SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT PERTH

[2017] FAI 20

B366/16

DETERMINATION

BY

SHERIFF ALASTAIR CARMICHAEL

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

into the death of

MARK JOHN ANDREW SMITH

Perth, 14 September 2017

Determination

The Sheriff having considered the information presented at the inquiry, determines in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 that:–

MARK JOHN ANDREW SMITH, born 17 June 1992, of Dundee, was pronounced to be dead at 0254 hours on Saturday 31 October 2015 at Perth Royal Infirmary.

MARK JOHN ANDREW SMITH died as a result of suspension by the neck from a bedsheet ligature (hanging) in cell C2.56 at Perth Prison on 27 October 2015.

I find that there are no precautions which could reasonably have been taken that might realistically have resulted in Mark Smith's death being avoided.

I find that there were no defects in any system of working which contributed to Mark Smith's death.

Recommendations

I make no formal recommendations about taking reasonable precautions, making improvements to the systems of working, introducing new systems of working or taking of any other steps, which might realistically prevent other deaths in similar circumstances. I have, however, set out some observations below.

NOTE

Introduction

[1] This Fatal Accident Inquiry (FAI) was held into the death of Mr Mark John Andrew Smith ("Mark Smith"). It was held under the provisions of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 which is the predecessor of the recent Inquiries into Fatal Accidents and Sudden Deaths Etc (Scotland) Act 2016.

[2] Mark Smith's death was reported to the Crown Office and Procurator Fiscal Service (COPFS) which then carried out an investigation in the public interest. The COPFS applied to the Sheriff on 15 December 2016 for a FAI to be held. This application was granted on 16 December, and the court fixed 21 February 2017 as the date for a Preliminary Hearing and 22 March was fixed as the date for the FAI. The date for the FAI was later changed.

[3] The FAI was held before me at Perth Sheriff Court on 25 and 26 July 2017. The FAI was then continued for the written submissions of the parties, the last of which was received on 6 September 2017. The following representatives appeared at the FAI:

For the Crown: David Barclay, Senior Procurator Fiscal Depute.

For the nearest relative (Ronnie Smith, brother): Kristopher Gilmartin, Solicitor.

For Tayside Health Board ("THB/NHS"): Paul Reid, Advocate.

For the Prison Officers Association Scotland ("POAS"): Iain Cahill, Solicitor.

For the Scottish Prison Service ("SPS"): Sarah Phillips, Solicitor.

[4] The following witnesses gave evidence:

1 Detective Constable John Smith.

2 Mumtaz Hussain, charge nurse.

3 Claire Petrie, charge nurse.

4 Douglas McRitchie, prison officer.

5 David Anderson, prison officer.

6 Peter Lee, retired prison officer.

7 Adam Masterton, prison officer.

8 Elaine McAinsh, staff nurse.

9 Michaela Hunter.

10 Leslie McDowell, Health Strategy and Suicide Prevention manager.

[5] There were two joint minutes and an audio recording of a telephone call made by Mark Smith at 16:42 hours on 27 October 2015, and these were all entered into the evidence.

The Legal Framework

[6] The FAI was held under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("the Act") and its conduct and purpose were governed by the Act.

[7] The purpose of the FAI is to determine the cause of Mark Smith's death, to determine if there were any precautions that could reasonably have been taken that might realistically have presented his death, to identify any defects in the system of working that may have contributed to his death and to identify any other facts that may have been relevant to his death. The Sheriff can make recommendations as to reasonable precautions, improvements to the system of working or other steps that may realistically prevent future deaths in similar circumstances.

[8] The Procurator Fiscal's depute appeared at the FAI to represent the public interest. He was not there in his role as a public prosecutor.

[9] It is not the purpose of a FAI to establish civil or criminal liability.

Summary

[10] The evidence relevant to the issues in question, that I accepted as being credible and reliable, is as follows;

[11] **1 Detective Constable John Smith:** DC Smith went to cell 2.56 in C wing at Perth prison on the 28 October 2015. He ensured that the scene was protected and arranged for photographs to be taken. He identified from Crown production (CP) 5 that photographs 34 to 41 were photographs of that cell taken at that time.

