SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2017] FAI 25

B645/17

DETERMINATION

BY

SHERIFF FIONA TAIT

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES (SCOTLAND) ACT 1976

into the death of

MANDY JANE ROSS

Edinburgh, November 2017

The Sheriff, having considered the cause, determines:

[1] In terms of section 6(1)(a), Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 that Mandy Jane Ross, born 29 August 1967, formerly residing in Levenmouth and while detained in lawful custody at HMP Edinburgh, died at Edinburgh Royal Infirmary, Little France Road, Edinburgh. Her life was pronounced extinct at 1025 hours on 29 March 2014.

[2] In terms of section 6(1)(b) of the said 1976 Act that the cause of death was 1(a) complications of hanging.

Note

The Evidence

[3] Evidence in the inquiry was led on 31 October 2017. Mrs Karen Rollo, Procurator Fiscal Depute, represented the Crown. Mr Stuart Holmes, solicitor, represented NHS Lothian. Mr Dominic Scullion, solicitor advocate, represented the Scottish Prison Service.

[4] The Crown led evidence from Dr Christine MacGregor. Dr MacGregor is a retired consultant psychiatrist. She was instructed by the Crown to review Miss Ross' medical records, including her general practitioner records, records from HMP Edinburgh and from Edinburgh Royal Infirmary, which are Crown production numbers 3, 5 and 4 respectively. She also considered what she termed the prison review into Miss Ross' death but what was in fact Crown production number 6, referred to at the inquiry as the Death in Custody Pack. Dr MacGregor's report is Crown production number 7.

[5] On behalf of the Scottish Prison Service, evidence was led from Mrs Lesley McDowell. Mrs McDowell is a health strategy and suicide prevention manager based at the service's headquarters in Edinburgh.

[6] No evidence was led on behalf of NHS Lothian.

[7] A Joint Minute of Admissions was entered into on behalf of the parties. In terms thereof, the post mortem and toxicology reports, Crown production number 2, Miss Ross' general practitioner records, Crown production number 3, and her Scottish

Prison Service records, Crown production number 5, were agreed. The following further matters in paragraphs [8] to [17] were agreed.

[8] On 6 March 2014, Miss Ross was sentenced at Kirkcaldy Sheriff Court to ten months' imprisonment in respect of charges of theft by shoplifting and sent to HMP Cornton Vale, Stirling. She was transferred to HMP Edinburgh on 12 March 2014. At the time of her death, Miss Ross was lawfully detained in custody.

[9] Miss Ross was placed in Ratho Hall on her arrival at HMP Edinburgh. She was placed in cell number 3/17 along with serving prisoner Agnes Reid.

[10] Miss Ross acquired heroin while in custody which she smoked. The heroin was ingested and from 24 March 2014, she began suffering withdrawal symptoms which resulted in her vomiting, sweating, shaking and having difficulty walking and standing.

[11] On 26 March 2014, Miss Ross was given an injection by prison nurse Kimberley Powell to assist with her withdrawal symptoms.

[12] Agnes Reid, with whom Miss Ross shared a cell, noted at 1915 hours on 26 March 2014 that Miss Ross' withdrawal symptoms had increased. Miss Ross complained to Ms. Reid that staff would not permit her to see a nurse.

[13] Agnes Reid left the cell at 2010 hours to make a telephone call, leaving Miss Ross alone in the cell. Miss Ross had asked her to return quickly.

[14] At approximately 2030 hours on 26 March 2014, Agnes Reid and prison officer Pauline Anderson entered the cell and found Miss Ross hanging from the top bunk by shoe laces.

[15] Miss Ross was lifted and the ligature cut by Steven Hughes, Kate McDougall, Martin Macgregor and Pauline Anderson. They were joined by Louise Anthony, Melanie Cammige and Fiona McCullough, all prison nurses, who commenced chest compression until the arrival of ambulance staff. A faint pulse was detected.

[16] Miss Ross was taken to Edinburgh Royal Infirmary where she was found to have sustained a severe brain injury. Her condition did not improve and she suffered a number of seizures. On 29 March 2014, treatment was withdrawn and life was pronounced extinct at 1025 hours.

