

SHERIFFDOM of TAYSIDE CENTRAL and FIFE at PERTH

DETERMINATION

by

LINDSAY DAVID ROBERTSON FOULIS, Esquire, Sheriff of the Sheriffdom of Tayside Central and Fife at Perth following an INQUIRY held at Perth on 20th and 21st October and 2nd December 2014 into the death of Steven Taylor

PERTH, 26th February 2015. The Sheriff, having considered all the evidence adduced, Determines:-

1. In terms of Section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, that Steven Taylor died on 27th December 2011 at 8am within cell B18 at H M Prison, 3, Edinburgh Road, Perth.
2. In terms of Section 6(1)(b) of the said Act, that the cause of his death was suspension from his neck by a knotted bed sheet used as a ligature tied to the upper frame of a bunk bed within said cell.
3. In terms of Section 6(1)(e) of the said Act, that the vulnerability assessment form completed by police custody security officers in respect of persons held in police custody should accompany such persons in addition to the Personal Escort Record.
4. In terms of Section 6(1)(e) of the said Act, that investigation should be carried out by the Scottish Prison Service into the establishment of an effective system whereby any concerns which may be held by persons visiting prisoners as to the wellbeing of prisoners, including concerns of self harm and suicide, can be brought to the attention of the appropriate prison staff.

5. In terms of section 6(1)(e) of the said Act, that such a system should include an effective method whereby visitors to the prison are made aware of the appropriate procedure to bring any such concerns for the wellbeing of prisoners to the attention of the appropriate prison staff.

NOTE

This Fatal Accident Inquiry into the death of Steven Taylor at H M Prison Perth on 27th December 2011 took place on 20th and 21st October 2014 when evidence was led from various witnesses led by the Crown. Thereafter the Inquiry was adjourned until 2nd December 2014 when parties made their submissions. Those parties, who were legally represented, provided their submissions in writing and these are appended to this note. I have noted in the body of this note any additional oral submissions made on 2nd December 2014. Mr Neil Taylor, the father of the deceased, represented himself and addressed me orally on that date. Miss Ross, Procurator Fiscal depute, presented the case for the Crown. The other parties represented were the Chief Constable of Tayside Police, now Police Scotland, Tayside Health Board, and the Scottish Prison Service. These parties were represented by Mr Reid, solicitor, Glasgow, M/s Devaney, advocate, Edinburgh, and Mr Burton, solicitor, Edinburgh respectively.

Evidence was led solely by the Crown. In addition to leading evidence from Mr Neil Taylor, the Crown called his wife, Mrs Helen Taylor, Messrs James Watt, George Stewart, Michael Keith, Derek McKeown, Gary Maxwell, Andrew Agnew, Adam Trotter, and Andrew Millar, M/s Mary Duffus and Lesley McDowall, and Doctor Peter Kay. The evidence of Mr Graham Whyte who performed the post mortem on the deceased was presented in affidavit. In considering the evidence led, there was not much that was actually in dispute. There was only one factual matter of some significance which, in my opinion, had to be determined, namely whether an expression of concern was passed by Mr McKeown to Prison officer Maxwell on 21st December 2011. I shall deal with this matter in due course but I firstly shall set out facts which I consider are

established as they are important when ultimately considering the submissions made on behalf of parties and the provisions of section 6(1) of the 1976 Act.

The deceased, Mr Stephen Taylor, sadly was a thirty six year old male with a lengthy criminal record. He had significant drug issues. He was arrested on 7th December 2011. In the months before his arrest, his parents had concerns as to his mental and physical health. His father told the deceased he should see his doctor. An appointment was made but the deceased did not attend. The deceased had concerns about his relationship with his girlfriend. He had been admitted to hospital as a result of developing an abscess in his groin from injecting an ecstasy tablet. When he was in hospital, the deceased called his mother sobbing and saying that he shouldn't be here and that no one listened to him. He mentioned the bad things he had done. She had not heard him sob in that way before. After his release from prison, he had been provided accommodation at a scatter flat. He was drinking. On occasions when his father visited the deceased was not present. He had issues with his benefit.

The deceased was arrested on 7th December 2011 at Queen Margaret Hospital, Dunfermline in relation to a contravention of section 38 of the Criminal Justice and Licensing (Scotland) Act 2010. This involved him shouting and swearing and pulling a needle from his arm causing blood to spray. He arrived in police custody at 9.50pm. He was assessed by James Watt, the police custody security officer, as constituting a high risk after the vulnerability assessment was carried out. The assessment involved the deceased being asked thirteen questions. He was also assessed as being a special risk. The relevant responses to the questions in this assessment confirmed the deceased had taken alcohol within the last twenty four hours, was dependent on drugs and in receipt of methadone, suffered drug withdrawal four to five years before, suffered from hepatitis C, and had previously suffered from depression and been given medication in jail. In answer to a question concerning suicide the deceased answered that he had suicidal thoughts at present and said 'If I was going to jail, yes I would.' These responses, the demeanour of the deceased, and the manner in which he answered the questions resulted in certain assessments being made. An assessment of special risk included threat to life and possible self harm. As a result of these assessments, the deceased was placed in an observation cell which had constant camera coverage. At the time there were less than a quarter of the cells at Dunfermline Police station with this camera coverage. He was given a blue anti rip suit to wear. The cycle of cell visits was reduced from one hour to thirty minutes. Within thirty minutes of his arriving in police custody the deceased was very tearful. When Mr Watt finished his shift at 11pm, he told his colleague,

Mr Bob Robinson, coming on duty of the risk assessment made and the comment referred to above. The deceased left police custody for court at 8.45am on 8th December 2011. Comments such as that noted are regularly made by persons in custody but not followed through by these persons.

On being passed to the escort for court, Mr Robinson completed a Personal Escort Record. This largely involves the ticking of boxes. The form as completed indicated that the deceased had issues regarding medical conditions, violence, drugs and alcohol, and suicide/self harm. A box for further information included entries the following 'HEP C, ABCESS ON GROIN, VIOLENT.' The indication of suicide/self harm does not require there to be a current risk. The information may come from the police national computer and may not be currently relevant. The vulnerability assessment which specified the comment made by the deceased does not accompany the prisoner. The Personal Escort Record accompanies a prisoner to prison if remanded.

