INQUIRY UNDER THE FATAL ACCIDENTS AND INQUIRY (SCOTLAND) ACT INTO THE SUDDEN DEATH OF MAIRI TAYLOR

SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE

Determination by Andrew MacInnes Cubie, Solicitor Advocate,

Sheriff of the Sheriffdom of Tayside Central and Fife at Stirling

of an inquiry held at Stirling on 28th, 29th,30th and 31st August and 1st September and 3rd October 2006

into the death of Mairi Taylor,

Stirling, 12th day of October 2006.

The Sheriff, having considered all of the evidence, determines:-

1. In terms of Section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 that Mairi Taylor, born 20th October 1983 died on 13th October 2004 at 14:29 hours at Stirling Royal Infirmary as the consequence of hanging herself in her cell at Unit 3/6, Skye House, HMP Cornton Vale, Stirling between the hours of 22:35 and 22:45 on 9th October 2004.

2. In terms of section 6(1) (b) of the said act, the cause of Mairi Taylor's death was hypoxic brain injury due to cardiac arrest due to attempted hanging.

3. There are no reasonable precautions whereby the death may have been avoided in terms of s6(1) (c) of the Act.

4. There were no defects in the system or systems of working which contributed to the death in terms of s 6 (1) (d) of the Act

Parties Represented at the Inquiry

Evidence was presented on behalf of the Procurator Fiscal by Mrs Aileen Gordon. Mr RM Thompson, Advocate appeared for the Scottish Ambulance Service. Miss Bennie, Solicitor, Glasgow appeared for the Prison Officers' Association Scotland serving prison officers and members of that association, although on two occasions her colleague Mr Hay stood in for her. Ms Ennis, Advocate appeared for the Scottish Prison Service. Mr Steven Taylor, brother of the deceased, represented himself.

Mr Brian Taylor, another of the deceased's brothers had proposed to be a party to the proceeding and was represented by Mr Forbes, Solicitor, Ayr. However, Brian Taylor did not appear at the first day of the Inquiry and Mr Forbes could not make contact with him and withdrew from acting. I acknowledge my debt to all parties for their assistance in the preparation of and lodging of a joint minute of admissions. Mr

Forbes helpfully assisted in relation to the first of these in respect of which he was satisfied that he had a mandate in respect of both Steven and Brian Taylor.

Legal Framework

The Fatal Accident and Sudden deaths Inquiry (Scotland) Act 1976 provides that a public inquiry should be held into the death of any person held in legal custody. The purpose of the Inquiry is for the Sheriff to make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction- (a) Where and when the death and any accident resulting in the death took place; (b) The cause or causes of such death and any accident resulting in the death; (c) The reasonable precautions, if any, whereby the death and any accident resulting in the death may have been avoided; (d) the defects, if any, in the system of working which contributed to the death or any accident resulting in the death; (e) any other facts which are relevant to the circumstances of the death (all in terms of Section 6(1) of the Act)

The Court proceeds on the basis of evidence placed before it and although described as an Inquiry, the Sheriff's powers do not go beyond making a determination in relation to the circumstances established to his satisfaction by evidence following upon investigation by the Procurator Fiscal and any other party if so advised.

Facts and Circumstance

History of Admissions and 'ACT' record

The Scottish Prison Service has a suicide Risk Management Strategy known as the ACT strategy to provide a framework for the care of those at risk of self-harm or suicide. All prison officers who gave evidence together with Dr Sayers and Dr Howie are trained in and familiar with the ACT strategy. The strategy is to identify prisoners who are more likely to harm themselves, any trigger or event which might make self harm or suicide more likely and to recognise the signs, both verbal and non-verbal which might indicate a risk of self-harm or suicide.

Mairi had been admitted to Cornton Vale on a number of occasions. Crown production no 17 was a record of her supervision under the ACT care scheme. She was subject to such supervision from 12th June 2003; supervision proceeded at various levels until 24th June 2003 on which date it was closed (crown production 17 p23).

