SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS at ABERDEEN

DETERMINATION

by

SHERIFF J K TIERNEY

in

FATAL ACCIDENT INQUIRY

into the death of

DYLAN EVAN BRIAN STICKLE

Introduction

[1] On the 23rd October 2006, Dylan Stickle was admitted to HM Prison, Craiginches, Aberdeen, in furtherance of a warrant of the Sheriff of Lerwick remanding him in custody for the purpose of obtaining certain reports prior to sentence. On his admission he was assessed as being of "no apparent risk" of suicide or self harm. He was placed in a cell with another prisoner who was released on the 26th October. At about 2125 hours on that day a member of the prison staff conducted a regular evening cell check and saw Mr Stickle lying awake on the top bunk in his cell. He was the sole occupant of the cell. At about 0700 on the 27th October 2006, when the cell was next checked Mr Stickle was found dead in his cell. He had a noose made from a duvet cover round his neck. He appeared to have been dead for some time. The prison doctor, Doctor Gamba, pronounced life extinct at 0750 on the morning of the 27th October 2006. In the circumstances, the procurator fiscal of Aberdeen petitioned the court to hold an inquiry into the death in terms of Section 1(1)(a)(ii) of the Fatal Accidents & Sudden Deaths Inquiry (Scotland) Act 1976 (hereinafter "the 1976 Act")

[2] An inquiry was duly held at which the Crown was represented by the procurator fiscal depute, Neil Shand; the deceased's mother, Mrs Phyllis Stickle, was represented by John Halley, Avocate; Doctor Pauline Larmour and Doctor Christopher Pell were represented by Miss Denise McVey, solicitor; Doctor Belinda Porter and Doctor Kenneth Mitchell were represented by Douglas Jessiman, solicitor; Grampian Health Board were represented by Iain Scott, Advocate; the Prison Officers' Association of Scotland was represented by Calum Anderson, solicitor and the Scottish Prison Service was represented first by Mrs Kirsten Raeburn and later by Ms. Jillian Martin-Brown.

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1. Dylan Stickle

[3] Dylan Stickle's mother Mrs Phyllis Stickle was present for every day of the inquiry and gave evidence to it. She explained her son's history, and in particular the great behavioural changes he underwent in later childhood, adolescence and early adulthood, ending up as a clearly unhappy but unfortunately also a violent and dangerous young man, particularly in respect of his close family. As a consequence of this and because of her obligations to her other younger children, Mrs Stickle had to agree to Mr Stickle being raised separately from his family, although she never ceased to love him and to care for him. Up to the date of his death she was in regular contact with the prison authorities and the prison social work department concerning his welfare and in particular concerning her great fear that he would one day be successful in taking his own life. This was something which he had attempted to do on occasions and talked about frequently. Doctors had told her that there was a real risk that he would take his own life. Sadly he did indeed take his own life. When he did he left a note to

his mother indicating his love for her and his despair at his own situation. In explaining her son's history to the inquiry and in her demeanour throughout her constant attendance at it Mrs Stickle displayed great dignity and had the respect and sympathy of all participating in it.

[4] Mr Stickle was born and raised in Shetland, being the eldest of three children. As a child he had violence inflicted upon him by his father and also witnessed his mother being attacked by his father. By the age of 12 his behaviour had become very difficult. He was beyond his mother's control. At the age of 12 he was seen by a clinical psychologist in Lerwick who indicated that he was showing symptoms of personality disorder. By the age of 13 he was subject to compulsory measures of care, and was under the supervision of the Children's Hearing. He was placed in foster care in terms of his supervision because of the difficulties he was causing at the family home. When he was 14 he was diagnosed as having a dissocial personality disorder, perhaps triggered by the violence he had experienced as a child and the violence on his mother which he had witnessed as a child. Later in his life he was also diagnosed as having a borderline personality disorder. At the age of 15 he was placed in a children's home in Lerwick and his behaviour and his situation deteriorated further. He expressed a wish to die. He blamed his mother for his situation, namely being in care. In due course he was placed at Oakbank School in Aberdeen where he remained until he was 16. While there he began to abuse solvents and lighter fuel and at the age of 15 was prescribed anti-depressant medication. When he left Oakbank School at the age of 16 he was placed in supported accommodation in Aberdeen. He began taking illegal drugs including heroin, and continued abusing solvents. He remained on prescribed anti-depressant medication. Between the ages of 16 and 20 he lived for various periods in Elgin, Inverness, Glasgow and Shetland. In about July 2002, aged 20, he was diagnosed under the system for the International Classification of Diseases 10 (ICD 10) as suffering from dissocial personality disorder. At that

time he was identified as a high suicide risk and was considered to be a danger to others. Between 2003 and 2006, Mr Stickle lived in Portugal with his partner, an older man. He regularly abused drugs and alcohol and became addicted to prescribed drugs. He was violent and aggressive to others. He attempted suicide on different occasions and by different methods including overdosing on drugs and alcohol, cutting his wrists, and throwing himself through a balcony window. He was detained in a mental hospital in Portugal. His partner could no longer cope with his behaviour and Mr Stickle returned to Shetland on the 30th March 2006. On the flight to Aberdeen he was drunk, and assaulted a female member of the cabin crew. He was arrested. It is not clear whether any criminal proceedings were taken against him in respect of that matter.

[5] Between 30th March 2006 and the 17th June 2006, Mr Stickle lived first with his father in Shetland thereafter with his mother in Shetland. On 13th June 2006 he attempted to commit suicide and was admitted to the High Dependency Unit at Gilbert Bain Hospital, Lerwick. On the 17th June 2006, he was transferred to Royal Cornhill Hospital in Aberdeen where he remained until the 13th July 2006 as a voluntary patient. On the 13th July 2006, he left Royal Cornhill for a few hours with the consent of his doctor to go into Aberdeen.. He returned later that day drunk and aggressive. His behaviour was such the consultant responsible for his care discharged him from Royal Cornhill with immediate effect. As a result of his behaviour at Cornhill he was arrested and appeared in Aberdeen Sheriff Court on charges of assault and breach of the peace. He was released on bail. He returned to Shetland and was arrested there on charges of assault. He appeared in Lerwick Sheriff Court on 20th July and was remanded in custody for the purposes of obtaining pre sentencing reports, including a psychiatric report, and was taken to HM Prison, Craiginches.

[6] The Scottish Prison Service operates a suicide risk management strategy called Act 2 Care (hereinafter referred to as ACT). I will deal with this strategy and its implications for Mr Stickle in detail in a later part of this determination. For present purposes it is sufficient to say that the strategy is intended first of all to identify prisoners who are possibly at risk of suicide or self harm. Thereafter ACT assesses the degree of risk attaching to the prisoner as high risk, low risk or no apparent risk and by means of regular case conferences manages the supervision and care in custody of prisoners who have been found to fall into one or other of the two at risk categories.

[7] On the 8th August, Mr Stickle was placed on ACT and was determined to be at high risk. He was subject to appropriate supervision. At a case conference on the 11th August it was decided that Mr Stickle's risk category should be reduced to low risk. This status was continued by case conferences on the 16th and 22nd August.

[8] On the night 27th/28th August, the day prior to his transfer to Lerwick Sheriff Court for sentencing, Mr Stickle apparently attempted to commit suicide in his cell, which he shared with another prisoner, by hanging himself by means of a torn duvet cover. His cell mate intervened and this attempt was forestalled. He was placed on high risk ACT. Doctor Gamba, the prison Doctor, categorised this as a serious attempt at hanging and requested an urgent psychiatric review. Doctor Pauline Larmour, consultant psychiatrist, saw Mr Stickle for this purpose on the 28th August. She had previously seen him during his time in Royal Cornhill in June/July for the purpose of providing specialist forensic psychiatric advice to a fellow consultant psychiatrist, and in Craiginches and earlier in August for the purpose of preparing a report for the court. She noted that Mr Stickle had a:-"long history of serious self-harm in

response to adverse life events and will pose ongoing risk for future particularly around life crises. Not however suffering from any treatable mental illness…….Will need high risk measures /equivalent while up in Shetland for court." She also noted in his SPS Mental Health Record, among other things, "Not mentally ill or amenable to psychiatric treatment. Should continue diazepam withdrawal and then withdrawal of venlafaxine after that. Ongoing risk of self harm particularly at times of crisis – court, sentencing, discontinuation of meds. ACT should be used as appropriate for this"

[9] Mr Stickle returned to Lerwick Sheriff Court on 30th August where he received a back dated sentence of imprisonment with a release date of 16th October 2006. On return to prison, Mr Stickle remained on high risk ACT with five case conferences between the 31st August and the 15th September. On the 18th September, he was placed on low risk which status was confirmed at five subsequent case conferences, the last being 13th October 2006.

[10] On the 31st August, Mr Stickle had expressed to a social worker in the prison, Mrs Sheena Williamson, his continuing intention to kill himself either in prison or after his release into the community. A note to this effect was made in his prison social work records.

[11] On Mr Stickle's release from prison on 16th October following communication between the prison social work department and the criminal justice social work department in Aberdeen attempts were made to find Mr Stickle accommodation. Bed and breakfast accommodation was found for him. He drank a quantity of alcohol and phoned his mother. He was abusive to her and indicated an intention to commit suicide at the bed and breakfast accommodation. The proprietors of the bed and breakfast accommodation required to be told of this and declined to have Mr Stickle stay with them. He was taken into police custody and

then to Royal Cornhill. He was seen by Doctor Pell, a senior house officer in psychiatry. Mr Stickle's previous clinical notes at Cornhill had been lost and were not available to Doctor Pell at that time. They were not available at the inquiry. Mr Stickle indicated that he wished to be locked up in Royal Cornhill to stop himself from using alcohol and from self harming. Doctor Pell did not consider that there was a clear medical role for admission to Cornhill and did not admit him.

[12] Mr Stickle was charged by the police with breach of the peace and held in police cells overnight. He was released on 17th October. The matter did not proceed to court.

[13] Later that day Mr Stickle told social workers that he had taken an overdose of heroin and alcohol with the intention of killing himself. He was taken to Aberdeen Royal Infirmary where he gave a similar history to medical staff, was treated for a chest infection and discharged the following day.

[14] On the 19th October 2006, Mr Stickle travelled by ferry to Shetland. He contacted his mother, demanded that he be allowed to live at her home and was abusive and threatening towards her. He was apprehended by the police at 7.30 am on the 20th October at Holmsgarth Ferry Terminal on his arrival in Shetland. He appeared in court on the 23rd October on a charge of breach of the peace. He was remanded in custody in respect of this matter and returned to Craiginches prison. Mrs Joy Whitelaw, a criminal justice social worker in Shetland, wrote to Christine Hendry, the prison social worker at Craiginches, stating that she assessed that Mr Stickle was at risk of suicide and should be managed accordingly. She reported that Mr Stickle said that although he found the thought of suicide scary he did not see a future alive and wanted to kill himself. She believed that even if he did not really want to do

so he might do so accidentally. This letter was sent by fax to Miss Hendry at about 1400 on 23rd October and was received by her. It was not passed to the reception authorities at HM Prison, Craiginches in accordance with the ACT procedures as it should have been.

[15] The procurator fiscal in Lerwick considered that Mr Stickle was a suicide risk. He dictated a letter to the governor of Craiginches prison stating that Mr Stickle was a suicide risk and should be dealt with accordingly, and instructed that this letter be sent to Craiginches by fax. There is no evidence that this fax left the procurator fiscal's office in Lerwick. The fiscal's office at the time did not maintain a dated and timed record of outgoing faxes. Craiginches prison maintains and at the time maintained records of incoming fax messages. There is no record of the fax being received by the prison. It was not available to the reception staff at Craiginches as it also should have been.

[16] I will deal in some detail with procedures surrounding the admission of Mr Stickle to Craiginches prison in a later part of this determination. Suffice it to say meantime that he was seen by a prison officer and by a nurse, both on reception duties on the day of his arrival, namely 23rd October. Each of them assessed Mr Stickle under the ACT procedures and concluded that he was at no apparent risk of suicide or self harm, and he was admitted to the general body of the prison population. On the 24th October Doctor Belinda Porter, a GP at the prison, carried out a statutory medical examination of Mr Stickle. She also assessed him as being at no apparent risk for the purposes of ACT

[17] On the 24th October 2006, a meeting took place in the Social Work offices in Aberdeen attended by social workers, the police and Doctor Pauline Larmour, the purpose of

which was to attempt to put in place strategies in respect of Mr Stickle when he came to be released from prison.

[18] For the first three nights of Mr Stickle's last period in prison he shared a cell at Craiginches prison with Mr Gavin Kemp. He told Mr Kemp that there were many ways of committing suicide in the cell which they shared.

[19] On the evening of the 26th October 2006 Mr Kemp was released from prison, leaving Mr Stickle as the sole occupant of the cell. That night Mr Stickle committed suicide by hanging himself in his cell by means of a ligature fashioned from bed linen. He was found dead on the morning of the 27th October 2006.

2. The Act 2 Care Strategy (ACT)

[20] The Scottish Prison Service has a strategy for dealing with the known risk that some prisoners who will find themselves from time to time under great strain and stress may attempt to commit suicide. There is no question that the Scottish Prison Service has a duty of care in respect of such prisoners, and equally there is no question that it recognises this duty. Similar duties fall upon other agencies, such as the police and Reliance Custodial Services in respect of the short-term custody or the transportation of prisoners who are in custody. The procedures that have been put in place to implement the current strategy to prevent suicide are contained in the ACT scheme and in particular version 2 of that scheme, which was in effect from April 2006 and remained in place at the time of Mr Stickle's death.

[21] The implementation of the strategy involves co-operation of many agencies involved in dealing with prisoners, the prison service itself, the police, Reliance, and in addition to these bodies the procurator fiscals service, and court social workers.