The deceased pled guilty to the offence he faced on 8th December 2011 and was remanded in custody until 4th January 2012 pending the preparation of a criminal justice social work report. He was admitted to H M Prison Perth at 4pm on 8th December. Prison Officer Michael Watt carried out the first ACT 2 Care assessment of the deceased. He received the Personal Escort Record which had been completed by Mr Robinson. In the ACT 2 Care assessment form cues and clues as to the risk of self harm would include any stated intent of self harm, prior history, and an uncommunicative and non engaging attitude. Examples are set out in the form. Reference to stated intent could come not simply from the prisoner but also anyone else who had dealt with the prisoner such as escort staff. Officer Keith, in completing the first section of the assessment form, considered that there was no apparent risk of self harm. The deceased answered all questions in the negative. These included questions directed towards suicide and self harm. He was not displaying any adverse behaviour, with the exception of suffering from the effects of drink or drugs. In particular, he was not assessed as being disturbed or low in mood. Officer Keith noted specifically that, apart from methadone withdrawal, there were no issues. There were no suicidal or self harm thoughts. Prisoners could threaten self harm with no actual likelihood of such a threat being carried out. If he had been aware of the comment the deceased made in police custody, he would have questioned the deceased further and might have placed him on ACT 2 Care. The deceased was not down or tearful. He was aware and noted that the deceased had previously been on ACT 2 Care.

In terms of the ACT 2 Care procedure, the deceased was then seen by a prison nurse, M/s Mary Duffus. She recorded that the deceased had received treatment for mental health problems, psychological treatment, and had attempted self harm. He denied being suicidal or self harming. She noted that he had self harmed twelve years ago but had no issues at the time of interview. He evidenced good eye contact and communication. She assessed him as constituting no apparent risk. His urine sample tested positive for benzodiazepines, methadone, and opiates. A mental health referral was made as a result of his prior history and the previous suicide attempt. The referral was an alert as opposed to an in depth investigation.

The deceased was seen after 8th December for the administration of medicine twice daily. On these occasions he could have asked for help if desired at that time. He had not been prescribed medication for depression on admission. His behaviour caused no concerns. If she had been aware of the comment made in police custody, she may have initiated the ACT 2 Care procedure but there was nothing in the presentation of the deceased on 8th December to suggest that was necessary. She saw the Personal Escort Record. Prisoners can make comments to others which indicate a risk and when challenged respond that they were not serious.

On 9th December 2011 the deceased, in accordance with normal procedure, was seen by the prison doctor, Doctor Kay, and also the addictions nurse. Their purpose is to assess any medicinal requirements, psychiatric/psychological issues and generally to deal with any medical needs. Doctor Kay recorded the previous suicide attempt twelve years ago. However, he concluded that the deceased constituted no apparent risk of self harm. The deceased's history of recent medical care was poor. The deceased denied any recent attempts at self harm or any thought of suicide. He was communicative. There was nothing in his presentation to cause concerns. He had seen the Personal Escort Record and had questioned the issue regarding suicide and whether it was recent. If he had been aware of the comment made in police custody it would not have changed his assessment of the deceased although he would have questioned him about it. His assessment was independent of any prior assessment. The addictions nurse did not identify any risks or concerns as to the mental wellbeing of the deceased.

The ACT 2 Care procedure involves the investigation and assessment to which I have referred. Information from others such as police or escort officers is considered as is any prior history of self harm. The purpose is to obtain any indication of self harm on the part of the prisoner and to

assess the risk of such an act in custody. Accordingly, any remark made by a prisoner to others is relevant and the comment made by the deceased in police custody was not covered simply by highlighting suicide/self harm on the Personal Escort Record. If, after the admission assessment, a prisoner is put on ACT 2 Care, there is a case conference within twenty four hours. The persons carrying out these assessments consider the general demeanour of prisoners as comments can be at odds with their actions. If placed on ACT 2 Care, there were various measures which could be initiated. These included cell sharing, frequent observation, and anti ligature cells. The case conference involves the manager, nurse, and staff member who know the prisoner. If the prisoner is assessed as posing no risk of self harm, then he is paced in normal accommodation and no precautions are taken. In normal accommodation a prisoner can call for assistance by means of a buzzer or two way intercom. If subsequent concerns surface, anyone can initiate the ACT 2 Care procedure.

On the deceased being remanded in custody, neither parent visited him. The deceased spoke to his mother and asked her to speak to his social worker as he suffered from mood swings and wished help. She did contact his social worker and although unable to recall his name, it can be assumed that she spoke to Mr McKeown.

Mr Derek McKeown was a social worker with Fife Council. He was the social worker assigned to work with the deceased as a result of his being part of the Through Care Team which dealt with the supervision of prisoners in the community. The deceased's attendance at appointments was inconsistent. At an appointment around the beginning of November 2011 the deceased advised Mr McKeown that he was suffering from depression. At some point in discussion with Mr McKeown he raised issues of self harm and suicide. The deceased was advised to discuss matters with his general practitioner. Mr McKeown saw the deceased on 5th December. The deceased appeared emotional when discussing his relationship with his girlfriend and the effect his actions had on her care of her children. He perceived that there was a risk that the children might be taken into care as a consequence of his relationship with her. The deceased's actions observed by members of the social work department were inconsistent with his reported lifestyle. For example, he reported being isolated and depressed but was seen socialising immediately after reporting isolation. Mr McKeown saw the deceased's mother on 6th December to discuss the position of the deceased generally.