[12] **2 Mumtaz Hussain**: He is a charge nurse with the SPS and has been nursing for 27 years, 13 of which had been with the SPS. On 27 October 2015 he received a Code Blue message when he was in C Hall getting ready to do a medical round. He went straight up to cell 2.56 at 18:45 hours and administered medical help to Mark Smith.

Having found no pulse on his arrival he then used the Hall defibrillator in combination with oxygen and these produced a pulse from Mark Smith. It took 5 to 10 minutes for paramedics to arrive. The defibrillator analyses the patient's state of health and advises when a shock should be administered.

[13] **3 Claire Petrie:** She is a charge nurse who works at HMP Perth, has been in nursing for 18 years, 3 of which has been in the SPS. She also received the Code Blue message at 18:45 hours and gave assistance to Mark Smith. The paramedics arrived at around 19:00 hours. CP7 is the note that Douglas McRitchie found and handed to her in the cell. She had worked in reception and did risk assessments on prisoners and confirmed that a nurse cannot participate in this unless he or she has been specifically trained by the SPS.

[14] **4 Douglas McRitchie:** He is a prison officer who has 28 years of service in the SPS. He had spent all of his 28 years in SPS working in prison halls, including remand areas and protection areas. He saw Mark Smith at around 17:30/17:40 hours when he had been given the use of a phone. He saw Mark Smith go to the phone on the landing in order to make the call, but he did not listen in. He went into Mark Smith's cell to search it at the end of a staff break at around 18:40 to 18:45 hours. He unlocked the door and when he entered he saw Mark Smith who had apparently used a sheet with a ligature to hang himself from the toilet door. He held Mark Smith and lifted him up, removed the ligature and then started to do CPR on him, but could not find any signs of life. He put out a Code Blue alert. He continued giving CPR until nursing staff arrived shortly thereafter. He stayed with the nursing staff and kept Mark Smith's airway open

as they worked with the defibrillator. He stayed there until the paramedics arrived. He found CP7, which is a note, on top of a work top beside the window in the cell.

[15] New prisoners are put into the First Night in Custody Suite (FNICS), unless it is full, and stay there until seen by the doctor the following day. Mark Smith's cell was in the FNICS. A new prisoner will be interviewed by staff on the wing to make sure that they know the prison routine. The officer is usually given information about new prisoners including their personal details, any issues raised at reception and is told whether they are remand or sentenced prisoners. This information will also include whether or not the prisoner has been assessed as 'at risk'. Once in the FNICS a new prisoner is allocated a cell, is given prison clothing, is told the rules about receiving visits, is informed about prison routine and is asked if he has any issues. A prisoner could either be allocated a cell to himself or could share with others, but a single cell is usually allocated if there is a medical need for this. Mr McRitchie did not receive Mark Smith into the FNICS. If a prisoner is not assessed as being 'at risk', the officer would not be given information about any mental health or drug problems. Mr McRitchie thought that this information would be of assistance. If a prisoner is assessed as being 'at risk' then he is allocated a safe cell and would be given different kit depending on the level of risk, and this could include different clothing and bedding. He may also receive regular observations.

[16] The prisoner's details received at FNICS would say if the prisoner had previously been assessed as 'at risk' and would say if there is any kind of health marker against the prisoner. If a prisoner requested to share a cell, then that could be organised.

Each cell has a button for an intercom which sets off an alarm light outside the door should the prisoner wish to request some sort of assistance. The prisoner is told that he can speak to staff or to a nurse or to a chaplain if he wishes. There are Listeners available to go and speak to the prisoner in confidence. SPS productions ("SPSP") 5 and 6 are documents that are given to new prisoners. SPSP5 explains the routine and responsibilities for the prisoner and gives information about available supports. SPSP6 is a checklist which is filled in with the prisoner in the cell. It is signed by the prisoner and also by a member of staff.

[17] **5 David Anderson:** He is a prison officer who has 29 years of experience in SPS. He had been aware that Mark Smith was in the FNICS on 27 October 2015 and that his brother, Alex Smith, was also a prisoner in Perth. He advised both prisoners of the other's presence in the prison, but neither wished to share a cell with the other.