[22] The purpose of the strategy is to identify at the earliest possible time in respect of each individual prisoner whether he is at risk of committing suicide or harming himself, and, if he is, to put in place measures designed to prevent the prisoner from committing suicide and to give him support and understanding in respect of the difficulties which he is facing in his life at that time.

[23] The strategy involves (i) formal assessments of a prisoner at the time of his reception into prison and (ii) procedures being put in place appropriate for the individual prisoner in respect of whom concerns as to his harming himself or committing suicide have arisen.

[24] Every member of staff in a prison, whether employed by the Scottish Prison Service, the Health Service or the social work department, will at some time be trained in the operation of the ACT procedures. In addition, annual refresher courses are provided to staff.

[25] The detailed nature and content of this training were beyond the scope of the inquiry and were not explored at it.

[26] At any given time there may be some staff who have recently started work in the prison and who have not had the time or opportunity to conclude their training in the Act procedures. They would not be engaged in reception duties. There is no suggestion that this was an issue in the death of Mr Stickle.

[27] The procedures in respect of both assessment at the time of reception into prison and assessment and subsequent care in respect of a prisoner once admitted to prison are contained in separate booklets each of which have on the outside of the back cover a flow chart showing in graphic and clear form the steps which require to be taken in respect of any individual. Each booklet contains detailed guidance notes to those using the procedures set out in the booklet. The content of the guidance notes forms part of the ACT training. Each of the books has on the outside of the front cover a statement of the key aims of ACT namely:-

"To assume a shared responsibility for the care of those "at risk" of self harm or suicide. To work together to provide a person centred caring environment based on individual assessed need where prisoners who are in distress can ask for help to avert a crisis. To identify and offer assistance in advance, during and after a crisis."

Risk Assessment at the time of reception into Prison

[28] Those escorting a prisoner to a prison bring with them a written record known as a Personal Escort Record (PER) which records the movements of the prisoner, and contains an assessment as to whether the prisoner is at risk or has no known risk. It lists a series of checks in respect of which risks can be identified for medical, security or other reasons. It contains space for information to be given concerning a prisoner's risk, details of those responsible for the prisoner's supervision, details of the movement of the prisoner and, and a record of events as to what has happened with the prisoner during his period in custody.

[29] The PER requires one of two prominent boxes on the front page to be ticked, one marked "No known risk" the other "Risk". This is followed by three columns, one for each of

the three categories of risk factors namely medical, security and other. Each of the three columns contains a number of examples relating to the category of risk, which should be ticked if appropriate. There is a panel which can be completed giving further information about risk. The details of the escort and the persons involved in it are also set out. The persons involved are named and sign in respect of their involvement.

[30] Attached to the PER and forming part of it is a Record of Events, which records the time of any event, the details of the event, the name of the person speaking to the event and his signature in respect of it. In addition, each event contains a box which can be ticked if the person recording it considers that the event recorded is significant.

[31] The formal reception risk assessment document is part of the ACT procedures and is set out in a dedicated booklet which contains detailed guidance notes. There are two separate assessment forms which have to be completed. The first is completed by the receiving prison officer, the second by a nurse. Both must be trained in ACT. In each case there are three classes of reception namely admission, transfer, and return. "Admission" deals with a prisoner commencing a new sentence or period in custody; "Transfer" deals with a move from another establishment and "Return" deals with the return of the prisoner after he has been out of the establishment for one of a number of reasons including court appearances. Each assessor is required to satisfy himself as to the prisoner's ability to communicate and understand the assessment.

[32] The final stage of the admission procedures involves the completion of a Booking-in form designed to be completed after the ACT reception assessments have been carried out. The aim of the booking in form is to identify appropriate cell arrangements for the prisoner

having regard to a number of factors including the potential benefit of cell sharing, the risks to the prisoner, including risks of suicide and self harm, and the risk of harm to others caused by the prisoner.

[33] Of the three types of reception the inquiry focussed on procedures on admission, being the relevant procedures for Mr Stickle's last period in custody.

[34] Section 1 of the assessment first of all requires the officer conducting the assessment to check the record of the prisoner's prison history from previous admissions. This is known as the PR2 record and is computerised. This record contains the stark facts of the prisoner's previous prison history, but not the details. The PR2 will disclose the fact and times of previous ACT episodes, but again will provide no details. The assessor is required to circle either yes or no as to whether or not the record discloses that the prisoner has been subject to ACT in any previous period of custody

[35] Next in section 1 the assessor is required to check the PER record and any additional information which accompanied the prisoner and to answer yes or no to the question "Has there been any information received from PER or other source that has raised concerns with regard to "At Risk" status."

[36] The first part of Section 2 of the assessment contains a number of questions which according to the guidance notes are to be asked and answered as part of a general interview process, rather than as a verbatim check list. The specific questions are designed to elicit the concerns that the prisoner might have and his feelings in respect of suicide and self harm. The

second part of this section requires an assessment by the officer of how the prisoner presents, does he show anxiety, anger, low mood and the like.

[37] The third part of Section 2 requires the assessor to record in summary form the course of the interview, the impressions given by the prisoner and the level of risk presented. The guidance notes require the impressions to be recorded as fully as possible and an explanation given as to the reasons for the decision as to the assessment of risk.

[38] The assessment concludes with a formal assessment of the prisoner being either "at risk" or being at "no apparent risk". There is no attempt at this stage to quantify the risk. The only two alternatives are "No apparent risk" and, if that box cannot be ticked, the "At Risk" box must be ticked.

[39] If the conclusion is "At Risk" a formal Act 2 Care Document must be raised and the full procedures as set out in that document are followed.

[40] The next part of the reception assessment is the Healthcare Risk Assessment. The form for this part also states that the person completing it must be Act 2 Care trained. It is to be used only for the purposes of recording general information in respect of suicide risk. Other clinical details are entered in the healthcare records and are confidential.

[41] As with the Reception Risk Assessment, section 1 identifies three types of reception namely admission, transfer and return and the inquiry in Mr Stickle's case focussed on the admission part. This requires the medical assessor to check the PR2 and PER documentation and answer yes or no to the same questions. The first part of section 2 requires the nurse

carrying out the assessment to ask a number of questions designed to elicit whether there is a suicide risk, to be asked as part of the interview process which should be carried out in a relaxed manner. Part 2 of section 2 requires a summary of how the prisoner presents and the giving of reasons for the level of risk assessment. Again, the only two alternatives are "No apparent risk" or "At risk". If the prisoner is assessed as "At risk" an Act 2 Care document must be opened for the prisoner.

[42] If no Act 2 Care document has been raised, the prisoner is admitted into the main body of the prison. He is then seen within 24 hours by the prison doctor for a medical examination which is required by the statutory prison rules. The prison doctor carries out and records his or her own risk assessment as part of that initial medical examination of the prisoner . Again there are only two levels of risk, namely "No apparent risk" or "At risk". If "At risk" formal Act 2 Care procedures are put in place.

The Act 2 Care Document and Procedures

[43] This procedure is contained in a separate book which contains detailed guidance notes. On the ACT procedures being opened a new book is started for the prisoner and a case conference is held immediately or, if it cannot be held immediately, an intermediate care plan is immediately put in place the purpose of this is to keep the prisoner safe and to provide him with support until a case conference is convened, which must be within 24 hours

[44] The intermediate care plan sets out the concerns which the person opening the plan has, summarises any recent events or precipitating factors and sets out the level of support, the maximum interval between contacts, the nature of clothing, the nature of items not permitted and also identifies the manager who is to be responsible for the intermediate care plan and the

nature and extent of his responsibilities for the particular individual. The booklet records any relevant information on the prisoner's mood and behaviour and also any action taken to help the prisoner. It requires at least one "quality" entry for each of the three day periods (am, pm, and night) and allows for more formal entries at other times.

[45] Prior to the first case conference there should be a further healthcare assessment by a nurse who should if possible be a mental health nurse. The assessment sets out a number of risks or predisposing factors to be considered in respect of the prisoner together with a record of the interview with him, the prisoner's perceptions, and gives the nurse's recommendations for action.

[46] The case conference is described in the guidance notes as a multiple disciplinary team assessment of the level of risk and needs of the individual and the nature and level of the care required. There is a requirement for the manager responsible for the prisoner's location, a residential officer who works in the area and a nurse to attend every case conference. Others who may attend are the initiating person, if he is available, and anyone else with a contribution to make such as other staff members, family, friends, a prison listener, the prison chaplain, a social worker. Names of those attending are recorded and the individuals sign to signify their attendance. The prisoner should be invited to attend unless there is a justifiable reason for not doing so in which event that too must be recorded. The record of events and triggers which brought about the case conference is available and is discussed, the present state of the prisoner is discussed, the care regime is reviewed and a formal risk assessment is completed. At the case conference the level of risk is for the first time addressed. There are two categories of risk, high risk or low risk. If there is no apparent risk the ACT document is closed and a transitional action plan activated.

[47] The case conference decides what actions must be taken and by whom and a person is appointed as the accountable person to see that these actions are carried out.

[48] A care regime is put in place for the prisoner detailing the nature of the new regime, the maximum contact intervals, clothing, items not permitted and the location. The regime and location could, for example, require the prisoner to be placed in an anti-ligature cell in special clothing so that the risk of suicide or self harm can be minimised.

[49] If the prisoner is assessed as being at high risk he must be seen by a doctor within 24 hours.

[50] At the conclusion of a case conference a date is set for the next case conference.

[51] As a matter of practice a prisoner's risk status will only be reduced from high risk to low risk or from low risk to no apparent risk if every person attending the case conference, including, if he is there, the prisoner, agrees to the reduction.

[52] Detailed records of supervision of the prisoner are kept and recorded in the book. The booklet remains open for however many case conferences are necessary until the prisoner is agreed as being at no apparent risk when the book is closed and the prisoner moves on to the transitional arrangements. In the event that a booklet is filled up whilst the Act 2 Care procedures are still open a continuation booklet should be used to record further procedures.

[53] I have set out the Reception procedures and the full ACT procedures in some detail as I consider that they demonstrate that the system is a fully thought out one which is quite suitable for its purpose (subject to the minor comments I make in paras [140] and [212]). Indeed the evidence was that it (and its predecessor) had had considerable success in reducing prison suicides in Scotland

3. Mr Stickle's reception into HM Prison, Aberdeen

[54] On the 20th October 2006, Mr Stickle was arrested in Shetland on a charge of breach of the peace involving the uttering of threats of violence against his father and his brother in law, and was detained in custody by the police. On the morning of 23rd October he was transferred from the custody of the police to that of Reliance Custodial Services for the purposes of his court appearance later that day.

[55] Prior to the handover to Reliance a police officer opened a PER in respect of Mr Stickle. This is Crown production 1. The first six parts of the front page of this record were completed by the police officer. The first two parts contain certain demographic information relating to Mr Stickle. Part 3 consists of an instruction that one of two boxes be ticked as appropriate namely "no known risk" or "risk". Neither of these boxes is ticked.

[56] Part 4 of the record completed by the police involves the identification of risk categories. The police officer completing the form identified three medical risks, namely that Mr Stickle had a medical condition, had a psychiatric condition and that medication had been issued to him; one security risk for violence was ticked, and two other risks, namely the risk of drugs/alcohol issues and the risk of suicide/ self harm. The second part of part 4, namely a box for further information about risk contains details of Mr Stickle's medication. Part 5 of

the form deals with the prisoner's property and parts 6, 7 and 8 contain signatures by the relevant officers of the police and Reliance transferring custody of Mr Stickle from the police to Reliance..

[57] Attached to the PER is a "record of events" consisting of five sheets.. The first part of the record on each sheet is part 10 of the PER document and repeats some demographic information. Part 11 records the events by reference to the time of the event, the details of it, the name and signature of the person having custody of the accused .

[58] The first entry in Part 11 on the first sheet of the Record of Events is information about Mr Stickle which had been written on the form by the police and was accordingly information for Reliance to take into account in their handling of Mr Stickle. The entry reads:- "Custody has demonstrated violence towards family members in the past. He has received treatment and is on medication for depression. He has attempted suicide in the recent past. Abuses controlled drugs. Has Hep C".

[59] The first entry written by Reliance on this sheet is timed 0740 and was written by Mr Murray who gave evidence. The entry reads:- "Received custody res. Custody checked spoken to by SCO Murray no problems. Custody in blue suit due to him being a high risk self harmer."

[60] Mr Murray explained that the blue suit is a suit of singlet and shorts in which self harmers or suicide risks are dressed to minimise the opportunity to use clothing to cause self harm.

[61] From 0740 until 1043 Mr Stickle was checked on ten recorded occasions by either Mr Murray or his colleague, Mr Obern. The checks narrate either that he was showing movement from the last check, or that he was responsive, or that he was spoken to. Mr Stickle was checked so frequently because of the information provided to Reliance about the various risk categories, and in particular the information provided to Reliance by the police in the first entry in the record of events to the effect that Mr Stickle had attempted suicide in the recent past. Mr Stickle was then taken for a shower after which he had a visit from his solicitor, after which he was taken upstairs to the court at 1215. At 1230 he was brought back down and it was noted that he had been remanded in custody till the 8th November. The entry for 1230 also notes that Mr Stickle was put back in his blue suit.

[62] At 1235, the record shows that Mr Stickle was seen by Mrs Whitelaw, the Criminal Justice Social Worker in Lerwick. He was returned to his cell at 1251 and at 1300 was given lunch and checked and found to be "Okay". Between 1310 and 1450 Mr Stickle was checked on seven occasions with each entry indicating "no problems" or words to that effect.

[63] At 1510, Mr Stickle was taken from the cell to the charge bar and formally signed out of the police station and was then taken to the Reliance Custodial Services van for transportation to the airport. Mr Murray inserted in the record of events the date for Mr Stickle's next appearance in court. Mr Murray and Mr Obern then accompanied Mr Stickle to Sumburgh Airport, checking him on the journey.