After the deceased was remanded on 8th December 2011 he wrote to Mr McKeown on 13th December 2011. He indicated that he was depressed about the situation in which he found himself and sought assistance from Mr McKeown. Mr McKeown met the deceased at H M Prison Perth on 21st December for the purpose of preparing the background report for court. During the meeting the deceased's mood swung from positive to despondent. He was persuaded to focus on the positives in his situation. Nonetheless Mr McKeown had concerns and when leaving told the prison officer Mr Gary Maxwell of these. He asked the officer to keep an eye on the deceased. The officer said he would notify hall staff of these remarks. In making these remarks, Mr McKeown did not anticipate suicide on the part of the deceased. Mr McKeown did not report his concerns to anyone in writing. He indicated that if he had concerns following the meeting on 21st December, he could pass information on to others in the social work department. There was no formal notification of the deceased's remark by social work to the prison authorities.

There was a discrepancy between Mr McKeown's recollection of the discussion with Mr Maxwell and that of the officer. I am satisfied the remark was made. If it had not been made, I can see no reason for the former saying that the comment was made. Further clear reference is made to the comment in a report from Mr McKeown dated 9th January 2012. This report was prepared less than a fortnight after the deceased took his life. Events would be fresh in the mind of Mr McKeown. Mr Maxwell was trying to recall events in evidence three years after they took place. It is also possible that after escorting Mr McKeown from the prison, Mr Maxwell's time was taken up with other matters and he simply forgot the remark having been made albeit in evidence he said if the remark had been made he would have acted upon it. Another less charitable explanation is that failure to act on such a remark was said to be potentially a disciplinary matter and his subsequent denial was self preservation.

On 26th December 2011 the deceased was locked up in his cell B18 for the evening in accordance with the normal practice. There was no indication that there was anything untoward with the deceased. When the cells were opened at 8am on 27th December 2011 the deceased was found hanging by a ligature round his neck. There were no signs of life.

Following the suicide of Mr Taylor, the Scottish Prison Service carried out a Self Inflicted Death in Custody: Audit Analysis and Review. This review recorded that the deceased had a history of 'anxiety, phobia, panic disorder, OCD.' This information came from his prison records which

were held at H M Prison, Glenochil at the time of his death. It was disclosed that he suffered from a depressive illness and drug dependence. The review also recorded that the deceased's last contact with the Multi Disciplinary Mental Health team was more than twelve weeks before his suicide. The deceased was recorded as not constituting any risk of suicide. The review concluded the suicide of the deceased could not have been avoided but increased nursing in the prison and better compliance with a treatment plan on the part of the deceased might have lessened the prospect of suicide. The review recorded that neither prison staff nor cell mates of the deceased had any prior indication of his suicide. A referral to the mental health team had not been actioned due to staff issues in that team.

Against these facts the Crown submitted that if the comment made by the deceased had been passed on in documentation, then he could have been questioned about it on his admission to prison. This might have resulted in measures being taken to protect him from suicide. The failure to pass on the comment affected the initial assessments made.

Mr Taylor considered that it was unacceptable for his son to be assessed as high risk when taken into police custody and for this assessment not to be passed on. If this information had been passed on, then the outcome might have been different. The passage of information was a reasonable precaution to have been taken. This might have saved his son's life. Depression can result in a person's mood changing. His son should have been put on risk. Doctor Kay was a very reliable witness. If he had been aware of the comment made in police custody, then he could have questioned his son about it. The police would have had a fair idea that his son was going to be kept in custody. It is perhaps also appropriate to record that after being examined by the Crown, I invited Mr Taylor to advise me of any other concerns he had. He observed that the forms which accompanied his son to prison indicated that he was a suicide risk. Similar comments were made for nearly half the prisoners. This seemed high. He also considered that placing his son in a single cell did not appear wise when he was a suicide risk.

Mr Reid considered that any failure to pass on the remark made by the deceased in police custody did not amount to a cause in Mr Taylor's suicide. Over two weeks had elapsed from his admission and there had been a thorough assessment on his admission to prison. The notification of his comment to other parties might fall within section 6(1)(e). The only other additional remark was from Mr Burton who suggested that if Mr McKeown had genuine concerns for the welfare of Mr Taylor, he could have raised it through the appropriate channels as opposed to

simply making an informal remark to a prison officer as he left the prison establishment. Further, after the comment was made, a number of days passed before Mr Taylor took his life.

In considering the terms of section 6(1) of the 1976 Act I agree that the live issues are those identified by the parties. Determinations in terms of section 6(1)(a) and 6(1)(b) are straightforward. In relation to the time of death I have determined that it occurred at 8am just before Mr Taylor was pronounced dead.

I turn first to the comment made by the deceased 'If I was going to jail, yes I would.' This was made to Mr Watt on 7th December 2011 in answer to a query concerning whether the deceased was having suicidal thoughts. The deceased took his life on 27th December 2011. In the interim he was assessed in terms of the ACT 2 Care procedure in H M Prison, Perth. In the course of that procedure, he was assessed by a Prison Officer on admission, by a prison nurse, and then by a prison doctor. None of these persons considered that the deceased exhibited characteristics necessary for him to be placed on ACT 2 Care. Standing the period which passed between the comment in question being made and the deceased taking his life and the assessments which were carried out upon the deceased in that intervening period, I cannot determine that if information regarding this comment had been passed on to the prison staff it would have resulted in Mr Taylor's suicide being avoided. The deceased might have been placed on ACT 2 Care on admission. In that event, however, there would have been a case conference the next day which would have followed further assessments on the deceased. Standing the evidence, in particular from Doctor Kay, I do not consider that Mr Taylor would have remained on ACT 2 Care even if he had been placed on it on admission. Doctor Kay was quite clear that even if he had been aware of the comment, his assessment of the deceased would have been the same. I accept the evidence from Doctor Kay, in particular. His evidence was not challenged in any way. In addition, no one else had any concerns subsequent to Mr Taylor's admission apart from Mr McKeown. In his case those did not relate to suicide.