[18] He saw Mark Smith in tears after he had had a telephone call and spent 10 to 15 minutes with him, giving him some tobacco that he had got to pass on from Alex Smith. Mr Anderson told Mark Smith that he would arrange for him to meet his brother later. It was possible that Mark Smith had asked to use the phone again later. By the time he left the cell Mr Anderson was confident that he would see Mark Smith after the tea break because he had calmed down. Mr Anderson saw no signs of intention to self-harm in Mark Smith.

[19] At 18:45 hours Mr Anderson detected a strong phone signal coming from Mark Smith's cell. When the cell door was opened he saw Mark Smith hanging from the toilet door. He helped to move Mark Smith down to the floor and do CPR. There were no

signs of life at that stage. Mr Anderson called for nursing staff on his radio and they arrived in seconds.

[20] Mr Anderson was not aware of any previous 'at risk' marker for Mark Smith, and was unaware of any information about his mental health or drug misuse or withdrawal. The only information he had consisted of Mark Smith's personal details. Mr Anderson thought that it was possible that he may have dealt with Mark Smith differently if he had had all of that other information. This information was available on the PR2 system and could be accessed in the prison officer's office, but it has to be actively sought out and he did not always have enough time to access it.

[21] Mr Anderson had been trained in the ACT2 Care procedures that included spotting the risks of self-harm in prisoners. He had previously put people on the ACT2 Care 'at risk' status and would always err on the side of caution in doing so.

[22] **6 Peter Lee:** He is a retired prison officer. He had 9 years of experience in SPS and was carrying out reception duties on 27 October 2015. Mr Lee had received 6 weeks training at Polmont at the start of his SPS career and he then had assessments to do over the next 2 years. If he had not completed them successfully then he would have been rated as unsuitable for the job. He had no previous experience of dealing with people with mental health or drug/alcohol difficulties, but had gained experience of these things in his time in SPS.

[23] The ACT2 Care form is a risk assessment that is carried out for all arriving prisoners, even including a return from a day away to court. Like other officers he received annual ACT2 Care training, partly on-line as well as a class session. Each

reception officer must do this annual training. This includes training in 'cues and clues' which is about the sort of things that officers should look for in a prisoner's body language, conversation or behaviour that might give indications of vulnerability. He had worked in reception for 6 to 7 years and processed the arrival of at least 60 to 70 prisoners every week.

[24] The reception procedures are usually carried out by four people. One goes through the ACT2 Care form and checks the warrant, one goes through the prisoner's property including his clothes, one does a search of the prisoner and the fourth puts the information into the Personal Escort Record (PER) database. Each of the four observes, and engages with, the prisoner throughout this process. The reception officers have available to them on the PER system information about the prisoner from the police and court staff. CP9 is the PER for Mark Smith that was available to the prison staff. This includes information in categories about violence, weapons, escape attempts, drug/alcohol habits, suicide/self-harm risks as well as timings and records of events.

[25] CP11 is the ACT2 Care form relating to Mark Smith. Mr Lee completed the first part of this. He noted that there was a historic self-harm marker on the PER form while he completed the CP11 form. There was no record of any previous ACT2 Care 'at risk' marker on the system. If Mark Smith had had that previous status, then that would have appeared on the system. Section 2 of the form was completed based on what Mark Smith said to Mr Lee and on what Mr Lee observed of Mark Smith. Mark Smith was suffering the effects of drugs and acknowledged that he had taken some. Mark Smith stated clearly that he had no thoughts of self-harm and did not know why there was a previous

self-harm marker on the PER. He asked Mark Smith to roll up his sleeves and noted that there were no signs there of self-harm. Mark Smith spoke very fluently to Mr Lee and, although he looked a bit tired, he presented well. Mark Smith was very calm and displayed no signs of anger. Mr Lee ticked the box for Mark Smith being 'no apparent risk'. All of the reception team had looked at Mark Smith and none had any concerns. An example that Mr Lee gave was that the officer who searches a prisoner could spot self-harm marks whilst doing so. One of the team that day was an ACT2 Care trainer, and none of them had any concerns about Mark Smith. Nurse McAinsh completed her part next and if she had any concerns she could have come to Mr Lee or the others in the team.

[26] Mr Lee saw no information on the PER about any of the following: mental health problems, medical prescription, Mark Smith's last medication, drug use, details of previous self-harm or if he had eaten whilst in police custody.