[64] Mr Obern then accompanied Mr Stickle on the flight to Aberdeen, noting at one stage that Mr Stickle was quite chatty and had no problems.

[65] At 1800 hours, Mr Obern handed Mr Stickle over to a Mr Farrell of Reliance Custodial Services in Aberdeen who took him to Aberdeen prison, arriving there at 1840. The record of events shows that Mr Stickle was checked on three occasions, on the way to reception at the prison.

[66] I have set out the procedures followed by Reliance at some length to demonstrate what seems to me to be a very good example of the exercise of proper care in respect of a prisoner who was known to be at risk because, among other things, of a suicide attempt committed in the recent past.

[67] The risk was clearly taken seriously by Reliance and closely monitored by them. Mr Murray explained that the risk was taken seriously because they knew nothing more than that there had been a recent attempt at suicide which, as far as they knew, could have been very recent indeed.

[68] On arrival at Craiginches Prison, Aberdeen, Mr Stickle was seen by a prison officer for admission to the prison. This officer, Mr Mutch, had a responsibility to carry out a risk assessment and understood that he had such a responsibility. He opened an ACT reception risk assessment document for Mr Stickle and confirmed on the title page that he had received the PER for Mr Stickle and that he had not received any other information. He then moved on to complete section 1 of the risk assessment form. In the column headed "admission" he answered yes to the question "Check PR 2. Has the prisoner ever been subject to ACT during any previous period in custody."

[69] He did not answer on the form the question "Check PER and any additional info. Has there been any information received from PER or other source that has raised concerns with regards to "at risk" status?" In his evidence he said that he did check, and that there was no additional information.

[70] He accepted that he had not indicated whether there was any information in the PER that raised concerns with regard to the at risk status of Mr Stickle and that the correct answer to that should have been "Yes".

[71] Part 1 of section 2 of the form involves asking nine questions of the prisoner and recording the answers. Part 2 of section 2, requires the officer to record his own views as to whether the pursuer was displaying any of eight conditions relating to anxiety and anger, confusion, whether the prisoner appears disturbed in a number of different ways, suffering from the effects of drink or drugs, of low mood or with suspected learning difficulty/mental health problems. The Guidance Notes provided that all of these matters, including the specific questions, were to be adduced by means of a sensitive interview, and answered by circling either yes or no. All of the answers were circled. Of the questions to be asked of the prisoner in part 1 all were answered in the negative except one "Was your imprisonment/transfer unexpected" and Mr Mutch considered that in answering that "Yes" Mr Stickle had been incorrect. Specifically the questions "Are you feeling suicidal" and "Do you feel you might hurt yourself" were answered in the negative.

[72] So far as part 2 of section 2 is concerned, namely the conditions which the prisoner might be displaying, the first five were answered in the affirmative and the last two in the negative. It appeared from his evidence that Mr Mutch dealt with this part by asking Mr

Stickle questions on each of the topics and recording each of Mr Stickle's answers as Mr Mutch's assessment of whether Mr Stickle was displaying any of the conditions.

[73] According to the guidance for Part 3, repeated in summary in the opening words of Part 3 itself, the interviewer is required to summarise the interview and assess the level of risk presented by the prisoner and then to record as fully as possible his impressions of how the prisoner appeared, how he responded, and then to explain in his own words why the officer had come to the decision which he had come in relation to risk.

[74] Mr Mutch did not put anything at all in Part 3. He did not do so because he had ticked the box for "no apparent risk". He understood that if the assessment was "no apparent risk" there was no need to fill in part 3. This, he said, was what he had been told in training. He said repeatedly in his evidence that he had considered Mr Stickle to be "no apparent risk" because he had told Mr Mutch that he did not feel suicidal and because he made good eye contact.

[75] Having reached that conclusion Mr Mutch completed the form by ticking the box "no apparent risk", but gave no reasons for his conclusion.

[76] The reasons were Mr Stickle's denial of feeling suicidal, his making good eye contact with Mr Mutch and Mr Mutch's general feeling arising out of the interview that there was no risk.

The Nursing Healthcare Risk Assessment

[77] This document was completed by Nurse Helen Innes and at the conclusion of it she assessed Mr Stickle as being of "no apparent risk".

[78] The healthcare risk assessment has the same three columns in section 1 as does the reception risk assessment, namely admission, transfer and return. All three of the columns had been scored out but that clearly was a simple error. Nurse Innes was well aware that she was carrying out an assessment, and that it fell within the category of admission. She also required to answer the two questions posed in the admission column.

[79] The first question reads:- "Check PR 2. Has the prisoner ever been subject to ACT during any previous period in custody." She has circled the answer "Yes". Although she has answered this correctly she did not obtain this information from the PR 2 document as, notwithstanding the instruction to check the document, she did not do so. She did not do so because the PR 2 document is a computerised document which can be called up from the prison's computer system, to which she did not have access at reception. Her evidence was that whilst she was provided with a computer terminal in reception that terminal was not capable of being connected to the system. She thought that there was a cabling problem relating to the stone walls. It was accordingly just as if she had no computer. If she had had access to the PR 2 document she would have known the basic details of the ACT procedures to which Mr Stickle had been subject, and in particular that he was still assessed as being Low Risk at the time of his release on 16th October 2006, the last such assessment being dated 13th October.

[80] So far as the second question in Section 1 is concerned this reads:- "Check PER and any additional info. Has there been any information received from PER or other source that has raised concerns with regards to at risk status." She has circled the answer "Yes".

[81] Whilst this answer is also accurate in the sense that there were or should have been concerns regarding Mr Stickle's at risk status which arose from the terms of the PER document, Miss Innes did not read that document. She did not read it because it was not made available to her. According to her evidence PER documents were routinely not made available to her. She was shown Production1 and said that she had never seen such a document before.

[82] At the time she gave her evidence she said she believed she had obtained general information in respect of the PR 2 document and the PER document from the prison officer who had completed the reception assessment form.

[83] She did not have access to the letter from the social work department in Lerwick to the social work department in the prison stating the concern which the writer had about Mr Stickle's potential suicide risk.

[84] She completed Section 2 of the Health Care risk assessment. In Part 1 of that section she recorded the answer "Yes" to each of the questions "Have you ever received treatment, counselling or support for mental health problems?" " Have you ever received psychological treatment?" and "Have you ever attempted self harm or suicide?" She recorded the answer "No" to the questions "Do you feel suicidal?" and "Do you feel like hurting yourself at the moment?"

[85] Part 2 of Section 2 of the form requires the writer to "consider how the prisoner presented during the interview, record the details", and advises that the observations should include "whether the prisoner presented as anxious, aggressive, low mood, disorientated, suffering from addictions, or any presentation of disturbed behaviour". She completed that

box in the following terms:- "States no thoughts of suicide or self harm at time of interview". That statement repeats the answers to the last two questions I have narrated in the previous paragraph but does not provide any of the information sought to be included in part 2 of section 2, which calls for the nurse to come to a judgment as to how the prisoner presented and to record that and her detailed observations. In her evidence she too recollected that Mr Stickle had made good eye contact.

[86] It is probable, having regard to her own evidence, that had Miss Innes been aware of the detailed contents of the PER document and its accompanying schedule of events, of the terms of the social work department letter, and of the details of the PR 2, showing Mr Stickle as still being at low risk some ten days before this admission, she would have placed Mr Stickle "At Risk".

[87] In my opinion, both Mr Mutch and Miss Innes misunderstood and misapplied the ACT procedures which they were required to carry out. In each case the assessment which they came to of Mr Stickle being "at no apparent risk" was effectively determined solely by the impression which Mr Stickle made on them at the time of their respective interviews with him. I do not consider from the evidence of each of them that either had been sufficiently trained in the very difficult art of interviewing someone for the purpose of ascertaining risk to entitle them to rely solely on this. In relying solely on the interview I considered that they did not follow the procedures which they were required by ACT to follow.

[88] In Mr Mutch's case whilst he may have noted in passing the contents of the documents which were available to him they played no real part in his assessment of the risk.

[89] In Mrs Innes' case she prepared an assessment and reached an assessment notwithstanding the fact that two important documents which she was instructed to have regard to, namely the PR 2 and the PER were not available to her. Each of those documents contained highly relevant information which she should have been able to take into account.

The Doctor's Risk Assessment

[90] **Doctor Belinda Porter** saw Mr Stickle at about 10 o'clock on the 24th October, being the day after his reception into prison. Although she was fairly new to the prison environment she understood the importance of the ACT procedures. Her assessment was part of the wider healthcare examination which in terms of the statutory Prison Rules every prisoner must undergo within 24 hours of his admission. Doctor Porter had a number of prisoners to examine as patients that day in respect of their general health, including mental health, and any risk of suicide. She would have had about 10 to 15 minutes for each patient. In the course of this time she would carry out necessary examination and form an assessment of each patient from her own discussions with him and her observations of him. Such an assessment by a doctor is a highly skilled procedure, developed with training and practice, and is quite different in quality from the type of assessment that either the admitting prison officer or the nurse at reception would have been able to carry out.

[91] Doctor Porter considered the issue of Mr Stickle's risk of self harm and suicide and came to the conclusion that there was no apparent risk. While carrying out this assessment she would, as with all prisoners, have had regard to his health records insofar as held by the prison, but would not have had time in the course of that general surgery, to read these in detail in respect of many of her patients.

[92] She did not have available to her the PR2 document, the PER documents nor, of course, the social work department letter.

[93] There can be no criticism of the professional clinical judgment which she reached on the basis of that examination, namely that Mr Stickle at the time of the examination showed no apparent risk of suicide or self harm.

[94] Had Doctor Porter had the PER documents available to her she would have taken the information contained therein into account when conducting her assessment. She considered that it would have been helpful for the purposes of that assessment if the PER documents had been available to her. Dr Gamba, a doctor with more experience of the prison environment stressed the importance of an examining doctor taking all relevant information into account in coming to a conclusion on the question of risk.

[95] The social work letter, which should have formed part of the additional information accompanying the PER, was not something on which she commented in her evidence as the existence of this letter was not known at the time she gave her evidence.

[96] I will deal with the consequences of the fact that Mr Stickle was not assessed as being "at risk" at the time of his reception into prison at a later stage of this determination.

The potential for subsequent placement of Mr Stickle on ACT

[97] I have already referred to the letter the prison social work department received from Mrs Whitelaw, the Lerwick Criminal Justice social worker on the day of Mr Stickle's remand in custody and transfer to HM Prison, Aberdeen. The letter was received by fax within the

social work office in the prison at 02.06 on 23rd October, more than 6 hours before Mr Stickle arrived at the prison reception. The letter clearly states that on that day Mrs Whitelaw, a professional criminal justice social worker, assessed Mr Stickle as still being a suicide risk, and that even if he did not truly intend to commit suicide she believed he might do so unintentionally. I consider that this was a letter of very high significance for all of those dealing with Mr Stickle's reception into prison and assessment under Act 2 Care. It was not made available by the prison social work department to those engaged in the reception of Mr Stickle into prison. As a matter of normal procedure the information should have been provided by telephone to the prison reception unit, which I was told did not have a fax machine, and a copy of the letter should have been sent by fax to the prison health centre which did have such a machine. The information should therefore have been available to both Mr Mutch and Ms Innes when they were completing their respective parts of the reception process for Mr Stickle. No satisfactory explanation was given for this failure to provide the information to those carrying out the reception. The information should also have been available to Dr Porter the following morning, but was not.

[98] **Miss Christine Hendry**, a senior social worker at Craiginches, having initially completed her evidence without mentioning the letter, brought its existence to the attention of the procurator fiscal, and produced it so that it could be lodged with the inquiry. It would appear that she did this when Mr Morris of SPS questioned her about the letter after she had given her evidence. She returned to court to give evidence in respect of it. She admitted she had been personally aware of the contents of the letter on 23rd or perhaps 24th October through discussion with Mrs Whitelaw even if she had not seen the letter itself (though as the person to whom the letter was addressed and having been on duty when it arrived she probably had seen it) and that she appreciated the importance of it.

[99] Mrs Hendry herself had obligations under the ACT procedures if she had information which raised concerns about whether Mr Stickle was at risk or at no apparent risk. She was aware of the terms of the letter and had discussed these terms with Mrs Whitelaw and she was also aware from her discussions with the social work department of Mr Stickle's conduct in Aberdeen after his release from prison some 7 days earlier when he had, apparently, consumed large amounts of alcohol together with heroin. Even if this was not intended as an attempt to kill himself it could certainly have been seen as an attempt to cause serious harm to himself. It does not appear to me that at any stage following the receipt of this letter, or her discussion with Mrs Whitelaw and having regard to the other information which she had both in respect of the immediate post-release behaviour of Mr Stickle on the 16th October and the fact that he had previously attempted to commit suicide, she made any serious attempt to assess whether Mr Stickle could be properly assessed as at no apparent risk, or whether he should have been assessed as being at risk. At any time between his reception into prison and his death Mrs Hendry could have raised ACT procedures, but she chose not to do so. Her decision not to do so at the time of Mr Stickle's reception on 23rd October, or after the meeting of 24th October, or at about the time of her meeting with Mr Stickle on 26th October were not adequately explained by her in her evidence. She admitted she had misled the inquiry.

[100] **Mr Gordon Morris** is the manager in HMP Craiginches responsible for overseeing the working of ACT. He considered that Mrs Whitelaw's letter by itself warranted an initial assessment of Mr Stickle as being "At Risk"

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4. Submissions in respect of ACT

[101] **The procurator fiscal** submitted that a reasonable precaution whereby the death may have been avoided would have been if Mr Stickle had been assessed as "At Risk" of suicide on his admission to prison on 23rd October. It would have been possible that his death may have been avoided. He stressed, however, that whilst placing Mr Stickle on ACT might have prevented the death it was likely that it would not have done so, and that Mr Stickle would still have taken his own life around this time.

