of self-harm by hanging which caused her death. This alleged defect in the Code Blue system is not therefore to be considered on the basis of Section

6(1)(d) of the 1976 Act. I do however consider that this alleged defect in the Code Blue system is a fact relevant to the circumstances of April's death (since April was alive in the limited sense indicated in Determination 2, and her transfer to more expert treatment with more equipment at hospital would have been delayed thereby) under reference to Section 6(1)(e) of the 1976 Act. I therefore refer back to this Determination in Determination 12(h).

12.I determine from the evidence heard at this Inquiry that (unless already reconsidered) there are various worries which may benefit from reconsideration by those with expertise in relation to prisoners assessed as at risk of self-harm/suicide, expertise which I of course do not have. These worries should in my opinion form part of my Determination under reference to Section 6(1)(e) of the 1976 Act ("any other facts which are relevant to the circumstances of the death", April's death). These "any other facts" have mostly been mentioned already when dealing with earlier parts of Section 6(1) of the 1976 Act (mainly as a result of Mr Findlay's concerns on behalf of the relatives, but several of them were supported also by the PF Depute in her submissions, and she added one of her own). These worries raised at the Inquiry are as follows:-

(a)Warning of speedy effects of hanging. Is there a way or ways in which information about the speed with which incapacity/ unconsciousness/permanent damage from self-harm by hanging is likely to occur can be the subject of safe warning to prisoners? Can the danger, that those wishing to die by hanging may not be recognised as having that wish and may be encouraged to try self-harm by hanging by such warning of speed, be overcome? Do Productions 16 and/or 15 require any alteration in relation to this proposed warning? I refer to Determination 8 from which this Determination 12(a) arises.

(b)Case Conference System: Attendance of Prisoner. Is sufficient effort made to help prisoners to attend their Case Conferences? Are there ways in which such attendance could be made more prisoner-friendly? How desirable is such attendance? Is the system in Productions 16 and 15 as specified and implemented adequate in this respect? I refer in particular to the parts of Determination 9 relevant to this worry.

(c)Case Conference System: Representation of Prisoner. If the prisoner declines to attend at Case Conference is there need for a designated person who is to attend the Case Conference to "take her instructions" (like, but not, a lawyer?), to put her suggestions to the Case Conference, and to report back to the prisoner of the outcome? Is there already, or can there be devised, some other way in which the prisoner can feel that she has input and a listening audience if she refuses to attend? Is the system in Productions 16 and 15 as specified and implemented adequate in this respect? I refer in particular to the parts of Determination 9 relevant to this worry.

(d)Case Conference System: A Designated Person to Chair It. Is there need for such a Chair Person? Is it supposed to be the co-ordinator mentioned in Productions 16/15 who Chairs? Is the role of the co-ordinator clear from these Productions? Should the Chair be the designated person to represent the prisoner (if there is to be such a designated person)? Is the system in Productions 16/15 as specified and

implemented adequate in this respect? I refer in particular to the parts of Determination 9 relevant to this worry.

(e)Case Conference System: Continuity of Participants. Is there a need for there to be a real continuity of personnel from one to another of a prisoner's Case Conferences and if so to what extent? Does the existence of written records which the participants in Case Conferences can see provide adequate continuity at Case Conferences without having the same personnel as participators? Is such continuity possible to provide, and if so to what extent? Is the system in Productions 16 and 15 as specified and implemented adequate in this respect? I refer in particular to the parts of Determination 9 relevant to this worry.

(f)Observations: What Do They Mean/What Is Their Purpose? This was the main worry in relation to Observations (and perhaps overall), and I refer to Determination 10 which is almost all relevant to this worry. Is there confusion as to the meaning/purpose of Observations in Productions 16 and/or 15, and if so can that confusion be resolved? Is there in any event confusion as to the meaning/purpose of Observations among management and staff in the prison? Is the meaning/purpose of Observations to seek to make friends with prisoners and/or to provide an obstacle to self-harm occurring by sightings, or to do both? Is the system in Productions 16 and 15 as specified and implemented adequate in this respect?

(g)Observations: A Designated Person/System of Visits Recorded. Again I refer to Determination 10 since almost all of it is relevant also to this worry. There was some evidence of an electronic system of recording visits to high risk prisoners at night when they were locked in, which visits have to be within 15 minutes of each other. Independently of all staff seeking to make contact with/make friends with/care for prisoners, which seems to be accepted by all as necessary and good, if a prisoner is placed on timed Observations should there be a designated person to carry out such Observations, and should such a designated person have an obligation to record such Obligations when accomplished? Are such measures of designated person and/or recording of Observations realistic and is it possible to provide them? Do timed Observations mean anything/enough without a designated person being responsible for them? Do timed Observations mean anything/enough without an obligatory system of recording their happening? Should timed Observations for low risk prisoners be used less frequently since their use as prevention of self-harm decreases with the length between Observations, or would this just increase the numbers of those assessed as of high risk in order to obtain such Observations? Is the system of Observations in Productions 16 and 15 as specified and implemented adequate without such a designated person to carry them out and/or recording of such timed Observations?

(h)Code Blue Alarm: Ambulance Call. On the evidence heard at the Inquiry, there may be (or have been in 2002) confusion as to whether, on a Code Blue Alarm being activated, the person on the gate at Cornton Vale Prison should summon an ambulance immediately or should await confirmation from a nurse attending the prisoner that he/she should call for an ambulance before doing so. I refer to Determination 11 which is all relevant to this worry. As that Determination shows delay, if there was delay, in summoning the ambulance for April did not further harm her because the damage to April was in my opinion irreversible by the time that she

was found hanging, and she was not by then conscious. I expect that any such confusion has already been removed with all those responding to Code Blue Alarms now in no doubt as to when an ambulance should be summoned. But if not, when an ambulance should be summoned should be considered, and the answer to that should be made clear to all those liable to respond to Code Blue Alarms.

(i)Code Blue Alarm: Entrance Blocked. As Miss Orr, PF Depute submitted, there was evidence that the ambulance which did attend for April could not proceed through the prison entrance because of a parked British Gas van without its driver present. On the evidence that blockage resulted in a delay of approximately 2 minutes in the ambulance crew reaching April. For the same reason as indicated in relation to Determination 12(h), such a delay did not further harm April. But consideration should be given, if this has not already happened, to Code Blue procedure involving some measure which would result in the expected path of a summoned ambulance on reaching Cornton Value being kept clear of obstruction.

15 December 2003(Sgd) R E G Younger