[27] Mr Lee had previously assessed prisoners as being 'at risk' and was aware that that could result in various protection measures being applied, including observations at 60/30/15 minute intervals, safe cells, anti-ligature bedding and anti-ligature clothing.

[28] If a prisoner has a historical marker for self-harm that would not necessarily mean that he would be assessed as 'at risk' on ACT2 Care. The officers assess how the prisoner looks at the time of arrival in reception. Mr Lee always erred on the side of caution and if he had any doubt about risk then he would assess a prisoner as being 'at risk' rather than 'no apparent risk'.

[29] **7 Adam Masterton:** He is a prison officer who has been in the SPS for 8 years. He went with officers Anderson and McRitchie to search Mark Smith's cell at approximately 18:45 hours. He assisted in trying to resuscitate Mark Smith. He was trained in CPR and administered CPR to Mark Smith. He saw the defibrillator machine being used and saw Mark Smith's colour changing for the better when that was done.

[30] **8 Elaine McAinsh:** She is a staff nurse who works in Perth prison. She has worked for the SPS for 2 years and had been nursing for 7 years before that. She has a bachelor of nursing degree from Robert Gordon's, she had worked in a nursing home although had not worked as a mental health nurse. She had received training from SPS on the ACT2 Care programme. This consisted of a full day of training for working in the prison reception and annual updating training. She had dealt with patients who had mental health problems and drug/alcohol problems when she worked in the care home sector.

[31] She completed the nursing assessment part of the ACT2 Care form for Mark Smith. Her participation is at page 4 of CP11. She looks for clues that might indicate the risk of self-harm in a prisoner including the presentation of the prisoner, the content of conversation, the level of eye contact and the body language. The "cues and clues" information to staff on the form assists with this. She assessed Mark Smith as understanding what was going on and being able to communicate with her. Mark Smith had not previously been assessed as 'at risk' in ACT2 Care. The PER showed that Mark Smith had a previous history of self-harm. Mark Smith told her that he had previously received treatment for mental health problems, had not previously had psychological

treatment, had previously attempted suicide, did not feel suicidal and did not feel like hurting himself. Mark Smith appeared to her to be relaxed, he clearly stated that he had no thoughts of suicide or of self-harm. Mark Smith had good eye contact with her and communicated well. She therefore ticked the box for him being 'no apparent risk'.

[32] There is always support available to nursing staff, whether on-line at the SPS or through colleagues or the NHS.

[33] She said that a previous history or marker of self-harm was relevant to the risk assessment for a prisoner. Similarly, information about drug use/withdrawal, mental health and prescribed medication are all relevant to the risk assessment process. She did not get told what a prisoner is in prison for. She was aware that Mark Smith had been prescribed antidepressant medication. It is possible that Mark Smith told her that he was withdrawing from drugs at that time.

[34] CP12 is the set of medical notes for Mark Smith that was available through the VISION system. Ms McAinsh did not recall if she had seen the entry of 1/9/15 about a mental health assessment, and did not recall looking at this document. Having been shown these notes in court, she believed that her decision to assess Mark Smith as 'no apparent risk' would have been the same even if she had seen the notes then.

[35] Mr Lee's assessments of risk do not influence her and she makes her own decisions about risk. There is no tension within the team if different members come to different views about the risk assessment for a prisoner.

[36] When a prisoner is taken into custody and has prescribed medication with him or her, that medication is destroyed. The prisoner would have to wait for the prescribed

medication until the following day when the prescription has been confirmed – unless it was emergency medication such as that for a heart condition or insulin.

[37] **9 Michaela Hunter.** She is 21 years old and is the long term partner of Mark Smith. She has a 9 weeks old child. *[Note; this witness became distraught and was unable to take her evidence any further. I am grateful to parties for then producing the second joint minute that is referred to below.]*

[38] **10 Leslie McDowell:** She is the SPS Health Strategy and Suicide Prevention manager. She is a qualified nurse who has been in the SPS for 20 years. Amongst other things she was the Head of Care at Cornton Vale prison and was the project manager of the Keep Well programme. Since 2013 she has been the SPS lead on health matters. Her current main work is liaising with the NHS on health strategy and this includes the suicide prevention policy. She has been an ACT2 Care trainer since 1998.