[102] So far as regards defects in systems of work which had contributed to the death he referred to the failure to adopt an effective system to ensure that information sent to the social work department within the prison was communicated to the staff dealing with the admission of prisoners. He particularly referred to the fax from Joy Whitelaw, social worker in Lerwick, to Christine Hendry at the prison, which he submitted, when looked at in the context of Helen Innes' evidence that such faxes regularly did not reach those admitting prisoners until the day after admission, amounted to a defective system.

[103] The procurator fiscal submitted that there was a second defective system to be found in the failure of those admitting prisoners to properly understand what they are required to do, or to follow the relevant ACT forms. He referred to the evidence of Mr Mutch who clearly did not understand the requirements to write his reasons for assessing a prisoner as being "no apparent risk" and who answered some of the questions on the admissions form by obtaining the prisoner's view, rather than by recording his own observation. In respect of the nurse, Mrs Innes, he submitted that she was carrying out admission assessments whilst still to some extent

learning on the job, that she was not confident in applying the ACT procedure and that she proceeded to make her assessment without full access to the PER and PR2 documents notwithstanding the requirement in the assessment form that she had regard to these matters. He submitted that it was a matter of concern that the fax from the procurator fiscal in Lerwick had not reached his intended recipient at the prison.

[104] **Mr Halley** submitted on behalf of Mrs Stickle that there were numerous deficiencies in the admissions procedures and a number of reasonable precautions by which Mr Stickle's death might have been prevented. His principal submission on this aspect of the case was that a reasonable precaution which might have prevented the death would have been the assessment of Mr Stickle at the time of his reception into prison as a person "At Risk". This would have brought about the immediate use of ACT with all the supportive and preventative measures appropriate once the issue had been fully considered by a Case Conference and a formal ACT assessment had been made. The individual reasonable precautions included the assessment of Mr Stickle by Mr Mutch as being at risk, a similar assessment by Ms Innes, and a similar assessment by or through the agency of Miss Christine Hendry.

[105] Mr Halley submitted that the ACT systems were deficient in that (i) the PER was not made available to the nurse for the purpose of the health risk assessment or to the doctor for the purposes of his or her assessment; (ii) The PR2 was not available to the nurse for the health assessment; (iii) over emphasis was placed on impression of mood and observation of eye contact at reception; (iv) there was a failure to ensure that faxed information from the Procurator Fiscal's office in Lerwick and the social work department there was urgently communicated to reception; (v) at one stage more than one ACT book had been opened for Mr Stickle.

[106] **Mr Jessiman** submitted on behalf of Dr Belinda Porter that her assessment of Mr Stickle as being "No apparent risk" for ACT purposes at the time of his medical examination on the day after his admission to Craiginches prison was reasonable in the circumstances. I accept that submission. Dr Porter's assessment of Mr Stickle was a part of an overall medical consultation. It was one of a number of such examinations which had to be carried out that day. Her risk assessment was based on her own clinical examination and observations. As a doctor trained and experienced in those matters her clinical assessment has to be respected. There was no evidence to contradict her.

[107] **Mr Anderson,** for the Prison Officers Association, submitted that there were no reasonable precautions whereby Mr Stickle's death might have been prevented and that there were no defects in any system of working that contributed to the death.

[108] Dealing with the question of whether Mr Stickle should have been subject to the ACT procedures when he was re-admitted to HM Prison on the 23rd October he referred to the three independent assessments by Mr Mutch, Miss Innes and Doctor Porter that Mr Stickle presented no apparent risk of suicide; Mr Orr, the prisoner officer in the hall, came to a similar conclusion later in the evening of Mr Stickle's reception as did many other members of the prison staff who saw Mr Stickle between his reception into prison and his death. He submitted that there was no evidence that Mr Stickle displayed any of the recognised cues or clues that he may be at risk of suicide or self harm while he was being admitted to the prison or at any later stage and that there was therefore no evidence that he should have been placed on ACT.

[109] He submitted that Doctor Larmour had described Mr Stickle as a complex and difficult individual to assess, and that it was difficult even for an experienced psychiatrist to manage him. He referred to the determination of Sheriff Principal Young in the Fatal Accident Inquiry into the death of Scott Currie where the Sheriff Principal said that "In concentrating so much on the duty of the SPS staff to take all reasonable precautions there may be a danger of losing sight of the fundamental point that, notwithstanding the fact of his imprisonment, a prisoner remains an autonomous human being and retains the ultimate responsibility, within the constraints of the prison system, to take care of his own life". He submitted that only formal findings should be made in respect of Sections 6(1)(a)(b) of the 1976 Act.

[110] **Miss Martin-Brown** made submissions on behalf of the Scottish Prison Service. Her principal submission was that there had been no evidence during the inquiry which would justify anything other than formal findings under the 1976 Act; that there had been no evidence of any reasonable precautions whereby the death might have been avoided, no evidence of any defect in any system of working which contributed to the death, and that there are no other facts which were relevant to the circumstances insofar as SPS were concerned. She referred to the well known cases relating to the restricted scope of a Fatal Accident Inquiry and in particular that such an inquiry had no power to make findings as to fault or to apportion blame, and that findings in terms of Section 6 should not be based on hindsight. She submitted that a conclusion that Dylan Stickle should have been assessed as being "at risk" on his admissions would be based on hindsight. She submitted that even if he had been assessed as "at risk" on admission there was no evidence that his death might have been avoided some three to four days later.

[111] She submitted that there was no evidence that the system of working the ACT procedures at HMP Craiginches, and in particular the admissions process and the use and significance of the PER form, contributed to Mr Stickle's death in any way. She submitted that there was no evidence that the Act 2 Care strategy, or the system of working at HMP Craiginches were defective. Indeed there was evidence that the Act 2 Care strategy had successfully reduced the incidents of suicide in prisons in Scotland since its introduction.

[112] She submitted that no facts should be found as being relevant to the circumstances of the death for the purposes of Section 6(1)(d) because there was no issues raised in relation to Scottish Prison Service policy and procedures which were relevant to the circumstances of the death. Any comments could be contained in the notes to the determination.

[113] She pointed to the fact that Mr Stickle had not tried to kill himself on the evening of his admission as indicating that at the time the assessment was made it was correct. She referred to the evidence of Doctor Mitchell to the effect that Mr Stickle had told him "in no uncertain terms" that he intended to commit suicide and would do so, and Doctor Mitchell's view that nothing could be done to stop another person determined to kill himself and so doing. She referred to Doctor Gamba's evidence that Mr Stickle had thoughts of suicide before coming into prison, that the way to deal with a person with such thoughts was to look for a sign that might give an indication of the thoughts turning towards acting. She referred to Doctor Larmour's evidence about the dilemma for SPS, health professionals, social care staff trying to balance keeping someone safe with giving him a quality of life, and the difficulty even for a medical practitioner to predict when someone with a long-standing suicide ideation would act on that ideation. She referred to Doctor Pell's evidence that there was obviously a

risk that people with such thoughts would act on them, but being able to predict when that would happen was not possible.

[114] She submitted that Mr Stickle received help from a number of sources both within the prison and externally, and that it had not been established that his death was as a result of anything said or done or left unsaid or undone on the part of the staff at HMP Craiginches. Rather he died because he acted upon his long-standing suicidal ideation when presented with an opportunity, and there was no evidence of any reasonable precautions whereby the death might have been avoided; no evidence of any system of working which contributed to it, and no other facts which were relevant to the circumstances of the death so far as SPS were concerned.

5. CONCLUSIONS in respect of ACT

[115] While I accept that there is much force in what Miss Martin-Brown said in respect of Mr Stickle dying because he had acted upon his longstanding suicidal thoughts when the opportunity presented itself, and in what Mr Anderson and Mr Scott (for Grampian Health Board) said about Mr Stickle having a personal responsibility for his own actions, and in what they and other parties submitted, based on the evidence of among others Dr Mitchell, namely that Mr Stickle's suicide was inevitable and was only a question of when and where, that does not provide an answer to the specific act of suicide which brought about this inquiry. It is that particular act of suicide, not the likelihood of him committing suicide at some time, which needs to be considered in terms of the questions posed by section 6 of the 1976 Act. I accept Mr Halley's submission that a reasonable precaution which might have prevented the death would have been the assessment of Mr Stickle at the time of his reception into prison as a person "At Risk".

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Reasonable precautions whereby the death of Mr Stickle might have been avoided

[116] In my opinion a reasonable precaution, or a series of reasonable precautions, which might have been taken by Mr Mutch and Miss Innes would have been for them separately to have assessed Mr Stickle as being "at risk" for the purposes of the ACT reception documentation. Placing him at risk in terms of this documentation would have necessitated an Act 2 Care booklet being opened in respect of Mr Stickle, a conference being called to consider his position and the procedures which I have set out in detail above being followed in the normal way. The initial assessment does no more than trigger the calling of the case conference with a view to an assessment being carried out promptly and by a number of experienced professionals as to whether Mr Stickle was in fact at risk and if so whether that level of risk should be characterised as High or Low. Depending on the assessment of the requirements of Mr Stickle further measures of care and supervision including, if appropriate, cell accommodation would have been put in place with a view to protecting Mr Stickle from any risk he may have been thought to present and to support him in dealing with that risk in prison.

[117] The Act 2 Care strategy is a carefully thought out strategy designed to meet the known risk that a proportion of prisoners will attempt to kill themselves or to harm themselves..

[118] The authorities at Craiginches Prison had a lot of information available to them when Mr Stickle was admitted on the 23rd October. They knew that he had been placed on ACT before, they knew that while he was in prison on the 28th August he had made an apparent

attempt to commit suicide by hanging; they knew that following that apparent attempt Mr Stickle had been on high risk ACT for a period of time and at low risk ACT until his release from prison at the conclusion of his sentence on 16th October; they knew that the ACT documentation was still open at the time of his release. In addition to these historical facts they had information as to Mr Stickle's position at the time of his admission. They knew that he had been assessed by Lerwick police as falling within a number of risk categories including the fact that he suffered from a psychiatric condition, that he was violent, that he had drugs and alcohol issues, and that he was at risk of suicide or self harm. This information was contained on the first page of the Personal Escort Record. This document had been inadequately completed in that neither the "No Known Risk" box nor the "Risk" box had been ticked but given the individual risk categories which had been ticked, there could be no doubt that the police assessment had been that Mr Stickle had a risk of suicide or self harm.

[119] In addition, the staff admitting Mr Stickle to prison had or should have had access to the record of events which ran from 0740 on the 23rd October in Lerwick to 18.40 on the same day when Mr Stickle arrived at reception at Craiginches. This document disclosed in the narrative before the first entry that Mr Stickle had demonstrated violence towards family members in the past, that he had received treatment and was on medication for depression, and that he had attempted suicide in the recent past. That information was provided by the police at Lerwick when handing Mr Stickle over to Reliance Escort Services for transfer to the prison in Aberdeen. The first entry by Reliance at 0740 stated that Mr Stickle was in a blue suit due to him being a high risk self harmer. It narrated that when he was taken up to court at 1210 he was given back his clothes and at 1230 on being taken back down to court he was put back in the blue suit. It narrated a number of entries to the effect that Mr Stickle had been observed a

number of times per hour which regime of observation was known to be indicative of the prisoner being at risk.

[120] There was also available within the prison, although it had not been passed to reception, Mrs Whitelaw's fax containing her assessment of Mr Stickle that day as being still a suicide risk. This fax had been received at the prison more than 6 hours before Mr Stickle's arrival.

[121] Mr Stickle was received into the prison by Mr Mutch, a prison officer with considerable experience of reception of prisoners. From his evidence it was clear that he had developed the practice, or at least in Mr Stickle's case applied the practice, of relying almost entirely on a personal estimation of the prisoner's presentation to him coupled with the answers not just to the questions which the procedures required him to ask the prisoner, but also the prisoner's answers to questions which were meant to be resolved by Mr Mutch himself. Critically he did not complete the summary and risk assessment. At the end of a lengthy period in the witness box, Mr Mutch accepted that from the information available to him, and not applying the test of hindsight, he should have categorised Mr Stickle as being at risk. I consider that he was right to accept this. It would have been a reasonable precaution in all of the circumstances which were apparent in respect of Mr Stickle from his documentation, however well he presented, for Mr Mutch to have placed him at risk in order that the more formal assessments of the Act 2 Care strategy could have taken place.

[122] The Healthcare Assessment was carried out by a nurse, Miss Innes, who felt that she was, to an extent, learning on the job. She did not have the basic information of the PR2 document or the PER and the accompanying documentation available to her. She gave evidence that she did not normally receive the PER and the accompanying documentation for

the purposes of completing her Healthcare Risk Assessment, indeed she said she had never seen such a document.. She did not have access to the PR2 documentation because this was stored on computer and the computer in her reception office could not be connected. Her evidence was, having regard to the information contained in the PER and the record of events that accompanied it, had these documents been available to her at the time she would have assessed Mr Stickle as being at risk. I do not consider that Miss Innes was entitled to assess Mr Stickle or indeed any prisoner as being at "No Apparent Risk" when she did not have access to either of the two documents which the formal procedures required her to take into account at the very outset of her assessment.

[123] It is clear from her completion of Section 2 of the Healthcare Risk Assessment Form (Nurse Risk Assessment) that she completed part 1 of Section 2 by asking Mr Stickle questions and recording the answers. Part 2 of Section 2 requires an assessment as to how the prisoner presented and provides that details of observations to be recorded. All that was answered in respect of this is a record of what Mr Stickle had stated, namely that he had no thoughts of suicide or self harm at the time of interview. No assessment is given. No observations are recorded.

[124] It would have been a reasonable precaution for Miss Innes not to have assessed Mr Stickle as being at "No apparent risk" in the absence of the documentation which she was obliged to take into account.