[17] A post mortem examination was conducted on 1 April 2014 by consultant forensic pathologist Dr Robert Ainsworth. The cause of death was certified as complications of hanging.

[18] In terms of the Joint Minute of Agreement the statements of a number of witnesses (prison officers, prison nursing staff and doctors) were admitted into evidence. From those agreed statements, the following facts at paragraphs [19] to [26] have been established.

[19] On being transferred to HMP Edinburgh on 12 March 2014, Miss Ross was risk assessed on that date under the standard ACT 2 Care Suicide Risk Management Strategy procedure by a prison officer and a nurse. She was risk assessed by Dr Craig Revill on 14 March 2014. It was recorded that while Miss Ross had attempted suicide in the past, she did not feel suicidal or feel like hurting herself. She was assessed in terms of both the nurse and doctor risk assessment as “no apparent risk”.

[20] On the date of her admission, Miss Ross was commenced on "detox". From 12 March until 26 March, Miss Ross was seen regularly by the addictions team and members of the wider healthcare team at HMP Edinburgh who monitored her presentation and symptoms. Her "detox" was extended.

[21] On 26 March 2014, the date on which Miss Ross was found in her cell having attempted to hang herself, she was seen by Dr Kevin Hinckley in connection with a migraine headache, nausea and visual blurring.

[22] On 26 March 2014, Miss Ross underwent a mental health assessment. Miss Ross' presentation was recorded fully. The assessment occurred during the 90 minutes before Miss Ross' attempt to hang herself. She was to be reviewed by the addictions team the following day. Miss Ross spoke about her future plans during the assessment.

[23] On 26 March 2014, Miss Ross was seen throughout the afternoon and early evening on four or five occasions by nurse Louise Anthony. Nurse Anthony was aware that Miss Ross was being treated by the addictions team and the mental health team.

[24] On 26 March 2014, Miss Ross was seen by prison officers Pauline Anderson and Martin McGregor in the hours immediately prior to her attempt to hang herself. She was seen by officer Anderson approximately 30 minutes before. They enquired about her well-being as she was obviously unwell.

[25] Between 12 and 26 March 2014, Miss Ross accumulated eight intelligence entries and two Governor's reports. The intelligence entries range from drug misuse, concealing medications, illicit articles found in her cell and a telephone call to her boyfriend

requesting that he arrange for drugs to be brought into prison. The Governor's reports were for having "hooch" in her cell and smoking in the work place.

[26] In the days prior to 26 March 2016, Miss Ross discussed her future plans with her cell-mate and made no reference to suicide.

Submissions on behalf of the Crown

[27] On behalf of the Crown, it was submitted that the evidence led or agreed established that Miss Ross had a troubled background, involving drug and alcohol misuse, mental health problems and that she had attempted suicide on three previous occasions. Those attempts were in 1997, 2002 and 2004. The attempt in 2002 was while in custody. Miss Ross' children were in care. The prison authority had attempted to provide a system of care to meet the problems and needs with which Miss Ross presented.

[28] Dr MacGregor, both in her report and in evidence, had made a number of observations about that care. It was fairly noted that Dr MacGregor and Lesley McDowell had the benefit of hindsight and the opportunity to assess Miss Ross' circumstances as a whole. No clinician had those benefits at the point of treating Miss Ross.

[29] It was also fairly conceded on behalf of the Crown that the way in which care is delivered within a busy prison setting will be different to the provision of care in the community. Dr MacGregor has limited experience of care within prisons.

[30] Both Dr MacGregor and Mrs McDowell had conceded in their evidence that it was impossible to say whether any different care would have prevented Miss Ross' death. As such, I was invited to confine any findings to those under section 6(1)(a) and (b) of the 1976 Act.

Submissions on behalf of the Scottish Prison Service

[31] On behalf of the Scottish Prison Service, and in inviting me to restrict my findings in terms of section 6(1)(a) and (b) of the 1976 Act, it was submitted that no evidence was before the Court which should form the basis of any finding under section 6(c), (d) or (e).