That having been said, clearly when he was taken into police custody on 7th December 2011, Mr Watt had significant concerns as to the wellbeing of the deceased. He had assessed the deceased as constituting a high risk after going through the vulnerability assessment. He was given an anti rip suit to wear and placed in an observation cell. The visits to the cell were also reduced as a result. However, the comment from the deceased was not transmitted to G4S staff nor on to the prison staff. In completing the Personal Escort Record, Mr Robinson did tick the suicide/self

harm box but that can be completed even although the risk is not current and thus not particularly relevant. Awareness of the deceased having made the comment might not have made a difference to the assessment of the deceased in relation to ACT 2 Care and in this regard I am aware that comments made by prisoners may not represent their genuine intentions. However, I consider that when assessments are made in terms of the ACT 2 Care procedure, the persons making such assessments should be in possession of as much information as possible. That is clearly the intention behind the procedure. I have made similar observations in previous determinations issued following the deaths of prisoners in custody. In light of that I consider that the vulnerability assessment completed on a prisoner in police custody should accompany the Personal Escort Record to G4S staff and to the prison in the event of that person being placed in custody. The assessment consists of one sheet containing thirteen questions and thereafter an assessment with a section providing reasons for the assessment.

Turning to the other issue, namely the exchange between Mr McKeown and Prison Officer Maxwell on 21st December 2011, as I have already determined, I am satisfied that Mr McKeown told the officer that he had concerns for Mr Taylor and asked him to keep an eye on him. These remarks were not, however, directed towards a risk of Mr Taylor taking his life and Mr McKeown did not report these remarks in writing to anyone. Mr Maxwell said that, in the event of the remark having been made, he would have contacted the Hall in which the deceased was held and have spoken to his personal officer. Accordingly, the remark having been made, Mr Maxwell should have done this. It would have been then up to that second officer to take matters further. If he had, he would have interviewed Mr Taylor on a one to one basis to determine whether the ACT 2 Care procedure should be initiated. On the basis of the evidence I heard in the inquiry, I cannot conclude that that procedure would have been initiated if the remark had been passed on. All the evidence I heard as to Mr Taylor's presentation in prison was that his behaviour and demeanour gave no cause for concern. It also has to be remembered that Mr McKeown himself did not consider that Mr Taylor was at risk of taking his own life. Accordingly, I cannot conclude that in the event of Prison Officer Maxwell passing on the remark, Mr Taylor's suicide would have been avoided.

Having reached that conclusion, however, it may be that the establishment of some kind of system for the transmission of concerns from bodies or personnel to the prison service might be worthy of consideration. Social workers are perhaps the most obvious category of persons visiting those in custody. Legal advisors are another. A number of instances can be envisaged in

which such persons, when meeting prisoners, might have concerns for their continued wellbeing. To leave the passing of potential concerns to an informal remark made on moving to the prison exit always carries with it the danger that the significance of the remark is lost. In those circumstances, other events can overtake the need to act on the remark. It also leaves the recipient vulnerable to criticism if the remark is not actioned and something tragic subsequently takes place. It was suggested that one way for such concerns to be transmitted to prison staff would be to make use of the existing means of sharing intelligence with prisons through the prison intelligence officer. This might be a possible method but I can foresee all would neither necessarily be aware nor have access to that facility.

Turning to social workers, it might be beneficial if they received some sort of training as to the circumstances in which it would be appropriate to pass on concerns in a more formal manner. It would appear that there exists a procedure whereby social workers can pass information on internally. It would also appear that there exists a procedure for the information to be relayed to the prison authorities. Mr McKeown clearly did not consider there was any need to pass his concerns on further with the exception of his comment to Prison Officer Maxwell. However, no evidence was led as to what, if any, information is given to social workers such as Mr McKeown as to potential pointers of self harm. Further no evidence was led as to what information might be appropriate and the feasibility of providing social workers with that. Accordingly I have decided not to make any specific recommendation. No doubt, however, my observation can be taken note of and, if feasible, acted upon.

For other visitors, it is difficult to envisage such steps being taken. For members of the legal profession or family members, it seems to me that the employment of common sense can only be relied upon. However, the prison service could take the initiative by making visitors of all descriptions aware that in the event of their having concerns for any inmate, they should bring these concerns to the attention of the authorities in a particular manner. One could envisage the likes of posters being displayed prominently in the visitors waiting area indicating that if visitors have any concerns as to the wellbeing of the inmates they are visiting, they should follow a certain procedure to bring these concerns to the authorities.

I conclude by offering my sincere condolences to the family of Mr Taylor.

FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976
SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT PERTH

DEATH OF STEVEN TAYLOR
FAI 20-21 OCTOBER 2014

SUBMISSIONS ON BEHALF OF THE CROWN

INTRODUCTION

On 27 December 2011 Steven Taylor, a prisoner lawfully held in the prison of HMP Perth, 3 Edinburgh Road, Perth, was found hanging in his cell. His life was pronounced extinct at about 0815 hours on 27 December 2011.

On 23 April 2014, a Petition was presented by the Procurator Fiscal under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("the 1976 Act"), intimating that it appeared that the death had resulted from an accident occurring in Scotland while the person who had died was in legal custody and seeking a mandatory Fatal Accident Inquiry in terms of Section 1(1)(a)(i) of the 1976 Act.

Section 6 of the 1976 Act requires the Sheriff to make determinations in the following matters:

- a. Where and when the deaths and any accident resulting in the deaths took place.
- b. The cause or causes of such deaths and any accident resulting in the deaths.
- c. The reasonable precautions, if any, whereby the deaths and any accident resulting in the deaths might have been avoided.
- d. The defects, if any, in any system of working which contributed to the deaths or any accident resulting in the deaths.
- e. Any other facts which are relevant to the circumstances of the deaths.

In terms of Section 6 of the Fatal Accident and Sudden Death Inquiry (Scotland) Act 1976, I would invite your Lordship to consider making the following determinations:

In terms of s6(1)(a) that the death took place at Cell B1-08, B Hall, Her Majesty's Prison, 3 Edinburgh Road, Perth PH2 8AT at 0815 hours on 27 December 2011 (evidence of Adrian Trotter, and affidavit of Dr Graham Whyte).