Mairi was next placed on the ACT strategy in December 2003. This was a result of her being given a sentence of detention at court. She equivocated about whether she felt suicidal or not and was accordingly placed on ACT under the high risk 15 minute supervision. This ACT was closed on 9th December 2003. She was readmitted to the ACT strategy on 6th January 2004 following a self-inflicted laceration to her forearm and Mairi's own admission of psychological distress. She was removed from this regime on 10th January 2004 when Mairi was transferred back to Younger House.

I have no doubt, having read the full text, that Mairi was subject to appropriate levels of supervision involving constructive input during her previous admissions to Cornton Vale and it is clear that the concerns that Mairi predominantly presented with were of deliberate self-harm rather than suicidal ideation. In each case there was a particular trigger.

Mairi's admission on 1st October 2004

Mairi appeared in Airdire Sheriff Court on 1st October 2004 at which time dates were assigned for intermediate diet and trial diet. She was remanded to HM Prison Cornton Vale. On admission she was seen by a Prison Officer (Younie) with whom she was familiar. She was noted to be in good spirits. The narrative (Crown Production No.4C) states 'never causes any problems'. On reception she was seen, as is customary, by a nurse who noted in the admission notes 'neither any suicidal intent/ideation on admission tonight.' (Crown Production 3, p7) . She was seen by Dr Howie the following day. No concerns were expressed by any of these experienced personnel.

3rd October

On 3rd October 2004 it was noted (Crown Production 4C) 'settled in and knows the regime. Has been quite and polite so far.'

4th October

On 4th October 2004 Mairi was alleged to have bullied and then, in a separate incident, assaulted another inmate in the cinema. The assault was captured on close-circuit television. The incidents gave rise to two separate consequences for Mairi. So far as the canteen incident was concerned, she was taken before Officer Gwynn Williams, a first line manager in terms of the anti-bullying strategy ("ABS"). The record of her appearance is Crown Production 4B. Mr Williams decided that there had been bullying , and of such an extent to justify moving straight onto the second level of ABS. The measures imposed on her were that she was inter alia located to a single cell, seven days in the cell, seven days no association or exercise, separately, seven days dining in room and no outside block activities. A review was due to take place in seven days. I will deal later in this determination with the ABS and way Mairi was dealt with in that regard. The ABS is designed to be a regime to mange the problem of bullying rather than as a discipline process.

So far as the allegation of assault was concerned, Mairi was sent to the "Orderly Room", where internal allegations of misconduct are dealt with, and internal discipline imposed. The inmate is required to receive at least two hours notice of the orderly room hearing. The hearing could not take place that evening, the assault having taken place at 1950 or so. A further date had to be fixed. In accordance with the ABS decision, Mairi was moved from her cell in Ross House to what is called the management suite, a self-contained unit of cells where supervision is easier and it is similarly easier to keep an inmate out of circulation. This is perceived by prisoners a punishment although it is sometimes effected for management reasons and sometime for risk management reasons (i.e. risk to the prisoner) as well as for punishment. One of the consequences of being kept out of circulation is that the

prisoner will lose her electrical power in the cell ("EPIC"), so that there is no incentive for a prisoner to spend all day in her cell watching television.

5th October

On 5th October 2004, despite Mairi being out of circulation, she had contact with other prisoners as she was taken to Airdrie Sheriff Court to be sentenced. Sentence was deferred for 24 hours in order that the appropriate Sheriff could preside.

6th October

On 6th October 2004, Mairi was again away from Cornton Vale for the day to be sentenced. These trips to court had the effect of ameliorating the effect of the ABS regime. When Mairi returned on the 6th October, she was a convicted prisoner, which meant she moved from Ross House to Skye House. Although the regime from the ABS disposal should have followed her, it was clear that she had some qualified contact with other inmates.

7th October

On 7th October 2004, the orderly room hearing was convened in respect of the allegation of assault from 4th October. The decision was that the police be involved and to take Mairi out of circulation whilst the police investigated the assault. This arose principally because of the availability of close circuit television and the need for all assaults to be dealt with and to be seen to be dealt with given the effect on prison order and discipline.