[32] In connection with deaths resulting from the exercise of a professional judgment, my attention was drawn to the Opinion of Lord Armstrong in the Petition of Fraser Sutherland FRCS [2017] CSOH 32 at paragraph 34:

> "It was submitted that it would be possible to envisage a situation, involving the exercise of clinical judgment, whereby a doctor was presented with two or more options and could not know which was in the patient's best interests. I accept that in such a situation where the optimal course was not taken, it would not be appropriate to determine that the selection of another of the available options would have been a reasonable precaution. I accept that to do so would distort the ordinary meaning of "reasonable precaution" and would in any event be of no assistance for the future."

[33] In respect of section 6(1)(e), it was submitted that the sub-section's wording gives wide scope and, unlike in sub-sections (c) and (d), there is no requirement for there to be

a causal connection between the fact and the death. Nonetheless, any fact established must be relevant to the circumstances of the death.

[34] If facts are established at the inquiry and they give rise to concern but they cannot properly be said to relate to the death, it was submitted that those observations should be made in a note appended to the formal determination without appearing in a finding under section 6(1).

[35] Having considered the evidence agreed or led at the inquiry, it was submitted that the evidence paints a picture of an individual struggling with addictions and who had made an impulsive decision which ultimately resulted in her death. Miss Ross had undergone a mental health assessment some hours before the incident. Prison officer Pauline Anderson had checked on Miss Ross' well-being 30 minutes before the incident. The NHS Lothian and Scottish Prison Service employees who had attended to Miss Ross in the days leading up to the incident, and on the day of the incident, provided her with appropriate care in the circumstances as they perceived them. Arrangements were being put in place to continue treatment of Miss Ross's withdrawal symptoms. There was nothing, it was submitted, which might have alerted any staff members to the possibility that Miss Ross was contemplating suicide.

[36] As such, it was submitted that Miss Ross's death was unforeseeable and that there was nothing in her presentation which ought to have made any Scottish Prison Service or NHS Lothian employee engage the ACT 2 Care Suicide Risk Management Strategy (hereinafter referred to as "ACT"). Rather, it should be borne in mind that

placing an individual on ACT might increase distress (particularly the removal of objects from a cell or the placing of an individual in an anti-ligature cell).

[37] Further, Miss Ross did not present in a manner which ought to have resulted in her being transferred to hospital.

Submissions on behalf of NHS Lothian

[38] On behalf of NHS Lothian, I was invited to make formal findings only in terms of section 6(1)(a) and (b) of the 1976 Act.

[39] Dr MacGregor had been critical of Miss Ross' care while within HMP Edinburgh in a number of respects. However, she had fairly conceded that she was not in a position to know if anything had been done differently and in line with her criticisms that Miss Ross' death would have been prevented.

[40] Dr MacGregor had criticised the lack of any notes by Dr Craig Revill when he had carried out the Doctor Risk assessment on 14 March 2014 as part of the ACT 2 Care Reception Risk Assessment Document. The document forms part of Crown production number 6. Dr Revill had indicated on the form that there was "no apparent risk" by ticking the relevant box. However, Dr MacGregor had accepted that Dr Revill had made detailed notes of the consultation in Miss Ross' prison medical records, using the VISION system. Specifically he had noted no current concern over mental health. These records are Crown production number 5.

[41] Dr MacGregor's evidence was that an earlier review of Miss Ross' medication would have been helpful in respect of her lack of sleep. However, the clinical impact was submitted to be unclear as sleeping tablets had been prescribed.

[42] Although Dr MacGregor had expressed the opinion that Miss Ross' withdrawal symptoms merited her transfer to a hospital setting, she had not been able to specify in what way Miss Ross' care would have been managed more effectively in that setting.

[43] Further, Mrs McDowell's evidence was to the effect that it would not be usual to transfer a prisoner suffering from withdrawal symptoms to a hospital setting. There may be a transfer where acute medical treatment was required or subject to an order under mental health legislation.

[44] It was the evidence of Mrs McDowell that nothing within the records of Miss Ross indicated that Miss Ross was at significant risk of suicide.

Determination

[45] In terms of section 1(1)(a)(ii), Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, the present inquiry is mandatory as Miss Ross was in legal custody at the time of her death, being detained in, or subject to detention in, a prison in terms of section 1(4)(b) of that Act.