[125] So far as the letter from Mrs Whitelaw, the social worker in Lerwick to Miss Hendry, the social worker at Craiginches Prison is concerned, this probably never reached Reception.. It would have been a reasonable precaution for this to have been brought to the attention of the

prison reception staff, as it should have been. Had this been done this too might, indeed having regard to the evidence of Mr Murray probably would, have brought about the assessment of Mr Stickle as being "At Risk".

[126] If Mr Stickle had been assessed "At Risk" this would have involved either an immediate holding of a first case conference or, if that could not be immediately convened the implementation of an immediate care plan to be followed within 24 hours by a first case conference. The first case conference would have been attended by a minimum of three persons, namely the manager responsible for Mr Stickle, a residential officer from the area where Mr Stickle was to be located and a nurse. Others who might have attended would include other staff members, the chaplain, the social work department, a listener, family or friends. At that first conference, Mr Stickle would have been assessed as being either at high risk, at low risk, or at no apparent risk. If at either high or low risk actions would be taken to address the risk and a care regime put in place.

[127] In these circumstances the next question to be addressed is whether, had the reasonable precaution of placing Mr Stickle "at risk" at the time of reception been taken, might his death have been avoided. Whilst it cannot be said with certainty that if Mr Stickle had been placed on ACT his death would have been prevented, that is not the relevant test for Section 6 of the Fatal Accidents Act. The test is whether a reasonable precaution might have been taken whereby the death "might" have been prevented. It is well established that the word "might" in these circumstances involves something less than a probability and something more than a mere outside possibility. It has been described as a real and lively possibility.

[128] The death to which this section refers is the particular death under investigation at the inquiry. In Mr Stickle's case this means whether his actual death might have been prevented or avoided, not whether he was likely to commit suicide at or about this time.

[129] The submissions of the procurator fiscal to the effect that the likelihood was that Mr Stickle would in any event have committed suicide at or about that time went far beyond Doctor Mitchell's evidence that Mr Stickle was likely to commit suicide at some time.

[130] The fiscal's submissions on this aspect were, perhaps surprisingly, supported in the oral submissions of Miss Martin-Brown on behalf of SPS. The whole purpose of the ACT strategy is to minimise the risk of suicide whilst the prisoner is in prison. It is, as I have said, a well thought out strategy which seeks to address the particular needs of the individual prisoner at the time he is undergoing ACT. Its purpose is to seek to reduce the chance of a prisoner committing suicide. So far as Mr Stickle is concerned its purpose, if it had been invoked at the time of his reception into prison , would have been to identify whether he was at risk of committing suicide, if he was whether he was at high risk or low risk, and whichever the level of risk to give him the necessary support and care to address the risk with a view to it not materialising. The procedure has worked generally to reduce the incidents of prison suicides in Scotland. Of course it cannot be said what the outcome of the first case conference would have been, whether Mr Stickle would have been assessed as at high risk, or low risk, or at no apparent risk. Even getting to the stage of assessing him at no apparent risk at a case conference would have involved those participating in the conference addressing the underlying factors that had led to him being placed at risk, deciding an immediate care plan and care regime pending the first case conference, reviewing the information supplied from the immediate care plan report, and would have resulted in a transitional action plan being

implemented to assist his safe return into his normal prison regime for the first seven days after the closing of the ACT document, including cell sharing risk assessments.

[131] If Mr Stickle had been assessed at low risk or at high risk more detailed plans with greater levels of intervention and observation could have been put in place as deemed appropriate.

[132] Against the background of the clearly thought out strategy behind the Act 2 Care plans it could not be said that Mr Stickle's death four days later could not have been prevented. The answer has to be that it might have been prevented. That is precisely what the ACT strategy has been carefully designed to achieve.

Were there defects in the ACT system of work which contributed to Mr Stickles death?

[133] Section 6(1)(d) of the Act requires that I consider "the defects, if any, in any system of working which contributed to the death or any accident resulting in the death".

[134] In my opinion this involves a different and stricter test than the test in respect of reasonable precautions by which the death might have been avoided. For the purpose of Section 6(1)(d) the evidence, in my opinion, requires to show on the balance of probabilities that there were defects in a system of work, and that these defects contributed to the actual death (or accident resulting in death) of the deceased.

[135] I approach the issue of defective system not on the basis of the written system as devised and set down in the ACT strategy, the guidance notes and the booklets , but as

operated in practice. In implementing a system of working in any given case, a failure to supervise an otherwise robust system sufficiently to see that it is being followed, or to audit it to pick up any difficulties or failures in its operation, could result in that system of working being seen as defective. So too a system which is robust on paper but which can not be fully implemented because of some impediment, or in respect of which there is insufficient training for it to be properly implemented, or for which necessary equipment has not been provided, or which is routinely not properly implemented could be seen to be defective.

[136] In his evidence Mr Mutch repeatedly said that Mr Stickle made good eye contact with him, and indicated that he did not feel suicidal. I consider that, experienced though he was, his evidence indicated far too great a reliance on his own essentially snapshot and untrained observation of Mr Stickle and gave far too little consideration to the ACT documents which were an integral part of the system and were intended to be important tools to be used to assist him in reaching his conclusion as to whether Mr Stickle was or was not at risk by considering all relevant information, including his recent history. An important part of Mr Mutch's regular duties was the reception of prisoners into Craiginches. The failure to attach proper weight to the documents clearly represents defective practice on Mr Mutch's part on the day. As I understood his evidence this reliance on observation evidence and exclusion of documentary evidence was a fair description of the way in which he carried out his reception duties. It would appear therefore that he routinely failed in all his admissions to give proper weight to the documents which ACT required him to have regard to.. While there was no evidence that other prison officers carrying out reception assessments failed to give proper weight to the ACT documents I consider that such a routine failure on the part of an officer with the specific task of implementing the ACT procedures, apparently undetected by his supervisors amounts to a defect in the system.

[137] So far as the Healthcare Risk Assessment is concerned, the position is very clear. The system of working required the nurse carrying out the Healthcare Risk Assessment to have regard to the PR2 record of the prisoner which, among other things, will indicate his ACT record whilst previously in prison. This record requires to be checked on every prisoner's admission to prison. If the prisoner has previously been in prison he will have such a record, and it will disclose his ACT history, if he has one. Nurse Innes was clear in her evidence that she did not have access to the PR2 record. This record was kept on computer. The computer terminal in her reception office was not connected to the system and, as she understood it, could not be connected to the system. This evidence was not contradicted by any other witness. I accept her as being truthful and accurate. The system could not be effectively operated by a nurse operating from the office from which Nurse Innes was operating and such a nurse would therefore be unable to check a record which the ACT procedures required her to check as the first check on an the prisoner. I consider that to amount to a clear defect in the system.

[138] The second matter which a nurse is required to have regard to on completing the Healthcare Risk Assessment is the Personal Escort Record (PER) and any additional information. I consider that the information contained in the PER, coming as it does from the police and Reliance Custodial Services, being two bodies who have themselves responsibilities for and experience of the protection of persons in their custody, has to be given considerable weight. It may contain very recent information that will be of considerable assistance to a person carrying out an assessment, whether it be the Healthcare Risk Assessment or the Prison Officers Risk Assessment. In Mr Stickle's case it did contain information that he was considered to be at risk for a number of reasons including suicide/self harm, that he had

recently attempted suicide, and that he had been considered sufficiently at risk by Reliance Escort Services on the day of his admission to prison, as to warrant him being put in a suicide suit and inspected regularly a number of times per hour. Nurse Innes, in her evidence, considered that that information was sufficiently material that, if it had been available to her at the time, she would have taken it into account and would probably have assessed Mr Stickle as being at risk. I accept that on the balance of probability she would have done so. She stated that she never received the PER for any prisoner. She was shown the PER for Mr Stickle and said that she had never seen such a document before for any prisoner, and that theuse of such a document had not been part of her training. On this aspect too she presented as an honest and truthful witness and her evidence was not contradicted. Either Nurse Innes is correct in her evidence and PERs were not made available to her to enable her to carry out the ACT health assessment or, if she is wrong, she routinely fulfilled such an important role in the admission system without understanding what the purpose of the PER documentation is, or that she was required to have regard to it. Either way this aspect of the system of working is defective.

[139] There was some evidence from Mrs Innes that social work letters relating to a prisoner frequently did not arrive at reception until the day after the date of reception. The matter was not sufficiently explored for me to be satisfied the problem amounted to a defect in system, rather than a one off occurrence in respect of Mrs Whitelaw's letter. Similar considerations apply in respect of the letter which should have gone from the Procurator Fiscal's office in Lerwick to the prison, but which never reached the prison. On the evidence it is likely that this resulted from a one off error and not a defective system. In each case however I would recommend that steps are taken to ensure, if it does not already happen, that when letters of this kind are received by the prison letters they are immediately forwarded to the prison officer and nurse carrying out the assessments

[140] I also consider that the system in so far as it relates to the doctor's assessment is capable of improvement in that potentially relevant information relating to a prisoner's risk of suicide or self harm is not made available to the examining doctor. Dr Porter considered that it might be useful to have the PER document. Dr Gamba considered that all relevant information should be taken into account. While he considered that the examination of the patient is the most important part of the assessment it seems to me that the examining doctor should have available all relevant information concerning the risk of suicide and self harm..

[141] A considerable amount of time was spent at the inquiry looking into matters relating to Mr Stickle's time under the ACT regime from 28th August to 16th October 2006. There clearly was an error at one stage in the operation of that procedure in that two ACT books were open for Mr Stickle at the same time. This should not happen, but the fact that it did on this occasion seems to me to be down to a simple human error and does not point to a defective system. The management of Mr Stickle by the prison authorities while he was on the ACT regime was appropriate and consistent with the provisions of the scheme. I did not consider that any of the evidence I heard relating to this period demonstrated either that there were reasonable precautions which might have been taken whereby Mr Stickle's death on the 26/27th October 2006 might have been avoided or that any system of working was defective in a way which contributed to that death.

6. The psychiatric evidence

Personality disorder

[142] **Dr Lindsay Thomson** gave evidence as to the nature of personality disorder. She is a consultant forensic psychiatrist, and is the Medical Director of the State Hospitals Board for

Scotland and of the Forensic Mental Health Services Managed Care Network. She has practised as a psychiatrist since 1989. She has a particular expertise in personality disorder and chaired the working group which had prepared a report into the provision of services for people with personality disorder in Scotland This group had considered the whole area of people with personality disorder who present a significant risk of physical or psychological harm to others and who come into contact with or are likely to come into contact with the criminal justice system

[143] One of her principal recommendations was that personality disorder should no longer be considered a diagnosis of exclusion from services. She said that it was a difficult area, one of the difficulties with personality disorder being that it is difficult to see it as being manifestly different from ordinary personality, being perhaps a more extreme form or manifestation of personality. She considered that the evidence for the successful treatment of personality disorder was weak. She considered that it was well within the competence of a consultant psychiatrist to comment on personality disorder but understood the reluctance to claim great expertise in the field, because there were few specialist units. Against that background she gave a definition of personality disorder as "an enduring and pervasive pattern of thinking, feeling, behaving, associated with problems with impulse control and gratification of needs that is manifestly different from the norm, and that leads to distress to the individual or to those around him (i.e. society) and those characteristics must be manifested in adolescence or early adulthood and be ongoing and they are not secondary to another mental disorder". There were different categories, anti-social and dissocial personality disorder, borderline personality disorder, mixed personality disorder. Antisocial personality disorder is most commonly found in the field of forensic psychiatry. Research has shown that approximately 70% of the prison population has personality disorder, by far the most common sub type being antisocial. One

would expect individuals with anti-social or dissocial personality disorder to exhibit a callous lack of concern for others, an intolerance of frustration resulting in aggression, a marked tendency to blame others, an inability to learn from experience and in particular to learn from punishment, difficulties in maintaining close personal relationships, and great difficulty in living by society's rules. The sorts of behaviour that you would expect in antisocial personality disorder are the sorts of behaviour that are more likely to lead to a person receiving a prison sentence. So the antisocial personality disorder is commonly found in the prison population. Psychopathy is the most severe type of antisocial or dissocial personality disorder. She described the matter by analogy to a Russian doll. The largest doll is the individual's personality. Within that there will be a subset whereby some people have a personality disorder. Some of those will have a subset of antisocial personality disorder. Some of those will have a further subset of dissocial personality disorder, involving additional emotional factors. Some of those people will have a psychopathic personality disorder. So the psychopathic personality is a tiny fraction of the whole population.

[144] Referring to the Mental Health (Care and Treatment)(Scotland) Act 2003 (hereinafter "the 2003 Act"), she explained that there were ten underlying principles of the legislation and that psychiatrists had a duty to consider those principles in any decision to use the Act or not to use the Act. One of the principles was using informal care whenever possible, another, when using detention, to use the least restrictive alternative. She considered that prolonged admission to hospital could make matters worse as when that is done the individual can hand over responsibility for his behaviour to others.

[145] Borderline personality disorder involved poor self image, internal conflict, fear of abandonment, chronic emptiness, difficulties in relationship, very stormy relationships. Self

harm is a very common feature. Much of the self harm is not done with the intention of the individual killing himself, but it would not be surprising that persons suffering from borderline personality disorder expressed suicidal ideas. Hospital admission was sometimes used for the purpose of saving a person's life. It would be short-term admission to get over a crisis.

[146] The evidence for using medication to treat antisocial personality disorder was limited, though there may be some poor quality evidence that low dose anti-psychotic medication at times can assist.

[147] Dealing with low dose anti-psychotic medication, she explained that this type of drug is a major sedative, and that drugs of this kind were not without their side effects. The evidence for this kind of medicine was not strong enough for it to be used compulsorily under Mental Health legislation.