Mairi was unhappy and angry with that decision. She was taken from the orderly room to her cell in the management suite. Almost immediately on being locked in to her cell, she smashed up the television and damaged a chair. This was reported as misconduct. This may or may not have been affected by her loss of electric power in her cell.

8th October

As a result of the vandalism to the television, she appeared again at an orderly room hearing on 8th October 2004 where she admitted that misconduct and was penalised by the removal of three days recreation privilege and five days prisoner personal cash privileges (preventing her from uplifting any of her own cash to buy canteen goods.) She was deemed by all who saw her to have accepted that disposal and she asked the prisoner officer (Stuart Robertson) if she could have a television. Mr Robertson, in Mairi's presence, spoke to Kenina Murchison and who agreed, in what appeared to be a light-hearted exchange, that a television would be provided to her. Mairi was apparently pleased at the agreement to return the television.

9th October 2004

Mairi was in theory out of circulation in terms of both the ABS strategy and the orderly room from 7th October. However, as noted already, she was in Skye House

in a cell in one of the blocks rather than the management suite and appeared to have a slightly more relaxed regime than might have been anticipated.

Nothing that happened during the course of 9th October appeared to have drawn Mairi to the attentions of the prison staff; there was certainly no record in either the narrative or medical records until the tragic events of the later evening.

The prison operates a night sanitation policy whereby prisoners can press a buzzer in their cell to be allowed out to the toilet. Only one prisoner is allowed out at a time. The prisoner's door is opened remotely and a period of seven minutes is allowed for the use of the toilet facilities. An alarm goes of if the door has not been reclosed. It is not uncommon for prisoners to stay out of their cell to the maximum permissible limit. Some girls will use the opportunity to chat with other inmates through the doors of their cells or indeed to take showers or baths. The alarm generated by a late return from night sanitation does not normally of itself cause concern to the officers on duty.

At about 10.35 or thereby, Mairi pressed the button in her cell, seeking to use the night sanitation facilities. The girls are allowed a period of seven minutes to return to the cell and shut the cell door over before the alarm goes off.

Unfortunately the dot matrix printer which should have recorded the movements was jammed for period in question but it can be reasonably assessed that she made such a request at about 10.35pm.An alarm went in the central control room to reflect that she had not reclosed the cell door. Prison Officers Doig and Gray were on duty in the Control Centre. They asked her to return to her cell by way of an intercom both in the corridor of Skye House block 3 and in the individual cell. There was no response and indeed no sound. It is customary for prison officers, in these circumstances, to hear either the sound of a shower running, or water running, or chatting amongst the inmate who is out her cell and other prisoners. They heard nothing and this caused alarm, in particular to prison officer Doig who very quickly determined to visit Skye House as she was concerned about the silence. She described it as 'eerily silent'. In order to obtain access to Skye House it is necessary for a prison officer to break a sealed packet of keys. Each sealed packet consists of a plastic purse-type bag with an upper zip and a seal. The seal is to be broken to allow access to the keys and each seal is numbered so that there is a record of which pack of keys is broken. The breaking of a sealed pack involved paperwork and administration and is not something done lightly.

Prison Officer Gray continued to try to raise Mairi by way of intercom while Prison Officer Doig made her way to Skye House. She was there in less than a minute. This involved her opening three separate doors, two of which she locked behind her. She saw what she thought was a ligature tied to the door handle of the cell. She called on her open radio frequency a 'code blue'. This is a code invoked when a person has difficulty breathing and is associated with, although not restricted to, instances of hanging or attempted hanging. The code blue call caused the prison officer at the gate to call the ambulance service. In the meantime PO Doig tried to lift Mairi's body down, but required the help of P O Ligget to do so. They commenced "by-stander" CPR within two minutes of the discovery

I do not regard the discrepancies between the evidence of Officers Doig and Gray to be material in the context of the overall reaction, but I should express the view that I preferred the evidence of Miss Grey, for the reasons suggested by Mr Thomson. She had completed the log, if not contemporaneously, at least very soon after. She had no reason to protract the time involved, and would have expected the printer to have confirmed the times of the various actions taken. I conclude that Miss Doig is less reliable and that an element of hindsight caused her to be mistaken in her recollection about the time taken to react. In the event I am satisfied that within four minutes or so of the night sanitation alarm sounding, the key pack had been broken and Skye House accessed. The reaction time was proportionate and reasonable.