[46] The facts of Miss Ross' transfer to HMP Edinburgh, of her risk assessment on transfer and of her subsequent care and treatment were agreed. Similarly, the circumstances in which she was found in her cell on 26 March 2014, of her emergency

admission to Edinburgh Royal Infirmary and the circumstances in which treatment was withdrawn were agreed.

[47] A Statement of Issues, lodged on behalf of the Crown at a preliminary hearing, identified the likely issues for the inquiry to be whether Miss Ross was adequately assessed in terms of her mental health risk and suicide risk and the reasonableness of the care provided. In essence, having heard evidence from skilled witnesses (as anticipated), the issue would be whether that evidence entitled me to find that any reasonable precautions or alternative treatment might have prevented the death.

[48] The Crown led evidence from Dr Christine MacGregor. Dr MacGregor retired from her practice as a consultant psychiatrist in adult psychiatry with NHS Highland in 2014. She is a fellow of the Royal College of Psychiatrists. She was a lecturer in mental health at the University of Aberdeen for three years. She was the clinical lead/director for NHS Highland mental health services from 2003 to 2011. She now undertakes clinical, supervisory and teaching roles in psychotherapy. Dr MacGregor's *curriculum vitae* is Crown production number 8.

[49] Dr MacGregor was instructed by the Crown to review Miss Ross' medical records, including her general practitioner records, records from HMP Edinburgh and from Edinburgh Royal Infirmary, which are Crown production numbers 3, 5 and 4 respectively. She also considered what she termed the prison review into Miss Ross' death but what was in fact Crown production number 6, referred to at the inquiry as the Death in Custody Pack.

[50] In her evidence, Dr MacGregor spoke to her report dated 24 June 2015 which is Crown production number 7. Firstly, she addressed the reasonableness of the care provided under the specific heads of risk assessment and treatment. Secondly, she addressed whether there were any reasonable precautions whereby Miss Ross' death might have been avoided. The report purports to comment upon what is termed the prison review although no evidence was led in respect of that section of the report.

[51] In relation to risk assessment, Dr MacGregor noted that the reception risk assessment on 12 March 2014 recorded "no issues on transfer" but that the pro-forma questions had not been completed. The health care risk assessment recorded "No apparent risk. In withdrawal but denies feeling suicidal". While it is recorded that there had been previous self-harm/suicide attempt, no detail is recorded. The doctor health risk assessment is noted by Dr MacGregor to show no entry but it is signed. In fact, the doctor health assessment (at page 24 of Crown production number 6) records "no apparent risk" as was accepted by Dr MacGregor in her evidence.

[52] In her report, Dr MacGregor's opinion on the issue of risk assessment is as follows:

> "Opinion: Elsewhere in the records, it is recorded that Ms Ross had made serious attempts on her life, both through overdose and at least two attempts at hanging- one when in HMP Cornton Vale in 2002 and one in the community in 2004. Such information should be recorded when carrying out a risk assessment, as it is relevant to ongoing risk of suicide. Whilst Ms Ross denied feeling suicidal, it is well established that drug and alcohol withdrawal lead to confused and unstable mental states, in which symptoms may fluctuate rapidly. It would be good practice to take note of this specifically at risk assessment. Patients who talk about suicide may often go on enact (*sic)* it. However, a patient who denies suicidal thoughts or plans cannot be considered to be free from suicidal risk, especially when undergoing withdrawal."

[53] In respect of treatment, Dr MacGregor notes that Miss Ross was offered care and treatment for her withdrawal symptoms on transfer to HMP Edinburgh. She was regularly reviewed and medication was prescribed in accordance with her clinical need. However, Dr MacGregor observes that it was clear that her withdrawal symptoms were increasingly distressing and with lack of sleep, Miss Ross experienced disturbance of sensory input. She made attempts to self-medicate by obtaining drugs. Her review by a general practitioner was delayed and by the time she was medically reviewed, she was significantly unwell.