[148] Doctor Thomson explained that many people with mental disorder and even mental illness do not come within the remit of the 2003 Act for compulsory detention. Ninety per cent of psychiatric treatment was on a voluntary basis.

[149] She said that the term "personality disorder" was a very stigmatising one.

[150] She said that looking to psychiatric interactions with the criminal justice system there was "some evidence" that applying a label of personality disorder may lead to increased sanctions on that individual and that there was "some evidence" that use of the term could make matters worse for an individual rather than better. She said there is an association between antisocial and dissocial personality disorder and violence.

[151] She disagreed with the proposition put to her by Mr Halley that the 2003 Act introduced a whole new approach to the way personality disorder was dealt with.

[152] The current practice in psychiatry in respect of people with personality disorder who commit criminal offences is not to make recommendations for a move to hospital but to leave the court to take the decisions as it would ordinarily. There was not evidence to justify changing that position.

[153] She said that it was common practice not to make the diagnosis of personality disorder unless it was relevant to the recommendation the doctor was making. She herself had refrained from advising a court that such a diagnosis had been made. The ethical issue for the doctor was that if the doctor was offering no treatment or therapeutic option for the patient, by disclosing the diagnosis the doctor gave information that might do harm to the patient by bringing about a more severe sentence.

[154] She was however coming to the view that in clinical terms psychiatrists needed to make the diagnosis if it was appropriate, and she saw the argument that psychiatrists needed to express that diagnosis to those involved with the criminal justice system. She did not, however, think that that was current psychiatric practice. She considered that current psychiatric opinion would be that a court need only be told that it is dealing with a mentally disordered offender if the psychiatrist intended to do something about it. She did not consider that when a mental disorder had been diagnosed there was an automatic duty to report that to the court.

The psychiatrists who treated Mr Stickle

[155] A significant amount of time at the inquiry was devoted to the evidence of psychiatrists who had had an involvement with Mr Stickle, namely Doctor Pauline Larmour, Doctor Kenneth Mitchell, and Doctor Christopher Pell. In addition to their evidence which was specific to Mr Stickle, Doctor Larmour and Doctor Mitchell both gave very helpful and clearly expert evidence on the topic of personality disorder.

[156] **Doctor Larmour** gave evidence over a number of days and was cross-examined by Mr Halley at considerable length and in considerable depth in respect of her involvement with Mr Stickle at the time he was admitted as a voluntary patient to Royal Cornhill in July 2006, at the time of his apparent suicide attempt on 28th August 2006, for the purposes of preparing a report to the court in August 2006, and in respect of her attendance at a meeting on 24th October 2007 in relation to a plan for Mr Stickle when he became to be released from prison.

[157] She is an experienced consultant forensic psychiatrist. She was aware of the provisions of the 2003 Act but did not consider that it had made a great difference to her professional practice. She too gave general evidence to the court concerning the nature of personality disorder and in particular antisocial personality disorder, the fact that it was not a mental illness or disease, but rather the description of the nature of the individual, that it was essentially not treatable. In Mr Stickle's case she saw a particular problem in that Mr Stickle tried to medicalise his problem and by doing so and by looking to doctors to provide him with medicine, he failed to address his own personal responsibility for his own conduct. She acknowledged the fact of his suicidal ideation, but was not convinced that his attempt to commit suicide on the 28th August 2006 was necessarily a genuine attempt to kill himself. She considered that he was manipulative in his behaviour. In addition to providing specialist

forensic psychiatric advice in July 2006 she had been involved with Mr Stickle following his attempted suicide in August 2006, by which time also she had prepared a report for the court for the purposes of Mr Stickle's appearance for deferred sentence on the 30th August.

[158] By her letter dated 12th July 2006 to Doctor Wield, a psychiatrist in Royal Cornhill Hospital, (Production 14) Doctor Larmour provided an assessment of Mr Stickle from the perspective of a forensic psychiatrist, as requested by a Doctor Wield on behalf of Doctor Palin, the consultant psychiatrist responsible for Mr Stickle'e treatment at that time.. She did not specifically make a diagnosis of a personality disorder. She suggested that there was little indication for the continued prescription of anti-depressant medications, she referred to Mr Stickle's history of saving up and then subsequently overdosing on medicine in the past, and to him using such medicine in a possible suicide attempt on 13th June 2006. Doctor Larmour recommended the withdrawal of anti-depressant medications whilst he was in hospital and relatively free from the effects of other substances, both to clarify his diagnosis and to reduce the risk of future potentially fatal self harm. She had become involved because of certain of her colleagues concerns about the threats of violence against members of his family including homicidal threats which Mr Stickle had been voicing.

[159] Doctor Larmour next saw Mr Stickle on the 18th August for the purposes of preparing a report for the Sheriff in Lerwick Sheriff Court for the sentencing diet of 30th August 2006. The note of that meeting in the prison medical records reads:- "Long history of repeated self harm, usually in response to difficult life events (so be vigilant around court and sentencing etc). Not however mentally ill. Keen for medical diagnosis + medication. Unclear if anything able to help him long-term unless he takes responsibility for his own lifestyle."

[160] On the same date, Doctor Larmour made an entry in the SPS Mental Health Records wherein she noted:-

"I endorse gradual withdrawal of diazepam in prison and recommend that this be followed by a withdrawal of other meds as not mentally ill. Ongoing fluctuating self harm risk."

[161] At that time Doctor Larmour considered that Mr Stickle's prescription of depixol, an anti psychotic drug, which had been prescribed for him by Doctor Mitchell in July, should be discontinued. She did not consider that it was beneficial, she did not understand why it had been prescribed, and she considered that there were side effects of the drugs. In addition, the withdrawal of depixol was part of her overall strategy proposed for Mr Stickle that medications should be withdrawn and that he should be discouraged from viewing his condition as a medical problem and encouraged to take personal responsibility for his own actions. She did not see the need to discuss her decision with others.

[162] Doctor Larmour next saw Mr Stickle on the 28th August following his apparent attempted suicide. Her note of this meeting reads "Following request for urgent psychiatric assessment after attempted hanging last night. Due to attend court 30.8.06. Long history of serious self harm in response to adverse life events and will pose ongoing risk for future particularly around life crises. Not, however, suffering from any treatable mental illness. For discussion at next week's MHT meeting. Will need high risk measures/equivalent while up in Shetland for court." This note is recorded in Mr Stickle's ACT book.

[163] On the same day, Doctor Larmour made a record in SPS Mental Health Records relating to Mr Stickle. The notes recorded the attempted hanging. It continued "Prior to my seeing him, mum on phone anxious re threats made by him against family because they won't let him stay with them. Calm, alert at interview and unchanged from when I saw him last week. Not mentally ill or amenable to psychiatric treatment. Should continue diazepam withdrawal and then withdrawal of venlafaxine after that. Ongoing risk of future self harm particularly at times of crisis – court, sentencing, discontinuation of meds. ACT should be used as appropriate for this. Can be discussed at next week's MHT meeting. Should go to court as planned." She was not clear about whether the attempt had been a serious suicide attempt.

[164] Doctor Larmour's psychiatric report to Lerwick Sheriff Court was dated 28th August but was prepared before that date following the meeting on 18th August. I am not clear from the evidence whether it had been signed by Doctor Larmour prior to her meeting with Mr Stickle at 3.45 pm on the 28th. It was not altered to disclose the fact of Mr Stickle's apparent attempted suicide. Dr Larmour did not amend the report to refer to that incident because she did not consider that the incident had a bearing on her opinion.

[165] The report did not disclose the fact that Dylan Stickle had been diagnosed as suffering from a personality disorder. It contained a summary of his psychiatric history and disclosed that in 1995 it was considered by a psychiatrist that he "appeared to have a personality disorder." It also referred to his "personality difficulties" at the time of his treatment at Royal Cornhll in June/July 2006. It recorded his threats of violence against his father and brother, his past aggressive behaviour from an early age, his threats of violence to specific individuals and recorded Doctor Larmour's view that he would pose a continued risk to his family if he were

in the community. Doctor Larmour stated in her formal opinion and recommendation that Mr Stickle "does not presently suffer from a treatable mental disorder and I have therefore no psychiatric recommendations for his disposal by the court."

[166] Prior to Mr Stickle's release from prison on 16th October and being aware of his stated intention to return to Shetland, Doctor Larmour wrote to Mr Stickle's G.P. on 11th October 2006. In that letter she stated:-

"It is my opinion that Mr Stickle does not suffer from any form of treatable mental disorder and that Mental Health Services have nothing to offer him at the present time. He is dependant on both alcohol and prescription drugs but I could find no evidence that he has benefited from any of the psychotropic medications prescribed to him over the years. …. My advice to the doctors at Cornhill and to the prison medical officer at Aberdeen Prison has been to withdraw his psychiatric medications and resist his request for prescription psychiatric drugs. To date he has been successfully reduced from diazepam 10 mg qid to 10 mg bd. His prothiaden has been discontinued. He remains on venlafaxine 75 mg bd, which I would recommend be withdrawn once he has completed discontinuation of his diazepam. It would be most helpful if this process could continue in the community as Mr Stickle's abuse of prescription drugs only serves to medicalise his anti-social behaviour towards himself and others. … Mr Stickle has a long history of dramatic self harm. He has continued to engage in dangerous behaviours during his stay in Aberdeen Prison. Once he returns to the community from prison there will undoubtedly be pressure from Mr Stickle and his family for his re-referral to Mental Health Services and his admission to hospital. Extensive assessment at

Royal Cornhill Hospital and re-examination of him by myself in prison has failed to link his self harm with any treatable mental disorder. Consequently re-admission to Royal Cornhill Hospital would not be an option for Mr Stickle at the present time."

[167] On 24th October 2006, Doctor Larmour attended a Risk Management Case discussion at Aberdeen Social Work Department along with three social workers, a police representative and others. A draft minute of that meeting was produced approximately one year after the meeting took place. It was not spoken to by the person who produced it. Doctor Larmour disputed certain of the phrases attributed to her. I cannot hold that it is an accurate record of what transpired. I am satisfied that at that meeting Doctor Larmour repeated her position that Mr Stickle did not suffer from a treatable mental illness, that past medications had made no change of his behaviour, and that medication would not help, and that the only person who could help him was himself. That would be consistent with Doctor Larmour's view expressed in her letter to Doctor Maudsley and with the opinion which she had formed over some three to four months involvement in his case.

[168] Doctor Larmour was subjected to sustained cross-examination on the various aspects of her involvement in Mr Stickle's case, much of the cross-examination being critical of her. She maintained her position in respect of Mr Stickle throughout and gave clear reasons for the opinions which she had come to hold about him. I found her to be a very honest helpful and impressive witness

[169] **Dr Mitchell** gave evidence about his involvement in Mr Stickle's treatment in June to July 2006, and also at some length about personality disorders. He explained that as a

voluntary patient Mr Stickle could discharge himself at any time, and was also free to go into town if he wished subject to the hospital's regime. He considered the decision to agree to Mr Stickle leaving the hospital to go into town on the 13th July was a reasonable one. It could have been beneficial for him. It provides some relief from the rules and restrictions of hospital life and from the sometimes uncomfortable nature of life in a psychiatric ward. It accords with the principle of minimum restriction to the freedom of the patient contained in the 2003 Act. It can be detrimental to a patient with personality disorder not to be allowed out of the hospital environment from time to time. Dr Mitchell had clearly told Mr Stickle that alcohol and drugs were prohibited and that if he broke that rule he was liable to be discharged from the hospital. He returned to hospital in a drunken state. He was abusive and threatening. In particular he threatened to kill Doctor Mitchell. Dr Mitchell took his threats seriously. It was not appropriate that he remain in the hospital even though he wanted to do so. Nor was it appropriate to detain him compulsorily. Such detention is only available if a number of conditions are met, one of them being that the patient does not agree to in patient treatment.

[170] Doctor Mitchell explained that he had prescribed the use of the anti psychotic drug depixol for Mr Stickle as there was weak evidence that some patients with borderline personality disorder sometimes derived benefit from this treatment. He did not know if depixol would help Mr Stickle or not, he realised that its use was controversial, and had anticipated that other doctors might discontinue the treatment. He considered that Mr Stickle's eventual suicide may well have been inevitable.

[171] **Doctor Pell** gave evidence about his involvement with Mr Stickle when he was brought to Royal Cornhill Hospital by the police on 16th October He considered that Mr Stickle was experiencing long standing suicidal ideation and dysthymia (low mood or despondency) as

part of a personality disorder. He concluded that there was no clear role for admitting him to the hospital as an in patient. In his evidence Dr Pell gave his reasons for coming to this view. He found it difficult to identify what could be done for Mr Stickle as an in patient. His suicidal thoughts were longstanding and there were no particular triggers presenting that day; there was in any event little the hospital could do in terms of containing the suicide risk because Mr Stickle would have been admitted as a voluntary patient and could have left at any time. The usual way to help people who self harm was to have them engage with out-patient services. Finally Dr Pell considered that it could be detrimental to admit patients such as Mr Stickle to hospital, because it could lead to them relying on hospital as a safety mechanism rather that than taking responsibility for their own problems in the outside world.

7. Submissions on the psychiatric evidence.

[172] The procurator fiscal submitted that the decisions made by the psychiatrists were reasonable and there was no reason to think that adopting an alternative approach would have led to a different outcome. He submitted that there was no basis for findings that were critical of any medical witness

[173] **Mr Halley** submitted on behalf of Mrs Stickle that a reasonable precaution whereby Mr Stickle's death might have been avoided would have been if he had been properly identified as a person having a mental disorder within the meaning of Section 328(1) of the 2003 Act by Doctor Larmour in her report to the court dated 28th August 2006; if he had been properly identified as a person having a mental disorder within the meaning of Section 328(1) of the 2003 Act by her in her professional approach to and advice to other professionals concerning Mr Stickle and if he had been properly identified as a person having a mental

disorder within the meaning of Section 328(1) of the 2003 Act by her in the discharge of her duties as visiting psychiatrist to Craiginches Prison..