Scottish Ambulance Service response

The telephone call from Cornton Vale was made at 20.50. The call went to the dispatch depot in Oxgangs, Edinburgh which is the depot with responsibility for Stirling. Crown Production 15 is the "screen Dump" record of the call and the response of the Ambulance Service. That shows the call being answered at 10.51:06. If any caller has to wait for too long for an answer at Oxgangs, the call will automatically be re-routed, first to Paisley and then to Inverness so that the ambulance dispatch is not held up. The fact that the call was answered at the Edinburgh centre confirms that it was answered within a minute or so; I did not accept Prison officer Doyle's evidenc ehtta there was an appreciable delay in the call being answered. As Mr Thomson observed, the tape recording of the call did not give an impression of either urgency, nor of someone who had been kept waiting. The telephone call was taken by Claire Riley, an operator. The dispatcher for the area was Ian Lang. He was on another call and accordingly when the details of the call were first logged, the dispatch room supervisor, Caterina Rinaldi, began to deal with the dispatch. As I understood the position from the evidence, whilst the call went on between Claire Riley and prison officer Boyle, the computer screen, then being viewed both by Claire Riley and Caterina Rinaldi, was continually refreshed with information.

Having ascertained that there was an emergency at Cornton Vale, Miss Rinaldi interrogated the computer in relation to the nearest resources. The two nearest vehicles were an accident and emergency Ambulance (AEA) with paramedic and ambulance technician and a rapid response unit (RRU) with one paramedic. The Rapid Response Unit has no facilities to transport patients to hospital. Miss Rinaldi decided that the ambulance which was then mobile and had an estimated response time of seven minutes was the preferred option. Although the Rapid Response Vehicle was nearer as it was at the Scottish Ambulance base in Stirling, it was not mobile. A text was sent to the ambulance at 22.51.51 advising them of a cardiac arrest at Cornton Vale prison. At 22.52.18, the ambulance service received confirmation that the ambulance was mobile. This is done by way of a signal through the phone but does not involve direct contact. At 22.57.56, the ambulance confirmed its arrival at the scene by which time further information had been relayed to the screen in the ambulance. It would have taken approximately one minute for the ambulance men to have reached Mairi Taylor. They determined that they reached her no later than 10.59.

In the meantime, prison officers Doig and Leggatt had been administering bystander CPR. There had been no vital signs from Mairi since she had been lifted down from the door. The ambulance crew took over. Mairi was intubated. Her airways were clear and they continued CPR. A defibulator was attached; it advised that no shock should be administered on the basis that there was no electrical activity in the heart. Paramedic Gale administered Epinephrine whilst they continued to administer CPR. At 2311, the ambulance notes record the return of circulation. There was no spontaneous respiration and they required to continue to ventilate Mairi. She was removed from the prison to the ambulance after applying a cervical collar, putting her on the stretcher to minimise the risk of any spinal damage and was thereafter taken to Stirling Royal Infirmary where she was admitted.

At 23:01:13 the ambulance crew had asked for assistance, if available, although the ambulance crew continued to act as though they would have to deal with the situation on their own. At 23.02.32, the rapid response unit was called. The paramedic on that was Rod Moore who had left the ambulance station within one minute of being asked to. He confirmed that at 23.02.54 he was mobile. He arrived on the scene at 23.05.11. He deponed that circulation had returned by the time he arrived but I think that must be an error standing the times of the ambulance crew. Mr Moore, of all the witnesses was the one most critical of the ambulance service. Mr Thomson took some time in his submissions to dissect Mr Moore's evidence with a view to demonstrating that he could not be relied upon.

It was clear that Mr Moore's assessment was predicated upon wrong information, i.e. that his journey was materially quicker than the ambulance. Even when corrected he maintained that his earlier arrival might have made a difference. I noted as he gave evidence that he was somewhat dogmatic and slightly melodramatic. I consider that there is force in Mr Thomson's criticism of Mr Moore's assessment of the situation and I preferred the other evidence in relation to the choice of vehicle to attend, the timescales in traveling and the important evidence of Mr Tullett, the Accident and Emergency consultant who gave expert evidence that no earlier attendance than the Ambulance would have made any difference. No different allocation of vehicle should have been made. The choice of the mobile ambulance was intelligible, justified and reasonable.