[54] Dr MacGregor's opinion on the issue of treatment is as follows:

> "Despite regular review, Ms. Ross experienced distressing symptoms of withdrawal which were not controlled to an acceptable degree by her treatment. It can be very difficult to treat withdrawal symptoms and many patients do find the process of withdrawal treatment very hard. However, it is clear that Ms Ross was struggling and her tolerance of the process was likely reduced by lack of sleep. An earlier review of medication would have been helpful to address the lack of sleep but it is unclear exactly how much of an extent this would have had an impact clinically (*sic)*.
>
> What is clear is that Ms Ross was in an unstable and unpredictable mental state by virtue of her withdrawal symptoms. With her past history of attempted suicide, this mental distress would have increased the overall risk of impulsive self-harm/suicidal behaviour. I can see no record of repeated risk assessment at this point, which would have been appropriate-both to carry it out, and of course to record it. The important outcome of review of risk assessment at this time would be the adjustment of clinical management to take account of increased risk:
>
> 1) Increased support to, and observation of the patient
> 2) Review of the patient's environment, removing potential ligatures and other opportunities for self-injury.

> In summary, I believe there are some interventions in the treatment of Ms Ross which could have been instigated, as above, and these could have affected the outcome."

[55] In respect of any reasonable precautions whereby death may have been avoided, Dr MacGregor's opinion is as follows:

> "As indicated above, increased support to Ms Ross, in terms of observation and support, and removal of means to suicide would have been reasonable precautions. In my opinion, a patient would have been much more appropriately nursed and treated in a hospital ward environment with such a severity of symptoms of withdrawal as were described from 15/03/14 onwards, and certainly by 26/03/14. Drug and alcohol withdrawal are potentially life threatening medical conditions and, as in this case, can progress to give rise to serious physical and mental health risks in some circumstances."

[56] On behalf of the Scottish Prison Service, evidence was led from Mrs Lesley McDowell. Mrs McDowell is a health strategy and suicide prevention manager based at the service's headquarters in Edinburgh. She has been in post for three years. Prior to holding her current position, she was clinical adviser for the service, following upon the transfer of responsibility for the provision of healthcare in the prison estate from the Scottish Prison Service to the NHS. Mrs McDowell qualified as a nurse in 1985 and she joined the Scottish Prison Service as a practitioner nurse in 1997. She was Head of Care at Cornton Vale between 2006 and 2010 and also the Keep Well programme lead for the Scottish Prison Service.

[57] Mrs McDowell was the national lead for the ACT 2 Care Suicide Risk Management Strategy introduced in 2005.

[58] Mrs McDowell described the treatment and management of drug or alcohol withdrawal symptoms as an everyday occurrence within the prison setting and spoke to

85% of female prisoners sentenced to imprisonment at Cornton Vale having a drug or alcohol addiction. She was unaware of any prisoner being transferred to a hospital setting primarily for drug or alcohol withdrawal treatment during her 13 years' experience. Such a transfer would arise if acute assessment or treatment was indicated or if any order were made under the mental health care legislation. Detoxification procedures seek to keep the patient stable and safe. The patient will be assessed on a daily basis each time medication is dispensed.

[59] Mrs McDowell spoke to the Scottish Prison Service production number 1 which is the ACT strategy document. ACT is an acronym for Assessment Context Teamwork. Its key aims are to assume a shared responsibility for the care of those at risk of self-harm or suicide; to work together to provide a person centred caring environment based on individual assessed need where prisoners who are in distress can ask for help to avert a crisis and to identify and offer assistance in advance, during and after a crisis.

[60] All prisoners entering prison go through a Reception Risk Assessment process. They are seen by a prison officer and a nurse immediately upon admission and subsequently by a doctor. In Miss Ross' case she was seen by a doctor on 14 March 2014. A series of questions is asked of the prisoner, the answers to which, together with the presentation of the prisoner, allow the assessor to mark the prisoner as being "at risk" or as being of "no apparent risk". If any of the three assessors marks the prisoner as "at risk", an ACT document is raised immediately. A decision is made on how to safeguard the prisoner. It is noted at page 4 of the ACT 2 Care Strategy Document, Scottish Prison Service production number 1, that "prisoners who are 'at risk' of suicide must be cared

for in a safe environment. This does not automatically mean a 'safe' cell and being stripped of their own clothing and belongings. ACT 2 Care is about identifying an appropriate safe environment, where the prisoner feels safe, comfortable and relaxed." Isolation is always the last resort.