[174] A further reasonable precaution by which Mr Halley submitted Mr Stickle's death might have been avoided was if reasonable appropriate and necessary professional consultation had taken place between Doctor Larmour and Doctor Mitchell prior to Doctor Larmour's decision to discontinue the prescription of depixol.

[175] So far as defects in systems of working were concerned Mr Halley submitted that I should find that Doctor Larmour's failure to advise the Sheriff at Lerwick of the fact that Mr Stickle was a person who had a mental disorder within the meaning of the 2003 Act constituted a defect in a system of work which contributed to Mr Stickle's death in the respect that he was deprived of the opportunity for a further opinion on the issue of treatment.

[176] On a related topic he submitted that the practice spoken to by Doctor Larmour and Doctor Thomson of forensic psychiatrists not advising a sentencing court that diagnosis had been made of accused persons having a mental disorder in the form of personality disorder lest a more severe disposal be visited by the court on the accused constituted such a defect in a system of working.

[177] He submitted that there were a number of factors relating to Doctor Larmour which were factors which, in terms of Section 6(1)(e) of the 1976 Act, I should find to be relevant. I do not consider there is any need to go into these submissions. Some of the matters which Mr Halley raised under Section 6(1)(e) both in respect of Doctor Larmour's evidence and in respect of the wider facts of the case were factors which are relevant for the purposes of

considering the issues of reasonable precautions and systems of work. They have been taken into account for those purposes and I do not see any benefit in making further findings in respect of them. I did not consider any of them which were in any way critical of Dr Larmour were supported by the evidence.

[178] **Miss Denise McVey**, who represented Doctor Larmour lodged written submissions on her behalf. She pointed out that Doctor Larmour is a consultant forensic psychiatrist with over 17 years experience in that specialist area which involved a therapeutic role for the patient, combined with the assessment and management of patients referred by the criminal justice system.

[179] Miss McVey's first submission was that Doctor Larmour, who had given evidence for a considerable length of time and had been asked to address a number of issues, should be considered as a credible, reliable witness, who gave sound and well reasoned explanations to the inquiry in respect of the events and of her clinical judgments. I entirely accept that submission.

[180] Doctor Larmour had first become involved with Mr Stickle because a colleague in the field of general psychiatry had become concerned that Mr Stickle had been voicing homicidal ideas and his treating team were concerned about how they should deal with this information. That was the context in which Doctor Larmour saw Mr Stickle on the 29th June, by which time she had familiarised herself with his medical records and discussed him briefly with her colleague Doctor Palin. He had explained that the issue upon which her opinion was specifically sought was whether or not she considered Mr Stickle to be clinically depressed, and what the team ought to be doing in relation to his threats of violence to third parties. She

had not considered that Mr Stickle was suffering from a major depressive illness, and wondered if his mood problems were more in terms of chronic unhappiness, emotional instability exacerbated by his chaotic lifestyle and substance abuse. She suggested then that his anti-depressant medication be withdrawn and advised her colleagues of their professional duty in certain circumstances to inform others about the patient's homicidal threats.

[181] Doctor Larmour had explained that in August 2006 she had been asked by the Crown Office to provide a report to the court (it may have been that the request came from the court itself) in advance of Mr Stickle's forthcoming appearance for sentencing, but that in preparing the report she had also considered Mr Stickle's clinical management. This again included the process of withdrawing anti-depressants and ceasing the prescription of depixol, the anti-psychotic depot injection which Doctor Mitchell had prescribed in July. At the time she recorded these matters in her notes and also her concerns regarding Mr Stickle's ongoing fluctuating self harm risk. She concluded her report by stating that Mr Stickle was sane and fit to plead, did not suffer from a treatable mental disorder and that she had no psychiatric recommendations for his disposal to offer to the court.

[182] Doctor Larmour had given evidence relating to her involvement with Mr Stickle on the 28th August following his apparent attempted suicide. By the time she attended Mr Stickle was already on high risk ACT. She made notes in prison medical records and the ACT document to the effect that he was an ongoing risk of further self harm particularly at times of crisis, that he had a long history of serious self harm in response to adverse life events, and would pose an ongoing risk for the future particularly around life crises. On returning to hospital having seen Mr Stickle on the 28th August she did not have the opportunity to amend her court report to include a summary of recent events. She was not concerned that the

omission of these details affected the accuracy of her report, because they did not impact upon her views of Mr Stickle's mental health nor her recommendation to the court.

[183] Although she did not see Mr Stickle after the 28th August she remained in contact with the prison's psychiatric team on an ongoing basis. In addition, she had attended the meeting of 24th October. Doctor Larmour did not consider that the minutes of that meeting were entirely accurate to the extent that they related to her own opinions, and did not properly reflect her contributions to the meeting. Miss McVey pointed out one patent error on page 4 of the minutes where it is said that Doctor Larmour first saw Mr Stickle as an emergency admission from Shetland out of hours. I accept that the minutes cannot be regarded as accurate and I prefer Doctor Larmour's recollection of the meeting which is consistent with the views she was expressing at the time. In particular I accept Doctor Larmour's explanation that the sentence on page 6 of the minutes "Jackie enquired if there was any reference to Mr Stickle having a personality disorder and Pauline felt this was not an issue" does not accurately reflect Doctor Larmour's views at that meeting. Her views were to the effect that the diagnosis of personality disorder was not the main issue in Mr Stickle's case. She considered it was in Mr Stickle's best interests to steer the meeting away from a "purely diagnostic approach". Dr Larmour was concerned that a diagnosis of personality disorder might operate to prevent Mr Stickle having access to services or support. She also had pointed out in her evidence, when being cross-examined by Mr Halley, that a recent report by the Mental Welfare Commission supported her view that the term "personality disorder" is believed to be regarded by social services as a reason to exclude somebody from care. Doctor Larmour also did not accept the minute when it related to her purported description of Mr Stickle's self harm attempt on the 28th August as being "purely manipulative behaviour". What Doctor Larmour had thought was that there had been a manipulative component in his behaviour and she had good reasons for

thinking this, having regard to his recent history, threats to the family, and a self harm attempt whilst in a shared cell. He had also been manipulative for the purposes of seeking to obtain additional medication. Doctor Mitchell had seen Mr Stickle as being a controlling and manipulative person, and Christine Hendry had had a similar view.

[184] **Mr Jessiman** submitted on behalf of Dr Mitchell that when he decided to permit Mr Stickle to leave the grounds of the hospital for the afternoon of 13th July 2006, he was a voluntary patient who could leave the hospital at any time. In addition there would come a time when he would be discharged from hospital back into the community. That decision was a matter for his clinical judgment and was a reasonable decision for him to take in his management of Mr Stickle.

[185] He further submitted that Mr Stickle was aware of the rule that consumption of alcohol was not permitted. He returned to Royal Cornhill drunk and aggressive and showing signs of violence. He threatened to kill Dr Mitchell. Dr Mitchell was very concerned by the incident, and took Mr Stickle's behaviour and threats seriously. When Mr Stickle refused to calm down Dr Mitchell called the police and also decided to terminate Mr Stickle's admission as a voluntary patient at the hospital. Dr Mitchell gave clear reasons for his decision. There was no evidence to the effect that was a wrong decision.

[186] **Miss McVeigh** on behalf of Dr Pell, having summarised his involvement, and the evidence which he had given to explain the reasons for his decision not to admit Mr Stickle to Cornhill Hospital**,** submitted that there was no evidence which would support any criticism of him or warrant any finding that he failed to take some reasonable precaution in his management of Mr Stickle. I accept that submission.

[187] **Mr Scott,** advocate appeared on behalf of Grampian Health Board. Their interest in the inquiry arose out of the fact that they employed Doctor Larmour and Doctor Mitchell who were separately represented in their individual capacities. He made submissions supporting the actions of the two consultants which I have taken into account in reaching the conclusions which I have in respect of their involvement, and there is no need to repeat them here. I also accept the general submissions he made to the effect that psychiatry is a difficult and complex field in which there is scope for differences in professional opinion and clinical judgment; that the diagnosis of personality disorder is difficult and complex with many overlapping conditions; that some of those conditions are not treatable. He submitted that the fact that two psychiatrists differed, for example in respect of the depot injection of depixol, did not mean that one or other was wrong. He submitted that there was no evidence of any defect in any system of working on the part of the Health Board.

[188] Mr Scott also dealt with an issue which I consider is very important in this case, and which Mr Anderson and Miss Martin-Brown had also mentioned, namely Mr Stickle's own responsibility for his own behaviour and his own actions. He submitted that the evidence disclosed that over a number of years a great deal of effort was expended by psychiatrists, psychotherapists and social workers to try to assist Mr Stickle to overcome his difficulties, but that he failed to take advantage of that help. A clear example was Mr Stickles behaviour on 13th July 2006. In addition Mr Stickle's stated intention to commit suicide had been longstanding, and in the long term when there was such an intention it could not be guarded against. Life long restraint and 24 hour surveillance were clearly impractical.

8. Conclusions on the psychiatric evidence.

[189] I am satisfied that Doctor Larmour's recollection of what she said and what she was attempting to convey at the meeting of 24th October is to be preferred over the terms of the draft minute (which was not spoken to by the person who prepared it).

[190] In my opinion Doctor Larmour's position in respect of Mr Stickle was consistent throughout all of her dealings with him, and that remained her position at the time she gave her evidence. She considered that Mr Stickle had a personality disorder. Although this is a recognised and diagnosable mental health condition it is not a mental illness or disease, but rather a description of Mr Stickle's personality. He had the potential for violence against others and he was at risk of self harm. He abused alcohol. He abused prescription drugs. He sought to medicalise his problems in the sense that he sought to characterise them as a medical issue capable of being remedied by medical treatment and medication. His condition, his personality, was however not susceptible to being changed by treatment and medication. He required to take responsibility for himself and to make his own decisions to seek to change the way he behaved. He did not do this. Doctor Larmour considered that the advice she had given to her colleagues at Royal Cornhill Hospital, to the court in Lerwick for the hearing on 30th August, and to Doctor Maudsley in Shetland prior to Mr Stickle's release from prison in October 2006, had been correct advice. It reflected the professional opinion which she held at the time and which she continued to hold in respect of Mr Stickle. Her opinion was also contained in the various notes she made in Mr Stickle's medical records. I accept her evidence on these matters and it is important to note that notwithstanding the detailed criticisms made in cross-examination, and maintained in formal submissions to the inquiry, no evidence was led on behalf of Mrs Stickle to contradict Doctor Larmour's opinion on any of those matters. The

evidence which was led on Mrs Stickle's behalf from Doctor Lindsey Thomson to a very large extent supported Doctor Larmour's general views on the subject of personality disorder in the field of criminal justice. I consider that in all her dealings with Mr Stickle , or in respect of him and in her dealings with the court she displayed the high levels of knowledge skill care and professional responsibility to be expected of a consultant psychiatrist.

[191] Doctor Larmour's decision not to use the term "personality disorder" was a considered decision. At the time of Mr Stickle's voluntary admission as a patient in Cornhill in June/July 2006 she did not refer to this in her letter to Doctor Palin because she did not wish to pre-empt any decision that the psychotherapists who were then seeing Mr Stickle might make in relation to access to treatment in their department. This was in addition to the fact that she had not been asked to deal with issues relating to personality disorder.

[192] In the course of her evidence under cross-examination by Mr Halley, Doctor Larmour disagreed with the numerous criticisms which were put to her and explained her reasons for doing so. In the absence of any evidence to contradict Doctor Larmour's refutation of the criticisms it is perhaps surprising that many of them found their way into the submissions made on behalf of Mrs Stickle. It is trite to say, as juries are reminded daily in the criminal courts, that evidence is found in the answers to questions, not in counsel's questions themselves.

[193] I accept that Doctor Larmour was accurate in her description of Mr Stickle as "not suffering from any treatable mental illness". I also accept, as Doctor Mitchell said in his evidence, that it is quite common to read letters and reports by consultant psychiatrists and specialists who mention symptoms and signs but do not specifically state a diagnosis.

[194] Doctor Larmour's stated reasons for being reluctant to use the label "personality disorder" were supported by Doctor Mitchell and by Doctor Thomson.

[195] Criticism was also directed at Doctor Larmour by Mr Halley in respect of the withdrawal of anti-depressant medication. Doctor Larmour's evidence was clear that she did not believe that Mr Stickle was clinically depressed at any time when she saw him in 2006. The closest any evidence came to supporting the proposition that Mr Stickle was clinically depressed came from Doctor Mitchell who in July 2006 had been "willing to give Mr Stickle the benefit of the doubt" in terms of the symptoms which he was reporting, but he was not certain about this. I accept Doctor Larmour's evidence on this point., namely that Mr Stickle was not suffering from depression at any time he was seen by her.

[196] There were good clinical reasons for Dr Larmour withdrawing Mr Stickle's medication and advising others to that effect. Firstly, and perhaps obviously, given that she did not think he was clinically depressed there was no need for the prescription. Secondly, the withdrawal of the dosage would allow those involved in his care to make better assessments of his underlying diagnosis. Thirdly was her concern that Mr Stickle was seeking to medicalise his problem rather than trying to address his own personality issues and finally she noted that his attempted suicide in June had involved an overdose of anti-depressant medication. While Doctor Mitchell had continued the prescription of anti-depressants when Mr Stickle came under his care in June/July 2006 this was against the background of Mr Stickle giving different reports to Doctor Mitchell as to his reaction to that medication than he had done to Doctor Larmour. By the time Doctor Larmour again recommended withdrawal of this medication in August 2006 she had become aware of Mr Stickle's abuse of prescription drugs in prison.