Admission to Stirling Royal Infirmary

Mairi never regained consciousness, nor the ability to breath spontaneously. She remained respirited during the whole course of her time in SRI. There were some attempts to respirate, but none that were sustainable without assistance. In addition she experienced fitting, which were identified as being muscle spasms or cyclonic fits rather than brain activity. These were treated with anti convulsants. An EEG and her clinical status disclosed a very low brain function. Her poor neurological condition arose from two reasons; her hanging caused a lack of oxygen to her organs, and she suffered a cardiac arrest whereby the deprivation of blood caused further damage to her organs, most significantly her brain.

She showed no signs of improvement in the 72 hours after her admission; it was clear that she would not recover. Further treatment was futile. Life support was

withdrawn at 14.15 hours on the 13th October 2004. She was pronounced dead at 14.29. Her grandmother was with her when she died.

Aftermath of Death

Mairi had obviously left belongings in Cornton Vale. It appeared from the evidence that some of her belongings had been left in a black plastic bag in an office in Ross House. Although inmates are not supposed to do so, many will leave their belongings in a black plastic bag if they anticipate, for example, receiving a sentence of detention rather than liberation. It appears that Mairi may have expected to have received a sentence on 5th or 6th October and had packed up her belongings with a view to a return to Skye House.

Whatever the reason, these belongings included some letters. In addition, letters were retrieved from her cell. These are contained in Crown Productions 7, 8 and 9. Two of the letters make reference to potential for self-harm or even suicide. No prison officer or other member of staff had seen such a letter. They had not been posted to the recipients. Whilst they may have given some indication of a concern that would have invoked the ACT regime, I accept evidence (from Kenny McGeachie) that these were not, in terms, suicide notes and did not anticipate an attempt on her own life. Mr McGeachie's evidence was that suicide notes, of which he had seen a few, tend to express regret to the people who are left and have some element of conclusion and tying up loose ends. None of the letters could be construed in that way. They perhaps identified the accumulation of pressures that preyed on Mairi but, if anything, they demonstrate the difficulties that the regime at Cornton Vale were under in trying to identify which prisoners are the most susceptible to thoughts of self-harm or suicide.

One point is worth recording; it was clear from the evidence of prison staff from prison officers up to the level of Governor herself that the Act to Care strategy is to some extent a double-edged sword; it would reduce incidents of self-harm and possibly suicide to have every prisoner on a regime of scrutiny. However, each prisoner who is on that will suffer from isolation, loss of self-respect, loss of community and an exacerbation of some of the boredom and lack of stimulation that is part and parcel of prison life, however sympathetic the regime. It is accordingly not enough to assert that any prisoner who may seem to have the potential to be at risk be placed on supervision as it undermines the very valid attempts to treat each inmate as an individual and susceptible to different stresses and encouragements.

As a consequence of the death, a report was prepared by the National Suicide Risk Group. In this particular case it was prepared by Kenny McGeachie and Angela Morgan. (Crown Production13) The report is an attempt to address, on a paper review only basis and within a relatively short timetable any immediate lessons that can be learned from the death in custody. The case review was complimentary about the care which was received by Mairi Taylor and the management of her whilst in prison. It emphasized that her difficulties were recognised and identified and taken into account in the ongoing assessment of her status. There is a mild criticism of the anti-bullying strategy. Again, I will deal with this later but I should record that I do think that there is some force in Miss Brook's evidence that the ABS was not properly put in context when assessed as a contributor towards Mairi's death.