[61] Mrs McDowell gave evidence that all staff within the prison setting are responsible for suicide risk management. Staff who interact with prisoners are best placed to identify any risk. Any Scottish Prison Service or NHS employee may raise an ACT document at any time should they have concerns about a prisoner. All staff are trained on what are referred to as "cues and clues" and precipitating factors. They are alert to triggers which may affect prisoners' moods. It is vital for all staff to look for signs of increased risk throughout the period of custody.

[62] All relevant staff were trained in ACT procedures. Each staff member would receive an initial full day's training with an annual refresher course.

[63] In relation to any previous attempt at self-harm or suicide, Mrs McDowell said that such an attempt would always be considered as part of the risk assessment but would not automatically result in a categorisation of "at risk". In each case such an attempt would be explored and considered.

[64] Mrs McDowell was asked specifically about the circumstances of Miss Ross' care within HMP Edinburgh and her death. She had reviewed the circumstances around Miss Ross' death. She immediately conceded that the failure by the reception officer to complete the individual pro-forma questions at Section 2 of the Reception Risk Assessment before concluding that there were no issues on transfer and that there was

no apparent risk was not good practice. She was not concerned that Dr Revill had not provided a narrative in the Doctor Risk Assessment as his detailed observations were recorded within Miss Ross' medical records under the VISION entry system.

[65] Mrs McDowell's evidence was that Miss Ross had had a lot of contact with health staff and had undergone a mental health assessment shortly before her attempt to hang herself on 26 March 2014. It would have been open to that member of nursing staff to put Miss Ross on ACT if she had been concerned. Further, a prison officer had also had contact with Miss Ross shortly before. Mrs McDowell considered that good practice had been followed during the detoxification process by recording fully Miss Ross' presentation such that any changes would be apparent.

[66] Nothing which Mrs McDowell read in Miss Ross' records suggested that there was a significant risk of suicide on 26 March 2014, the date on which Miss Ross attempted to hang herself. Nor did she consider that there was any indication that hospital care was required. She considered that the care and treatment were appropriate.

[67] Dr MacGregor's experience until her retirement in 2014 was in adult psychiatry in the community. She readily accepted that her only experience of treatment and care in the prison setting would be as an on call consultant. In her health authority, the practice was for there to be a designated psychiatrist who would have responsibility for patients in prison. That designated consultant would have specialist forensic experience. During her early training, she had specific experience of working in a unit specialising in alcohol and drug addiction. Necessarily, the impact of alcohol and drug addiction was encountered in Dr MacGregor's psychiatric practice in a community setting.

[68] In his submissions on behalf of the Scottish Prison Service, Mr Scullion did not dispute Dr MacGregor's experience of treating patients with significant mental health problems, who would suffer the symptoms of drug and alcohol withdrawal and who may have been suicidal at the time or in the past. He declared a degree of sympathy for the opinion and concerns expressed in Dr MacGregor's report from the perspective of someone practising in the community. However, he submitted that those observations and, in particular, her observations on the impact of previous attempts at suicide on an assessment of imminent risk displayed a lack of experience and a lack of expertise in health care and suicide prevention in the prison setting.

[69] Under cross-examination and when asked about ACT procedures, Dr MacGregor offered that her knowledge of ACT derived only from what she had researched. She had no experience of ACT in practice or of its implementation.

[70] Questioned closely by Mr Scullion on behalf of the Scottish Prison Service on whether her position was that the initial assessment under ACT should have resulted in Miss Ross being assessed as "at risk" or whether her criticism was solely of the way in which the document was completed, Dr MacGregor was not clear initially. When pressed, her evidence was that Miss Ross should have been marked as "at risk" on initial assessment.

[71] Further, Dr MacGregor was unable to assist the court with the practical steps which would follow a prisoner being assessed as "at risk". She readily conceded that she had limited experience but outlined her understanding that such an assessment would trigger procedures to keep a prisoner safe. Questions would be asked about the nature

of the risk and what should be done to manage that risk. The prisoner's environment would be considered, including potential ligature positions, and a care plan would be formulated.

[72] Given Dr MacGregor's limited experience of ACT, she was unable to explain what step or steps may have been taken under ACT which might have prevented Miss Ross' death.