[39] Every member of the SPS completes one day of core ACT2 Care training before they have any access to prisoners. This core training teaches staff about the policy, the assessment of risk factors, what are the at-risk groups and the triggers for self-harming. The latter includes factors such as a prisoner having received a sentence that is heavier than expected, having gone through a difficult visit or having suffered bereavement. The ACT2 Care programme uses 'cues and clues' that inform staff on the verbal and non-verbal signals that may advise that a prisoner is struggling to cope. These include prisoners being tearful, eye contact, body language and whether a prisoner is conversing with staff, and if so, to what extent. Thereafter there is annual training consisting of one hour in a class session and one hour of e-learning.

[40] When a prisoner arrived at a prison in 2015 he or she was assessed at reception by ACT2 Care trained officers who completed the ACT2 Care forms. The officers would have the PER form and may also have other relevant information e.g. from the social work department or specific police information. The nurse has access to healthcare records through the VISION computer system, although those records are not available to the prison officers for reasons of confidentiality. The reception assessment of a prisoner is not a full mental health assessment, it is an assessment of the prisoner's apparent state made at that time. The assessment forms were passed on to the Hall ready for the medical examination the next day.

[41] If the prisoner was assessed as being 'at risk' then an ACT2 Care book would be completed and a care/protection plan would be formulated. The line manager of the prisoner's Hall will be advised of this status and would be involved in formulating the care plan.

[42] Safe cells can be part of the care plan for 'at risk' prisoners. However, safe cells do make prisoners feel isolated and, as a result, where possible the staff do try to maintain the prisoner's routine in as a normal way as possible.

[43] CP9 is the PER for Mark Smith. There are four boxes that have been ticked and these can be historical information, often from the police. The reception staff are trained to explore these things further by asking the prisoner about the subject that has been ticked.

[44] CP11 is the reception risk assessment for Mark Smith. Nothing about this form stands out as being out of the ordinary. Mr Lee has spoken to Mark Smith about

previous self-harm and Mark Smith has said that he has no idea why that marker was there. The health care part completed by Ms McAinsh shows that there is a positive for previous attempts at self-harm or suicide, but this does not mean that Mark Smith should therefore be assessed as 'at risk'. Looking at the form as a whole it has been correctly completed with Mark Smith assessed as being 'no apparent risk'.

[45] Focus groups with prisoners tell that they feel worse if their own clothing and belongings are taken away from them as happens if assessed as "at risk." The special risk clothing is not warm, is uncomfortable and shapeless and identifies the wearer as a person who is at risk. Anti-ligature bedding is made from tough material and is a different colour from the bedding of other prisoners. Anti-ligature pillows are made from solid foam and are not comfortable.

[46] SPS audits show that prison staff err on the side of caution, and if in doubt do tend to put prisoners in the 'at risk' category. Staff are aware that by putting prisoners into this category they do remove some of the prisoner's rights and that the decision to do so must therefore be capable of being justified.

[47] The ACT2 Care system has now been replaced by Talk To Me. This new system was brought in mainly because the NHS took over medical care in the prison estate in 2011 and the ACT2 Care system did not reflect this NHS involvement.

[48] Talk To Me is an updating of the old system. SPS staff received a half day of conversion training from the old system to the new system. Talk To Me started in December 2016. It uses the same 'cues and clues' as ACT2 Care.

[49] There are currently about 25,000 prisoners admitted into the prison estate every year. The prison population varies every day and in 2015 the average was 7652. 5% of suicides by prisoners were prisoners who had been admitted within the previous 24 hours. Over 50% of prisoners report some form of mental health history.

[50] In 2015 the ACT2 Care strategy said that the reception nurse should be a mental health nurse where possible. But, due to a shortage of nurses trained in mental health, the SPS nurses are often general practice nurses who were trained by SPS in the ACT2 Care system.

[51] If a prisoner has been prescribed medication and does not have access to that medication then the possibility of suicide increases.

[52] The reception assessment of a prisoner amounts to a snapshot of the prisoner at that time in the opinion of the reception officers and nurse. Prisoners may not be honest in the answers they give during the reception process.

[53] SPS considered a system of risk assessment where a prisoner would be assessed as being "at risk" if he or she ticked a number of boxes during the assessment. This was used in an English private prison but had received criticism. The Mental Welfare Commission thought that this system was not good because it resulted in too many prisoners being put into safe cells/clothing which, in turn, could be bad for their mental health. The SPS does not therefore accept this as a good approach.