There is reference to the suicide note although Mr McGeachie, as I have noted earlier, confirmed that he would not characterize any of the letters as suicide notes. The conclusions reached by the authors (para 4.3) are prescient. I accept the submission from Miss Ennis that even with the benefit of hindsight, there was no criticism in this report of the regime of care generally and relating to Mairi particularly

Even before receipt of the report and indeed before Mairi's death, the Governor at Cornton Vale had looked at ways of implementing the anti-bullying strategy. As is often the case, individual prisons are constrained by the fact that a number of policies are national policies (such as the Act to Care and the anti-bullying strategy) giving limited room for manoeuvre even if these policies are seen to have imperfections. However, it appropriate to record the current initiative to tackle bullying and violence at HMP Cornton Vale.

These are contained within Crown Production 22 and include inter alia restorative practices, bullying courses and implementation of new Rule 80 paperwork whereby there is an attempt to manage bullying rather than discipline the perpetrators. The new paperwork is described by Miss Brooks as much more robust. Practical measures included the installation of close circuit television in Skye House and a new recording system in the central control room which means that all night sanitation activity is recorded other than by way of the printer which failed on the evening of 9th October. All of these are to be commended and welcomed.

The Anti-Bullying Strategy

The sanctions imposed by Gwynn Williams were the subject of some comment during the course of the inquiry; essentially, the Procurator Fiscal Depute put in issue whether is was appropriate that someone at the level of first line manager had the apparent power to impose a greater sanction than the Governor. The anti-bullying strategy appeared to allow sanction of up to seven days out of circulation whereas both the Rule 80 and Rule 95 breach of discipline sanction was for a maximum of 72 hours before renewal and such renewal may require the approval of the Scottish Ministers if not sought timeously. However, with one exception, all prison staff considered that the sanction imposed by Gwynn Williams fell within the range of reasonable responses to Mairi Taylor's bullying. Not every officer would necessarily have imposed the full range of sanctions which Mr Williams did, but all accepted his power to do so. The one exception was the Governor herself, Sue Brooks, who felt that he had exceeded his powers. However, when it was put to her in cross examination by Miss Bennie that the anti-bullying strategy appeared to anticipate the power to impose a seven-day regime (and on one view did not allow any discretion to deviate from seven days) she accepted that this was how the matter may have been interpreted, not only by Mr Williams but by other members of staff.

It was for that reason that she preferred the more robust rule 80 approach. She was able to point to some aspects of the anti-bullying strategy which were unhappily phrased and which gave rise to the lack of clarity about the precise sanctions that could be imposed. That is a national strategy that cannot be departed from by any individual institution, but it is clear that the anti-bullying strategy might benefit from a review which can incorporate inter alia restorative justice, but that is a matter outwith the scope of this enquiry.

Submissions of Parties

I heard very helpful submissions from all except Mr Taylor. Ms Ennis had helpfully prepared written submissions. I hope that it is not a discourtesy to parties not to rehearse these submissions in detail; some elements have been referred to in the course of my factual narrative. Essentially all parties urged me to make formal findings only on the basis that there was nothing in the evidence which showed that there were any reasonable precautions which may have avoided the death, nor any defects in the system which may have contributed to the death.

Whilst it is open to the court to set out "any other facts...relevant to the circumstances of the death (Section 6(1)(e) of the Act) I agree with Mr Thomson (although he addressed only those issues affecting the Scottish Ambulance Service) that there was an insufficiency of evidence to allow more wide ranging findings. I am thinking of matters such as, for example, the criteria for dispatching emergency vehicles, or the Anti-bullying strategy.

Mrs Gordon addressed me first and her position was that the only the matter which might give rise to recommendation was the level of care offered, particularly whether Mairi Taylor should have been subject of special observation. In practical terms if anti-ligature conditions had applied at the time of death, it may have made a difference. There was evidence that self-harm was a coping mechanism and not necessarily an indication of suicidal ideation. In her submission, the ABS regime could not possibly be looked at in isolation as it was not the only issue she was dealing with. It was clear from the letters that were found that she was unhappy in prison, she had drug, alcohol and other problems, and she had tried to avoid a further sentence. There were a number of issues, none of which individually would have caused concern to SPS staff, and even cumulatively had not caused a number of experienced staff to invoke the ACT regime. Whilst the extent of Mairi's problems may point to someone vulnerable, she was one of a number of inmates who shared similar backgrounds, addictions, problems and concerns, all of whom were dealt with by a sympathetic regime. She could not identify any trigger which should have alerted a member of staff to Mairi Taylor being at a higher risk and she accordingly invited me to make a formal determination.