In terms of s6(1)(b) that the cause of death was I(a) Suspension from the neck by a knotted bed sheet ligature (hanging) (affidavit of Dr Graham Whyte).

In terms of s6(1)(c) it is submitted that the following are reasonable precautions whereby the death might have been avoided:

1. The Police Custody Support Officer (PCSO) completing the Personal Escort Record (PER) could have recorded on the PER the specific answers to the questions asked during Mr Taylor's vulnerability assessment. Alternatively, the sheet containing the answers to these questions could have been printed off and attached to the PER which accompanied Mr Taylor to court and Prison. This would have allowed prison staff to know that the deceased had indicated on 7 December 2011 that he had considered suicide on 6 December 2011. In particular they would have been aware that in answer to the question *"Do you have thoughts at present of self-harm or suicide?"* he had replied, *"If I was going to jail yes I would."*

Witnesses Duffus, Kay and Keith indicated that while that information in and of itself would not have meant that Mr Taylor would have been automatically made subject to the ACT2Care procedures in Prison, had they received this information it would have made them question Mr Taylor more closely about his intentions and may have resulted in Mr Taylor being subject to the ACT2 care procedures. Witness George Stewart, at that time a manager within HMP Perth and the Deputy ACT2CARE coordinator, gave evidence that this is the sort of information that the prison would hope to receive from the police to inform their decision-making. Had this information been made available, it is likely that it would have resulted in a more in-depth assessment of Mr Taylor's state of mind and needs. A wide range of options would have been available to the support Mr Taylor, including cell sharing, phone calls home, counselling, additional visits, anti-ligature clothing etc (evidence of George Stewart and Lesley McDowall).

Evidence was given by PCSO James Watt that the "suicide/self harm" marker is common among those being taken into police and prison custody. James Watt estimated that one in every six or

seven prisoners will have this marker on their record and once applied it stays permanently on record. George Stewart and Michael Keith also gave evidence that these markers can be historic. The value of marker in assessing someone's current risk of suicide or self harm without further information being added to the form is therefore diminished.

2. Police custody staff could share intelligence regarding potential suicide cases with the prison through the prison liaison officer. Evidence was led from prison intelligence officer PC Andrew Millar, that there is a system whereby intelligence is shared with prisons through the Prison Intelligence Officers. This system is most frequently used for prisoners who might be attempting to introduce drugs or weapons into the prison. However, this method could also be used to identify individuals at risk of suicide or self harm to the prison.

3. Another reasonable precaution whereby the death might have been avoided would have been for a message about the deceased's mental health to have been effectively passed from Derek Morris McKeown to the deceased's personal officer following the deceased's meeting with his social worker on 21/12/11. Mr McKeown gave evidence at the Inquiry that he met with the deceased on 21/12/11 and during this meeting the deceased appeared at times depressed and spoke of suicide. Mr McKeown's evidence was to the effect that although the deceased had periods of appearing to be despondent during this meeting, he was also able to recognise positive things in his life. Mr McKeown felt that by the end of the conversation on balance, the deceased was able to see a future for himself and was not at risk of suicide. However, he said that he still had concerns for the deceased and asked the prison officer who escorted him out of the prison to keep an eye on the deceased. According to Mr McKeown the prison officer said he would pass that information on to hall staff. Mr McKeown made no official report to the Prison.

The prison carried out an internal inquiry into the circumstances of the deceased's suicide and identified that the person who escorted Mr McKeown from the prison on 21/12/14 was Gary Maxwell. Mr Maxwell maintained during the Inquiry that the conversation alleged by Mr McKeown did not happen. However, he confirmed that the action he would have taken would have been to contact the deceased's hall and speak to his personal officer. The procedure thereafter would then have been for the personal officer to speak to the deceased and if he appeared to be at risk, ACT2CARE procedures could be instigated.

Given the very emotional state the deceased was in during his conversation with Mr McKeown it is possible that had this information been passed on to the escorting officer and then the personal officer, the deceased might have been placed on ACT2CARE at that point and this may have had an impact on the deceased's decision to end his own life on the night/morning of 26/27 December 2011. However, it is also recognised that the evidence from the prison officers who had dealt with the deceased in the days preceding his suicide, was that they had not noted any change in his behaviour.

In terms of s6(1)(d), the Crown has no submission to make. Systems of work exist to identify individuals at risk of suicide or self harm both within the police and prison systems and there are methods to communicate this information between the police, prisoner escort agencies and prisons. These include, writing on the PER, attaching a "special risk" form, telephoning the prison, and using the prison liaison officer. It is submitted that there are no defects within these systems of work, rather that the systems were not used appropriately to communicate the required information. It is submitted that there were no other systems of work which contributed to the death.

In terms of s6(1)(e), the Crown has no submission to make.

IN RESPECT WHEREOF

Nicola Ross

Senior Procurator Fiscal Depute

Scottish Fatalities Investigation Unit

Procurator Fiscal's Office, Dundee

FATAL ACCIDENT INQUIRY

DEATH OF STEVEN TAYLOR

SUBMISSIONS FOR THE CHIEF CONSTABLE

THE FATAL ACCIDENT AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976

Section 6(1)(a)

Where and when the death and any accident (or in this case perhaps more properly “incident”) resulting in the death took place.

It is submitted that the death took place in a cell B1-08 in B Hall of HMP Perth PH2 8AT.

Death occurred at some point between 1700 hours on 26 December and 0759 hours on 27 December 2011.

The deceased, Steven Taylor, was discovered hanging by Prison Officer Adrian Trotter at or about 0759.

At or about 0815 on 27 December 2011 Nurse Lynne Aitken pronounced life extinct (**Crown Production 14**).

Section 6(1)(b)

The cause or causes of the death and any accident resulting in the death.

The Post Mortem Report (**Crown Production 4**) by Doctor Graham Whyte, Pathologist, Academic Clinical Lecturer in Forensic Medicine, recorded the death as:-

1(a) Suspension from the neck by a Knotted Bed Sheet Ligature
(Hanging).