[73] Dr MacGregor was questioned by Mr Scullion on whether she thought there was a real risk of Miss Ross attempting suicide. Dr MacGregor responded that Miss Ross was unpredictable, very distressed and angry. The symptoms of her withdrawal were complex and severe. She was at risk of impulsive behaviour. Her condition was worsening and added to that was the fact that she had taken heroin. A clinical, medical decision ought to have been taken. It ought to have been in the minds of those looking after Miss Ross that she had a history of serious self-harm. As Miss Ross' condition deteriorated, staff should have been prompted to consider whether she was safe and whether more could be done to keep her safe. Dr MacGregor emphasised that any risk re-assessment ought not only to be in the context of ACT but ought to involve a clinician. That was the way to think globally.

[74] Dr MacGregor did not think that Miss Ross' death should have come as a surprise. There were clues. She could not know whether the outcome of Miss Ross' death could have been affected by any different care or treatment regime.

[75] Under cross-examination by Mr Holmes on behalf of NHS Lothian, Dr MacGregor accepted that Miss Ross had been reviewed regularly by nursing and

medical staff. She thought there could have been more medical input. The reviews had not resolved Miss Ross' inability to sleep. Sleeping tablets had been prescribed too late in her opinion. Dr MacGregor considered that there was a strong possibility of impulsive behaviour, including a suicide attempt. However, Dr MacGregor agreed that it was not possible to know if anything (by which I understood any alternative steps in care and treatment) would have made a difference.

[76] I do have reservations about Dr MacGregor's qualification and experience to comment upon the risk assessment of Miss Ross under ACT. Dr MacGregor fairly conceded, as did the Crown, that her experience of treatment in the prison setting was limited and that her knowledge of ACT procedures was theoretical rather than practical.

[77] Ultimately, Dr MacGregor's opinion was that Miss Ross' history of three suicide attempts, albeit from 1997, 2002 and 2004, combined with the symptoms of a complex detoxification process, necessarily placed her at risk of suicide. Dr MacGregor was unable to comment on how such a risk should have been managed differently in the prison setting.

[78] In her report, Crown production number 7, Dr MacGregor identified reasonable precautions whereby Miss Ross' death might have been avoided as increased support and observation together with removal of means to suicide. It seems to me that Dr MacGregor did not give appropriate consideration to the regular reviews of Miss Ross by nursing and medical practitioners nor to the various risk assessments and mental health assessment. Rather, Dr MacGregor appears to have concluded that Miss Ross' care would have been managed optimally in a hospital setting, certainly by

26 March 2014 on which date Miss Ross attempted to hang herself. Unfortunately, Dr MacGregor did not specify how Miss Ross' care would have been managed differently in a hospital setting.

[79] It ought to be remembered that the obligations imposed on all relevant persons in the prison setting under ACT were continuing and not limited to the initial assessment. The evidence before the inquiry was that none of those relevant persons assessed Miss Ross to be at significant risk of suicide.

[80] The circumstances of Miss Ross' care between 12 and 26 March 2014 do not support any finding that there was a lack of assessment or that there should have been increased observation and support. On the contrary, the medical records, Crown production number 5, disclose regular review by general, addiction and mental health nurse practitioners in addition to medical practitioners. I accept that the records note that Miss Ross was not seen by a general practitioner on 24 March 2014. She was then seen by Dr Kevin Hinkley on 26 March 2014.

[81] I also accept, and as was readily conceded by Lesley McDowell, that it is not good practice to fail to complete specific questions on the Reception Risk Assessment pro-forma before reaching a conclusion on a prisoner's risk status.

[82] Assessing the evidence as a whole, it seems to me that Dr MacGregor held firmly to her opinion that Miss Ross' previous attempts at suicide indicated a risk of suicide which risk was heightened by her withdrawal symptoms. Such opinion did not have proper regard to nor was it appropriately moderated by consideration of the specific care and treatment of Miss Ross and to her regular review by nursing and medical staff.

Further, the established facts did not indicate that Miss Ross ought to have been transferred to a hospital setting for acute treatment or assessment.

[83] It follows, then, that I do not propose any findings in terms of section 6(1)(c), (d) or (e) of the 1976 Act.

[84] Finally, I should like to extend my sympathy to Miss Ross' family.