Mr Steven Taylor did not wish to make any submissions.

Miss Ennis for the Scottish Prison Service very helpfully had prepared written submissions. I hope that it will not be thought a discourtesy not to record these submissions in their entirety in the context of this note. So far as the Scottish Prison Service were concerned she submitted that each of the Prison Officers who gave evidence did her or her best to recall events as accurately as possible and provide assistance to the inquiry although the lapse of time and difference in emphasis in recollection give rise to different accounts. She submitted that however chaotic Miss Taylor's life, her's was unremarkable. The staff at Cornton Vale were trained in the ACT to care strategy. In addition, there was provision for psychiatric services with a mental health nurse and comprehensive assessment on admission. Anyone within the prison community could activate the ACT strategy, including prisoners. It was a clear and well-understood system for providing care to those judged to be in need of it.

All the staff who gave evidence were experienced staff. She emphasised that no one who saw Miss Taylor on her admission on 1st October expressed any concern.

So far as the timing on 9th October was concerned, she urged me to accept Miss Doig's evidence that would make the delay between night sanitation alarm going off and Miss Doig reaching Miss Taylor to be three minutes. She asked me to prefer that evidence to that of Miss Roselli and Miss Gray.

In her submission, however long a period had elapsed, as there is no suggestion of an unreasonable delay in investigating the failed return from night sanitation, nor in the bystander CPR carried out, she described the efforts to recover the situation and revive Miss Taylor's life as excellent although ultimately ineffective. In her submission, no one in whom her care had been entrusted could have prevented her efforts to take her own life.

She invited me to make formal determinations in respect of Section 6(1)(a&b) only, and to make no determinations in relation to the discretionary matter.

Miss Bennie was unable to attend the submissions, due I understand toi ill health but had prepared submissions which were given by Mr Hay.

Mr Hay associated himself with the submissions MADE BY Miss Ennis and similarly invited me to restrict myself to the formal findings in terms of Section 6(1)(a) and 6(1)(b). He emphasised that at her admission on 1st October 2004, Miss Taylor was seen by a Prison Officer and a nurse and within 24 hours by a doctor, none of whom had any concerns in relation to Act to care policy. He submitted that the punishment/ anti-bullying regime upon which she had been placed had effectively ended prior to 9th October, having been undermined by the trips to Airdrie Sheriff Court and, in his view, effectively removed as at 9th October. He indicated that the Court should prefer evidence of Carol Gray; in any event, the reaction to the night sanitation alarm was within a reasonable timescale.

So far as the ABS strategy was concerned, he said that there should be no criticism of Mr Gwynn Williams, on the basis that the scheme appeared to indicate that there was a period of one week before there was a review. He submitted thatit was clear form the evidence that there was no indication at all to the many experienced and properly trained professionals with whom she had contact that there was any cause for concern, in particular any risk of suicide. In his submission any determination should be restricted to formal findings.

Mr Thompson made submissions on behalf of the Scottish Ambulance Service. These were separated into four chapters: (1) Facts prior to the SAS involvement which might be seen as having potential relevance; (2) The allocation of ambulance resources to the case and the attendance and care provided; (3) Whether a different allocation would have made a difference; (4) Whether a different allocation should have been made.

He began by submitting that all witnesses who gave evidence were broadly reliable and credible, although there were some exceptions that he proposed to touch upon.

So far as the situation before the ambulance service was concerned, he invited me to disregard the evidence of Mrs Doig and prefer that of Miss Gray, supported by Miss Roselli. In his submission, it was much more likely that there was a delay of five minutes rather than the two or three minutes asserted by Mrs Doig.

When looking at the frequency of alarms going off, there was no reason for an immediate suspicion. Prisoners cannot escape from the night sanitation area, they could not interact with other prisoners and it was a far from an uncommon situation. He said that Miss Gray's evidence was to be preferred. There was no benefit in her protracting the timescale. The other matter which supported this construction was that at the time Miss Gray filled in the form, she would not have known that the dot matrix printer was not working and expected independent confirmation. For these reasons a five minute delay at a minimum was much more likely.