This was supported by Dr Whyte’s Affidavit and the evidence of Adrian Trotter.

The Other Subsections of the 1976 Act

In Fatal Accident Inquiries there can be an overlap or potential overlap between three Subsections.

Section 6(1)(c)

The reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided.

Section 6(1)(d)

The defect, if any, in the system of working which contributed to the death or any accident resulting in the death.

Section 6(1)(e)

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

It is submitted that Subsections (c) and (d) are not applicable in this matter but submissions are made as follows in relation to Subsection (e), other relevant facts.

1. The late Steven Taylor was apprehended on 7 December 2011 at Queen Margaret Hospital, Dunfermline.
2. Mr Taylor was taken into custody at 21.50 (**Crown Production 6, Summary Report**).
3. Part of the Custody process is a Vulnerability Assessment. Such an Assessment was carried out in respect of Mr Taylor by PCSO James Watt.
4. Mr Watt gave evidence in relation to the Vulnerability Assessment (**part of Crown Production 6**). Mr Taylor's responses included:-

Question – “Have you attempted self-harm or suicide?”

Entry – “Cut wrists. Years go. Also thinking about it on 6.12.2011.”

Question – “Do you have thoughts at present of self-harm or suicide?”

Entry – “Suicidal thoughts at present. If I was going to jail yes I would.”

PCSO Watt assessed Mr Taylor as High Risk.

5. PCSO Watt went off duty at 11 pm on 7 December 2011. His understanding was that Mr Taylor was to go to Court the following day, 8 December.
6. Sometime after 11 pm and probably before 3 am it was the practice to fax a list of Custodies for Court to Reliance/G4S.
7. The Custody Staff would complete a PER (Personal Escort Record) for each custody. A PER was completed for Mr Taylor (**Crown Production 1**).
8. The PER was completed by PCSO Bob Robinson who was not led as a witness. Evidence in respect of the PER was taken from PCSO Watt.
9. The PER has various sections, including two “Risk Information” and “Risk – Additional Information”.

The first of these two sections has various boxes marked, including “Drugs/Alcohol Issues” and “Suicide/Self-Harm”.

The second section makes no reference to either of the two matters referred to above.

The comments noted by PCSO Watt on the Vulnerability Assessment (as noted above) are not noted on the PER.

10. Mr Watt was asked if he would have put the Vulnerability Assessment comments into the “Risk – Additional Information” section on the PER.

Initially he responded, “Not really, no” and then, at a later stage, in relation to the same question said “I wouldn’t have put it on”.

He was asked if the position was covered by ticking the “Suicide/Self-Harm” box on the PER and he said “Yes”.

In summary PCSO Watt clearly felt the position was adequately conveyed by the “Suicide/Self-Harm” box on the PER being ticked.

**Whether or not the comments should have been inserted,
did their absence make any difference to what occurred?**

11. Mr Taylor was admitted to HMP Perth on 8 December 2011 and died on 27 December 2011, approximately eighteen days later.

The Scottish Prison Service has its own Assessment procedure and Care procedure, ACT.

The initial Assessment has three stages:-

- a) A Reception Officer
 - b) A Nurse
 - c) A Doctor
12. On reception at HMP Perth on 8 December 2011 was Prison Officer Michael Keith. He was the first point of contact for Mr Taylor at HMP Perth.
13. Clearly, the more information available to a Reception Officer such as Mr Keith, the better.

However, according to Mr Keith, the fact that the PER did state “Suicide/Self-Harm” did not automatically mean that the individual would be put on ACT.

14. Mr Keith was taken through his ACT Assessment **(Crown Production 8)**. Page 3, Section 2 Parts 1, 2 and 3, includes a series of questions and provides for the Reception Officer to make an assessment.

15. Mr Keith explained the Clues and Cues approach which was part of the Assessment.

16. Mr Keith said:-

That Mr Taylor engaged in conversation with him

Mr Taylor was more than happy to divulge the circumstances of his arrest at the hospital

There was banter between them, almost light-hearted

Mr Taylor had no suicidal thoughts

Mr Keith did not consider Mr Taylor was suffering from low moods.

17. Mr Keith was asked about the reference in the Police Summary to Mr Taylor being tearful during Police Custody. In response Mr Keith said that Mr Taylor was not displaying “anything like that” on admission.

Mr Keith assessed Mr Taylor as presenting “no apparent risk”.

18. Mary Duffus, a Nurse employed at HMP Perth, spoke to her Assessment **(part of Crown Production 8, following Mr Keith’s Assessment)**.

She referred to Section 2, parts 1 and 2 of her Assessment and like Mr Keith, she referred to Clues and Cues over and above the actual Assessment questions, as set out in Section 2.

19. Mrs Duffus gave evidence that Mr Taylor spoke freely to her and was happy to talk. He looked at her and there was positive eye contact.

She said she wasn't concerned at all about Mr Taylor, he was very co-operative.

She too considered there was "no apparent risk" and ticked the appropriate box in her Assessment.

20. The comments made by Mr Taylor, as noted in the Vulnerability Assessment and not repeated on the PER were put to Mrs Duffus. She was asked if she had known of these comments, would they have made any difference to her Assessment?

Mrs Duffus responded that she would still have assessed Mr Taylor on his demeanour and "You go on what you see in front of you."

She also commented "People often say things to Police or G4S and when challenged will sometimes say they didn't mean it."

21. Mary Duffus also gave evidence on three other matters:-

- a) Because of Mr Taylor's history of depression she completed a Mental Health Team Referral Form (**Crown Production 8**).
- b) She referred to Mr Taylor being seen twice daily during his time in HMP Perth for medication purposes. Nothing that she was aware of had been recorded from any of these occasions to indicate Mr Taylor had any problems.
- c) She referred to various ways in which a prisoner could raise a health issue including, speaking to Healthcare Staff, asking for contact with Mental Health or completing a Referral Form.

The final stage in the initial Assessment Procedure was an examination by a Doctor. Evidence was given by Doctor Peter Kay, a GP at HMP Perth.