[197] I do not consider that there is a conflict between Doctor Mitchell's approach and Doctor Larmour's approach, given this difference in Mr Stickle's reporting background. To the extent that there is a contradiction between the two, Doctor Mitchell pointed out that there were various courses of action open and that many of these courses of action could be considered correct.

[198] So far as the discontinuation of the depixol medication is concerned, this is an anti-psychotic, described by Doctor Thomson as a strong sedative.

[199] Doctor Larmour gave her reasons for discontinuing the medication. She understood that prescription of depixol for a patient suffering from personality disorder was experimental, and she was not aware of any evidence to suggest that it was likely to be effective for Mr Stickle. She considered various factors including her concerns about Mr Stickle trying to medicalise his problem, rather than address them personally. She had concerns as to the degree of supervision which Mr Stickle would be subject to either in prison or in the community. She was aware of problems and side effects of the drug and she considered it potentially dangerous. She considered that it was in Mr Stickle's best interests to discontinue depixol. Mr Halley suggested to her that she ought to have discussed this matter with Doctor Mitchell. I do not accept that submission, and there was no evidence to support it. Doctor Larmour was the psychiatrist responsible for Mr Stickle's care and as such had a professional responsibility and accountability for his medication. I consider that she was entitled to reach the conclusion which she did without reference to another psychiatrist who had formed a different conclusion in different circumstances. Dr Mitchell was clear in his evidence that the treatment was experimental and that he was not confident that it would be successful, although he considered

it was worth trying in Mr Stickle's case. He, however, considered that a forensic psychiatrist such as Doctor Larmour would be better placed to make the decisions regarding the management of individuals with mental health problems whilst in prison. He considered that Doctor Larmour's decision to discontinue depixol might be considered perfectly reasonable and indeed he had anticipated that another doctor might decide to stop the use of the drug in Mr Stickle's case. Doctor Thomson agreed in her evidence in general terms that it might be perfectly appropriate for a second consultant to discontinue a treatment which had been started by another.

[200] So far as the report to the court was concerned dated 28th August 2006, Doctor Larmour's evidence was that she might have held back that report to the court if she had considered that the events of 28th August were of such importance that her overall view of Mr Stickle had altered to the extent that she felt she needed to amend her recommendation to the court. She did not feel that. She did not accept that she was under an obligation to notify the court about suicide attempts during recent periods in custody. Mr Halley put to her in cross-examination that she was under a duty to advise the court that Mr Stickle had attempted suicide on 28th August and that it was a possible contributing factor to this attempt that he had personality disorder. Doctor Larmour disagreed. Miss McVey submitted that Doctor Larmour's evidence on these matters should be accepted particularly as there was no contradictory evidence on the matter to support Mr Halley's contention. To the extent that Mr Halley sought to support the criticisms by reference to an interpretation of certain sections of the 2003 Act she submitted that the interpretation ought to have been specifically put to Doctor Larmour to allow her to explain her understanding of what the sections demanded of her as a consultant psychiatrist. As this was not done, and as no other witness was asked to comment, she submitted it would be unfair for me to determine that Doctor Larmour's admissions were

unreasonable or inappropriate. Mr Halley submitted in his oral submission that this was a matter of law and that evidence was unnecessary. I do not accept that. An Act such as the 2003 Act does not exist in a vacuum, nor do individual sections. The purpose is to deal with the care of patients and that is always going to raise practical issues including issues of interpretation. If Mr Halley wanted to criticise Doctor Larmour in this regard then I think it was incumbent upon him to follow the matter further either in cross-examination or by leading evidence from other psychiatrists as to the application of the Act in practice.

[201] It would I feel be fair to say that Mr Halley's submissions on behalf of Mr Stickle's mother sought, as Mr Stickle had done in his dealings with the psychiatrists, to medicalise Mr Stickle's problems, adding on the legal context of the 2003 Act. There is no evidence which supports that position. The clear and uncontradicted evidence was to the effect that Mr Stickle, while suffering from a mental disorder, did not suffer from a mental illness. His disorder related to his personality and was not amenable to medical treatment; he needed to accept responsibility for his own choices and his own behaviour; continuation of treatment by prescription drugs would delay him doing that. Dr Larmour's decisions were taken after proper professional consideration with the object of trying to focus Mr Stickle on the need to address his own problems himself. I do not consider that a consequence of the 2003 Act is that a consultant psychiatrist should be obliged by the Act to provide treatment when she considers it is not in the patient's best interests to do so.

[202] So far as the use of clinical terminology in the report to the court is concerned, and in particular the non reference to the diagnosis of personality disorder or anti-social personality disorder, Doctor Larmour's position was that she understood her primary purpose in the preparation of the report was to advise the court on whether Mr Stickle had a mental disorder

that would make it appropriate for him to be detained or assessed under the 2003 Act, and that her approach was therefore more medico legal than clinical in nature. She did not believe that the Act required her to advise the court of Mr Stickle's precise diagnosis, but rather to advise whether his condition was such that the statutory criteria for treatment or assessment were met. She considered that she had fulfilled her role in advising the court that Mr Stickle did not suffer from a treatable mental disorder, and it was therefore her opinion that the relevant criteria were not satisfied.

[203] In addition, she explained that current teaching is to avoid jargon and medical terminology when addressing a non medical audience.

[204] Doctor Thomson gave evidence to the effect that Doctor Larmour's approach reflected general psychiatric practice in Scotland and that she too had in the past refrained from advising the court that a diagnosis of personality disorder had been made. She said that forensic psychiatrists have to exercise clinical discretion in deciding what information is included in a report to the court. She also gave evidence that it was a common psychiatric practice to refer to "no treatable mental disorder" and to avoid a diagnosis of personality disorder unless it was directly relevant to the recommendations made. Accordingly Dr Larmour's decision was consistent with current general psychiatric practice

[205] I consider Mr Halley's submission that Dr Larmour was under a particular duty to report Mr Stickles's diagnosis of personality disorder in her report to the court in order that the Crown could consider applying for and the court could consider making a formal assessment order under sections 52D and E of the CP(S) Act of 1995 (which were inserted by the 2003 Act) to be misconceived. Section 52D lays down the circumstances in which such an order can

be made. They include the court being satisfied that there are reasonable grounds for believing (i) that the accused is suffering from a mental disorder (which includes a personality disorder) and (ii) that it is necessary to detain the accused in hospital to ascertain whether certain conditions apply to the accused (see subsection (3)(a)(i) and (ii)) The conditions which require to be met are contained in section 52 D(7) and are (a) that the accused in fact has a mental disorder; (b) that medical treatment which would be likely to prevent the disorder worsening or alleviate any of its symptoms or effects is available for the accused and (c) that if the accused is not provided with that treatment there would be a significant risk to the accused's health safety or welfare or the safety of any other person. If Doctor Larmour had included in her report the fact that Mr Stickle had been diagnosed as having a personality disorder consideration of the first of the conditions would have been rendered unnecessary – the court would know that Mr Stickle had a mental disorder as defined in the Act. Consideration of the second condition namely the availability of treatment would also be unnecessary as Dr Larmour's report clearly states that such treatment is not available. The third condition, which requires treatment to be available under the second condition, does not arise. Accordingly I do not consider that it is likely that the disclosure by Dr Larmour in her court report that Mr Stickle had a personality disorder and therefore a mental disorder would have resulted in an assessment order being made either at the time of his sentencing on 30th August 2006 or at the time of his remand for sentence on the 23rd October 2006.

[206] I accept Mr Jessiman's submissions that there is no evidence which would support any criticism of Dr Mitchell or warrant any finding that he failed to take some reasonable precaution in his management of Mr Stickle as a patient. Rather I consider that he too displayed the high levels of knowledge skill and care to be expected of a consultant psychiatrist. His decision to allow Mr Stickle to leave the hospital was a reasonable exercise of

his clinical judgment. I consider that his decision that Mr Stickle should be discharged from hospital with immediate effect as a consequence of his behaviour when he returned to hospital in a drunken state was a reasonable decision for him to take in the interests of the other patients and the staff at the hospital. There was no basis for Dr Mitchell having Mr Stickle detained as a compulsory patient.

[207] I accept Miss McVeigh's submissions on behalf of Dr Pell. Dr Pell gave clear and cogent reasons for taking the decision which he did. He was clearly a very competent Doctor who had reached an appropriate clinical judgment on the basis of the evidence of Mr Stickle's presentation on the day.

[208] I also accept Mr Scott's submissions to the effect that psychiatry is a difficult and complex field with scope for differences of opinion and that some conditions are not treatable; and that the fact that two psychiatrists differ in their opinion or treatment does not mean that one or other of them is wrong

[209] I am satisfied that there were no reasonable precautions which could have been taken by any of the psychiatrists involved in Mr Stickle's case whereby his death might have been avoided.

[210] I am satisfied that there were no defects in any system of work on the part of any of them or on the part of Grampian Health Board which contributed to Mr Stickle's death.

9. Determination

[211] I accordingly make the following determination in terms of Section 6 of the Fatal Accidents and Sudden Deaths (Scotland) Act 1976 :-

1. Dylan Brian Evans Stickle, born 17th October 1981 died in a cell in HM Prison, Craiginches, Aberdeen between 2125 hours on Thursday, 26th October and 0700 hours on Friday, 27th October 2006.

1. The cause of death was suicide by hanging. Mr Stickle committed suicide by means of a ligature made from bedding in his cell and attached to bars of the window in his cell.

2. **Reasonable precautions** whereby Mr Stickle's death might have been avoided

2.1 A reasonable precaution whereby the death might have been avoided would have been the assessment of Mr Stickle on his reception into prison on 23rd October at 18.40 as being "at risk" of suicide or self harm and him being placed under the Scottish Prison Service suicide prevention strategy of the Act 2 Care regime (ACT) in order that his risk be managed in terms of that regime.

2.2 A reasonable precaution whereby Mr Stickle might have been assessed as being "at risk" and therefore placed under the ACT regime would have been for the prison officer assessing him for reception into prison to have given proper attention to the information contained in the documentation before him. In particular he should have given more attention than he did to (a) the PR2 record showing Mr Stickle's previous prison history including the outline of his history under ACT) and (b) to the Personal Escort Record (PER) showing that Mr Stickle

had recently attempted suicide and that he had been under a strict monitoring regime while in the custody of Reliance Custodial Services. Had he done so he would have assessed Mr Stickle as "At Risk" for the purposes of the ACT strategy.

2.3 A reasonable precaution whereby Mr Stickle might have been assessed as being "at risk" and therefore placed under the ACT regime would have been for the prison nurse carrying out the health assessment for his reception into prison to have had available to her at that time the documents which she was required to have regard to for the purposes of assessing Mr Stickle for ACT purposes, namely the PR2 and PER documents. Had those documents been available to her she would have assessed as Mr Stickle "At risk" for the purposes of the ACT strategy.

2.4 A reasonable precaution whereby Mr Stickle might have been assessed as being "at risk" and therefore placed under the ACT regime would have been for the prison social work department to have communicated to the prison reception department and to the prison health department the information contained in the fax received from Mrs Whitelaw on 23rd October 2006 at about 14.15. This fax stated that following her interview of Mr Stickle that day Mrs Whitelaw considered Mr Stickle to be at risk of committing suicide or seriously harming himself. Had this information been available to the prison officer and nurse admitting Mr Stickle into prison it is likely that Mr Stickle each would have been assessed as "At Risk" for the purposes of the ACT strategy.

2.5 A reasonable precaution whereby Mr Stickle might have been assessed as being "at risk" and therefore placed under the ACT regime would have been for the prison social worker Miss Christine Hendry to have placed him on ACT in the light of her knowledge of him during his previous period in Craiginches prison and of his ACT history, of his apparent suicide attempt on 28th August 2006, of his behaviour following his release from prison on 13th October 2006 including his self harming on alcohol and heroin and of the information contained in Mrs Whitelaw's fax of 23rd October which was addressed to her.

4.Defects in the system of work which contributed to Mr Stickle's death.

4.1 The practice of the prison officer who admitted Mr Stickle into prison involved too great a reliance being placed on personal observation at the time of assessment and too little consideration being given to the documents which the ACT procedures required him to have regard to. This practice was not identified by supervisors.

4.2 The system for carrying out health assessments for the purposes of the ACT strategy was defective in that the nurse carrying out the health assessment of Mr Stickle needed in terms of the written procedures for the assessment (and for the assessment of all prisoners) to have access to his PR2 records which were stored on computer. These were not available to her because the computer terminal in her office could not be connected to the computer system. Accordingly she had no access to the records she was required to take into account in carrying out her assessment.

4.3 The system for carrying out health assessments for the purposes of the ACT strategy was defective in that the nurse carrying out the health assessment of Mr Stickle needed in terms of the written procedures for the assessment (and for the assessment of all prisoners) to consider the contents of his Prisoner Escort Record including the Record of Events. Either, as she said, she routinely did not have access to that document for any prisoner she assessed and had never seen a PER document, or she was carrying out health assessments without being aware of the importance within the ACT procedures of her having regard to the PER. Either way her health assessment of prisoners must routinely have been carried out without proper regard being had to that essential document and accordingly the system must have been operated in a defective manner.

10. Other relevant matters.

[212] I have indicated in para. [140] that I also consider that the ACT system in so far as it relates to the doctor's assessment could be improved in that potentially relevant information relating to a prisoner's risk of suicide or self harm is not made available to the examining doctor, in particular the prisoner's PER and additional information provided for ACT purposes such as social work or procurator fiscal letters. I realise that the doctor's ACT risk assessment is but a part of a general health assessment but recommend that consideration be given to making the PER together with any accompanying information relevant to the issue of suicide or self harm (such as social work department or procurator fiscal letters) available to the examining doctor at least in cases where any of the documents discloses any concern on the part of any other person as to the risk of suicide, or discloses a recent event of attempted suicide or self harm.