He made very full and careful submissions in relation to the timing of the ambulance service's involvement. It is not necessary to rehearse these in detail as I have indicated the matters which I accept. The Ambulance Service received a phone call at 22.51.06. In his submission, there was no material delay in the call being answered. The allocation of the accident and emergency ambulance was a judgement call made by an experienced supervisor who looked at what vehicles were available to her before assessing that the ambulance was best placed. This was partly based on the fact that the RRU was on a break. The decision was sensible and rational. In his submission, the biggest difference between the journey time of the two vehicles was two minutes 19 seconds i.e. that was the time at which the rapid response unit could possibly have been there before the ambulance.

It was not clear what Mr Moore did. The only evidence which seemed the support the view that the RRU would have made a difference to the chances of survival was Mr Moore. For a number of reasons he invited me to disregard that evidence. In his submission there was no evidence to show that a different ambulance would have made a difference. Accordingly there was no requirement to consider whether a different ambulance should have been sent. I have addressed these submissions in the factual narrative.

Conclusion

I express my sympathies to Mairi's family and friends. I am satisfied that the regime at Cornton Vale had a system well recognised by all staff, and effective in its application for identifying vulnerable prisoners. The harsh reality is that to a greater or lesser extent all prisoners are vulnerable. Mairi's actions on the evening of 9th October could not be anticipated, even with the benefit of hindsight. All those involved strived to have assistance to her as quickly as possible, but to no avail.

I am very grateful to those who conducted enquiry for their efforts.

I have undernoted a list of witnesses who gave evidence directly or indirectly.

Sheriff Of Tayside Central and Fife at Stirling

The following witnesses gave evidence during the enquiry :-

Julian Stevenson, Security and Intelligence Liaison Manager, HMP Cornton Vale.

Dr Craig Sayers, Prison Medical Officer, HMP Cornton Vale.

Yvonne Harrison, Practitioner Nurse, HMP Cornton Vale.

Glyn Williams, Retired Prison Officer.

Mrs Kenina Murchiston, Prison Officer, HMP Cornton Vale.

Philip Kennedy, Prison Officer, HMP Cornton Vale.

Jan Clark, HMP Cornton Vale.

John Stuart Robertson, Prison Officer, HMP Cornton Vale.

Alastair Howie, Consultant Physician, Stirling Royal Infirmary.

Sharon Shaw, Prison Officer, HMP Cornton Vale.

Maureen Doig, Prison Officer, HMP Cornton Vale.

Pamela Ligget, Prison Officer, HMP Cornton Vale.

Duncan Nicol, Police Officer, Stirling.

Carol Gray, Prison Officer, HMP Cornton Vale.

Mark Boyle, Prison Officer, HMP Cornton Vale.

Lorna Weir, Prison Officer, HMP Cornton Vale.

David Gale, Paramedic, Scottish Ambulance Service, Stirling.

Neil Reid, Ambulance Technician, Scottish Ambulance Service, Stirling.

Rodney Moore, Paramedic, Scottish Ambulance Service, Stirling.

Caterina Rinaldi, Supervisor, Scottish Ambulance Service, Edinburgh.

Ian Lang, Dispatcher, Scottish Ambulance Service, Edinburgh.

Isabella Younie, Prison Officer, HMP Cornton Vale.

Paul Rollo, Detective Constable, CID, Stirling.

Kenneth McGeachie, National Suicide Risk Group Co-ordinator, SPS, Calton House, Edinburgh.

Angela Morgan, Families Outside, 19a Albany St, Edinburgh.

Susan Brookes, Governor, HMP Cornton Vale.

Affidavit evidence was provided by the following :-

Dr Torquil MacLeod, Consultant Pathologist, Stirling Royal Infirmary

Dr Christopher Cairns, Consultant, ICU, Stirling Royal Infirmary

A police statement was read out from the following :-

Natalie Roselli, former prisoner HMP Cornton Vale