22. He was a particularly impressive witness and clearly someone who was very caring and took a detailed interest in his patients.

23. He advised that he took a particular interest in and had a concern over suicide risk. He was a member of the National Suicide Risk Management Group.

24. Doctor Kay had seen Mr Taylor on 9 December 2011 and spoke to his very detailed Note in the Care Records **(part of Crown Production 8)**.

In evidence he went through his Assessment in some detail, including the possibility of suicidal thoughts and self-harm.

25. He said Mr Taylor's demeanour was "absolutely unremarkable".

He explained that he had done two years psychology during his training (instead of the standard six months) and always tried to analyse the non-verbal as well as what the patient was actually saying to him.

26. Mr Taylor's comments, as recorded on the Police Vulnerability Assessment, were put to Doctor Kay and he was asked what effect that information would have had, if it had been available to him.

His reply was quite categorical, "It would have made no difference to my Assessment. Mine is completely independent."

He went on to say that the only difference it would have made was that he would have asked Mr Taylor to clarify what he meant.

27. A Prison Intelligence Officer, PC Andrew Millar, gave evidence and spoke to a system which provided for intelligence being shared with prisons. It appeared that the main purpose of the system related to questions of drugs and weapons.

28. It was suggested that the system could be used to pass on information in relation to potential suicide risk.

It is submitted that while this suggestion might appear superficially attractive, in practice Police Custody Officers do not know the ultimate destination of any custody leaving their

care for Court. The custody might have any prospective charges dropped or might be released to appear later, with or without bail.

Summary

29. The comments made by Mr Taylor when being assessed by the Police and as noted in the Vulnerability Assessment (**Crown Production 6**) are clearly relevant.

However, even if these comments had been transferred to or communicated to HMP Perth, it is submitted they would not have affected the result of the Assessments carried out at HMP Perth.

These comments, whether or not they had been available to HMP Perth had no part to play in Mr Taylor's subsequent tragic death on 27 December 2011.

SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT PERTH

SUBMISSIONS
FOR TAYSIDE HEALTH BOARD
in
Fatal Accident Inquiry
into the death of
STEVEN TAYLOR
Under the Fatal Accidents and Sudden Deaths
Inquiry (Scotland) Act 1976

1. In terms of section 6(1)(a) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 (the '1976 Act'):

1.1. It is submitted that Steven Taylor died within Cell 1-08 of B Hall at Her Majesty's Prison, 3 Edinburgh Road, Perth PH2 8AT at some point between 1720 hours on 26 December and 0800 hours on 27 December 2011 (Evidence of Andrew Agnew, Prison

Officer; Evidence of Adrian Trotter, Prison Officer; Affidavit of Dr Graham Whyte and Crown Production 4).

2. In terms of section 6(1)(b) of 1976 Act:

2.1. It is submitted that the cause of death of Steven Taylor was suspension from his neck by a knotted bed sheet ligature (hanging) (affidavit of Dr Graham Whyte and Crown Production 4).

3. In relation to sections 6(1)(c), (d) and (e) of the 1976 Act:

3.1. It is submitted there are no reasonable precautions that could have been taken on the part of Tayside Health Board whereby the death of Mr Taylor might have been avoided.

3.2. It is submitted there were no defects in any system of working which contributed to Mr Taylor's death.

3.3. It is submitted there are no other facts that are relevant to the circumstances of the death of Mr Taylor.

3.4. Following Mr Taylor's admission to HMP Perth on 8 December 2011, prison reception staff, nursing and medical staff carried out risk assessments, for the purposes of 'ACT 2 Care'. Nursing and medical staff were appropriately trained and well qualified. Mr Keith, Nurse Duffus and Dr Kay each considered that he posed "no apparent risk" of suicide or self-harm and they did not require to implement the ACT 2 Care procedures. There were no verbal or non-verbal cues or clues indicative of such risk. Nurse Duffus recalled, "he spoke freely, he was happy to talk". She recorded good eye contact and good communication. Dr Kay noted, "Appeared quite well, good eye contact". Mr Taylor consistently denied any thoughts of suicide or self-harm in response to direct questioning. He told Nurse Duffus and Dr Kay that his last episode had been twelve years before. (cf. Evidence of Mr Keith, Nurse Duffus and Dr Kay).

IN RESPECT WHEREOF

Catherine Devaney, Advocate
Advocates Library
Parliament House, Edinburgh
27 November 2014

Instructed by Central Legal Office
For Tayside Health Board

Sheriffdom of Tayside Central and Fife at Perth
Fatal Accident Inquiry
into the death in custody of
Steven Taylor
Submissions on behalf of:
Scottish Prison Service

Gary Burton, Anderson Strathern LLP, instructed by the Scottish Prison Service

1. Introduction

On behalf of the Scottish Prison Service, I would wish to address matters in the following order:

- The legal framework
- Section 6(1)(a)
- Section 6(1)(b)
- Section 6(1)(c)
- Section 6(1)(d)
- Section 6(1)(e)

2. The Legal Framework

2.1 The relevant statute is the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (“the 1976 Act”). The purpose of the Inquiry is defined in Section 6(1) of the Act which is in the following terms:-

"At the conclusion of the evidence and any submissions thereon or as soon as possible thereafter, the Sheriff shall 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 might have been avoided;
- (d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and
- (e) any other facts which are relevant to the circumstances of the death."

2.2 It is well settled that it is not the purpose of a fatal accident inquiry to determine any question of civil or criminal fault or liability.

Black v Scott Lithgow Limited 1990 SLT 612, Lord President Hope at page 615G-H:

"There is no power in this section [s.6(1)] to make a finding as to fault or to apportion blame between any persons who might have contributed to the accident..... It is plain that the function of the sheriff at a fatal accident inquiry is different from that which he is required to perform at a proof in a civil action to recover damages. *His examination and analysis of the evidence is conducted with a view only to setting out in his determination the circumstances to which the subsection refers, in so far as this can be done to his satisfaction.* He has before him no record or other written pleadings, there is no claim of damages by anyone and there are no grounds of fault upon which his decision is required. The inquiry is normally held within a relatively short time after the accident..."