[54] The staff in the FNICS can carry out observations on prisoners if there are concerns about, for example, drug withdrawal. SPS can also do 'buddy' cells for at risk prisoners, although single cells are generally favoured.

[55] Ms McDowell thought that the reception nurse should check a prisoner's medical records (if available) as routine.

[56] Some prisons have a prescribing nurse who can prescribe medication to prisoners.

[57] **The two joint minutes** agreed, amongst other things that:

[58] Mark Smith told a police officer on 12 January 2014 at a charge bar in the Dundee Custody Unit that, 'tried killing myself before when I was in jail. Can't remember when', this comment was added to the police computer system and a suicide warning marker was noted.

[59] Mark Smith appeared at Dundee Sheriff court on 27 October 2015 faced with 7 charges, one of which was a domestic assault. He pleaded not guilty and bail was refused, he was remanded to HM Prison Perth with a trial date fixed for 3 December 2015. Staff at court noted that Mark Smith was unhappy in the cell area at having been remanded in custody. Mark Smith allegedly punched two lights in the cell area and was charged with vandalism for this. He refused to leave his cell and refused to provide his details.

[60] At around 18:45 hours on Tuesday 27 October 2015 Mark Smith was found hanging in his cell. He was found by prison officer Douglas McRitchie. A 'Code Blue' radio message was issued. This message means that a prisoner has been found unconscious or is having difficulty breathing. All nurses that were then on duty attended at his cell and assisted with resuscitation attempts. At around 18:50 hours the first ambulance crew arrived there. Mark Smith was taken to hospital by ambulance

leaving the prison at 19:17 hours and arriving at Perth Royal infirmary at 19:30 hours. Mark Smith was admitted to the Intensive Treatment Unit but was found to have sustained severe irreversible hypoxic brain damage and that his condition was inconsistent with survival. He was being kept alive by a ventilator. After consultation with Mark Smith's family, the ventilator was removed, and he was declared to be dead at around 02:50 hours on Saturday 31 October 2015. A post-mortem was carried out on 4 November 2015 with a cause of death being recorded as 1(a) Suspension by the neck from bed sheet ligature (Hanging).

[61] At the start of November 2015 the Scottish Prison Service's computer records were searched and no record was found of any prior incidents of self-harm or attempts at suicide by Mark Smith.

[62] Mark Smith refused all meals while in police custody on 27 October 2015 and this information was not passed on to G4S or to Perth prison. A procedure is now in place whereby any person in police custody who refuses two meals in succession is immediately referred to a nurse.

[63] As at 27 October 2015 Mark Smith had a history of suffering from depression and was prescribed citalopram.

[64] Michaela Hunter gave a statement to the police on 9 December 2015 which confirmed, amongst other things, that she had been the partner of Mark Smith, that this had been a relationship of two years and they had lived together for eighteen months, that Mark Smith had previously said he would kill himself if they ever split up but she did not take the threats seriously, that when Mark Smith was last in Perth prison he

tried to slit his wrist because they had had another "domestic" and had split up again but that during his sentence they had made up again and things were okay between them and that at about 16:45 on 27 October 2015 she received a call from Mark Smith from Perth prison.

[65] I accepted all of the evidence in the joint minutes as being established fact, including that Michaela Hunter had given that statement to the police.

[66] **At the conclusion of the evidence**, all parties wished to make **written submissions**, as opposed to verbal ones. The last of these was received on 6 September 2017.

[67] The submissions from COPFS, THB/NHS, POAS and SPS all suggest that there were no precautions that could have been reasonably taken, that there were no defects in the system of work or other things that could realistically have prevented Mark Smith attempting to take his own life. They all suggest that there were no specific recommendations that should be made.

[68] The submissions from Mr Gilmartin on behalf of the nearest relative, Mr Ronnie Smith who is Mark Smith's brother, are different.