2.3 The court is to make a finding in terms of Sections 6(1)(a) and (b). In terms of Section 6(1)(c), the court must make a finding where it is satisfied that a *reasonable* precaution *might* have avoided the death. In relation to section 6(1)(c):

Death of James McAlpine, 17 January 1986, Sheriff Kearney observed:

“In relation to making a finding as to the reasonable precautions, if any, whereby the death and any accident resulting in death might have been avoided under(s.6(1)(c)) it is clearly not necessary for the court to be satisfied that the proposed precaution would in fact have avoided the accident or the death, only that it might have done, but the court must, as well as being satisfied that the precaution might have prevented the accident or death, be satisfied that the precaution was a reasonable one.”

Sheriff Kearney continued: “The phrase “might have been avoided” is a wide one which has not, so far as I am aware, been made the subject of judicial interpretation. It means less than “would on a balance of probabilities have been avoided” and rather directs one’s mind to the direction of *lively possibilities*”.

Sheriff Kearney’s remarks were adopted by Sheriff Principal Lockhart in his determination in the Fatal Accident Inquiry into the deaths at the Rosepark Nursing Home, issued on 20 April 2011, where he said:

“..the question of reasonableness is directed to the precaution which is identified. The issue is not whether an individual or an organisation behaved in a reasonable or unreasonable way, but whether or not there was a precaution which is a reasonable one and which might have made a difference”

- 2.4 It has been determined, there must be evidence of at least a "*realistic possibility*" of avoiding the death by the reasonable precaution suggested in the evidence. The causal connection need not be as strong as is required in a civil proof where it would have to be demonstrated that the death "would" have been avoided. *However, where the evidence is absent or witnesses cannot say that the death might have been avoided, the test is not satisfied.*
- 2.5 For a finding to be made under section 6(1)(d) there must be evidence on the balance of probabilities sufficient to justify the finding(s). The phrase ‘system of working’ must be understood as including.....any system - or lack of system – of working such as supervision where necessary, or routine in any custodial institution, where such has contributed positively to the death or accident resulting in the death. It must also include

systems (or lack of systems) and routines of laboratory, diagnostic, medical, surgical and therapeutic procedures.

2.6 For a finding under section 6(1)(e) there must be a nexus between the fact and the death.

3. Section 6(1)(a) of the 1976 Act

3.1 In my submission, Mr Taylor's death took place at Cell B1-08, B Hall, HMP Perth, 3 Edinburgh Road, Perth, PH2 8AT at 0815 hours on 27 December 2011.

4. Section 6(1)(b) of the 1976 Act

4.1 In terms of the Post Mortem Report based on the Post Mortem examination conducted by Dr Graham Whyte, Pathologist, and his Affidavit dated 12 August 2014, in my submission the cause of Mr Taylor's death was I(a) Suspension from the neck by a knotted bed sheet ligature (hanging).

5. Section 6(1)(c) of the 1976 Act

5.1 In my submission, there are no reasonable precautions that could have been taken on the part of the Scottish Prison Service whereby the death of Mr Taylor might have been avoided.

5.2 Mr Taylor was assessed upon his admission to HMP Perth by an admission officer, followed thereafter by a nurse practitioner and doctor. Had any of those individuals had any cause for concern in relation to Mr Taylor being at risk of suicide or self-harm they could have implemented the ACT2CARE procedure and a variety of options in order to safeguard Mr Taylor's wellbeing could have been undertaken.

5.3 The Inquiry also heard evidence from Mr Derek McKeown, Social Worker and Gary Maxwell, Prison Officer, in relation to a discussion following a meeting between Mr McKeown and Mr Taylor in 21/12/11. There is a conflict in the evidence between both

witnesses. However, the Inquiry heard evidence from Mr Maxwell regarding the informal and formal steps that he could have taken if he was concerned regarding Mr Talor's wellbeing. It was also accepted by Mr McKeown that he could have contacted the prison through his social work department regarding any concerns he had and he accepted in his evidence that he did not deem this necessary. Further, Mr Taylor was assessed by nursing staff on twice daily basis and on a daily basis by prison officers after this meeting, with none of those individuals raising any concerns regarding him being a risk at risk of self-harm or suicide. Therefore, in my submission, there were no reasonable precautions that could have been taken on the part of the Scottish Prison Service whereby the death of Mr Taylor might have been avoided.

6. Section 6(1)(d) of the 1976 Act

- 6.1 In my submission, there were no defects in any system of working which contributed to the death or any accident resulting in the death. George Stewart, Manager of HMP Perth at the relevant time, Michael Keith, Prison Officer, Mr Maxwell, Mary Duffus, Nurse Practitioner, Peter Kay, GP and Lesley McDowell, Clinical Adviser, all gave evidence regarding the prison ACT2CARE policy and how this operates on a daily basis within the prison. The purpose of this procedure is to identify any prisoners at risk of self-harm or suicide and provides clear guidance to all members of staff of the steps that are to be taken in the event of any concerns being raised regarding a prisoner.
- 6.2 The Inquiry also heard evidence from various members of staff at the prison, including Mr Stewart, Mr Maxwell, Ms Duffus and Ms McDowell that any member of staff can initiate the ACT2CARE procedure if they have any concerns regarding a prisoner being at risk of suicide or self-harm.
- 6.3 Finally, the Inquiry heard evidence from PC Andrew Millar, Prison Intelligence Officer, that there is a system of work in place whereby intelligence is shared between prisons which could be used to identify prisoners at risk of self-harm or suicide.
- 6.4 In my submission, there are no other systems of work which contributed to Mr Taylor's death.

7. Section 6(1)(e) of the 1976 Act

7.1 In my submission there are no other facts which are relevant to the circumstances of the death of Taylor.

IN RESPECT WHEREOF

Gary Burton

Anderson Strathern LLP

Instructing on behalf of the Scottish Prison Service.