[69] Mr Gilmartin suggests that there were reasonable precautions which could have been taken that could have prevented Mark Smith's death. These include that the officers in the FNICS should have been told about Mark Smith's history of mental health problems, his ongoing mental health problems, the fact that he had not received his citalopram whilst in police custody, that he had a previous marker for self-harm/suicide and that he had been remanded in respect of an offence against a family

member/somebody close to him. Mr Gilmartin suggests that a prisoner who 'scores' with a number of risk factors in the ACT2 Care/Talk To Me assessment should automatically be given protective measures on the first night in custody including observations by prison officers and that the prisoner should not be placed in a cell alone. He suggests that the PER should include information about any special measures that were taken during the detention of the prisoner in police/court custody, information about any incidents of aggression/violence displayed by the prisoner in police/court custody and information about the nature of the charge(s) faced by the prisoner.

[70] Mr Gilmartin suggests that there were defects in the system of working which did contribute to Mark Smith's death. These are that the prison officers working in the FNICS were not told about his history of mental health problems and his ongoing mental health problems, that he had been prescribed medication for ongoing mental health problems, that he had been deprived of medication while in police custody, that he had a marker of a previous self-harm/attempted suicide and that he was remanded in respect of an offence against a family member or someone close to him.

[71] Mr Gilmartin suggests that the ACT2 Care and Talk To Me risk assessments do not allow for special measures to be employed in a situation where a prisoner presents with a number of risk factors but has been assessed as 'no apparent risk'. He also suggests that PER should have recorded any special measures that were taken whilst Mark Smith was in police/court custody, any incidents of aggression/violence displayed by him in police/court custody and should provide information about the nature of the offence charged.

[72] Mr Gilmartin suggests that recommendations are made as follows:

(1) The implementation of a system allowing for the employment of special measures where a prisoner presents with a number of risk factors.

(2) The requirement to share certain information pertaining to a prisoner's risk category with prison officers working first night in the FNICS.

(3) The requirement to include information in the PER about any special measures taken during the detention of the prisoner in police/court custody, any incidents of aggression/violence displayed by the prisoner in police/court custody, and the nature of the offence alleged.

[73] Mr Gilmartin stated at the end of his submissions that, 'it cannot be said with any certainty whether these changes would have prevented the deceased from taking his own life. It can be said that the changes may have the benefit of preventing a death in the future."

Discussion and Conclusions

[74] I have to decide if any facts have been established on the basis of credible and reliable evidence, and whether I can make reasonable inferences from those facts. The standard of proof as regards the circumstances surrounding Mark Smith's attempt to take his own life is that of the balance of probabilities. I cannot hold facts as established on the basis of speculation alone.

[75] The main questions for the FAI were whether there were precautions that could have been taken that may have prevented Mark Smith attempting to take his own life

and whether there were defects in the SPS systems of work that may have contributed to him doing so.

[76] A timeline shows that;

14:35 ACT2 Care reception commenced

15:00 Mark Smith assessed as "no apparent risk" by Peter Lee

15:15 Mark Smith assessed as "no apparent risk" by Elaine McAinsh

16:42 Mark Smith has a 'phone conversation with Michaela Hunter and then seen to be distressed

18:45 Mark Smith found in his cell with a ligature around his neck

The evidence showed that there were several things that could perhaps have influenced Mark Smith's decision to attempt to take his own life. He had just been remanded in custody on a number of charges with a trial date set for the start of December. He therefore faced four weeks in custody on remand. He had a medical history that suggested that he had had some diagnosis of depression. He had been prescribed citalopram but had no access to that while in custody until such time as the prescription was confirmed with his GP and the medication released to him – likely to be a period of 24 hours or so. He had been told that his brother was also in the prison. He had initiated a phone call with his then partner, Michaela Hunter, who had told him, in effect, that he had assaulted her, that she would not be 'dropping' the charge and that she could not be with him anymore.

[77] There was no medical evidence led to expand upon the nature of the mental health difficulties Mark Smith had had in the past or the nature of any such difficulties

on 27 October 2015. There was evidence that his prescription for citalopram was 20mg, but no evidence to suggest what impact there might have been due to the drug being unavailable to him at that time in prison. In the absence of such evidence it would be speculation on my part to infer that either of these things had any impact on his decision to try to take his own life. I cannot therefore make that inference.

[78] There was evidence that Mark Smith was distressed after the telephone call with Michaela Hunter. His distress was observed and David Anderson went out of his way to spend time with Mark Smith to satisfy himself that he was calm. This change of behaviour following that 'phone call, combined with the content of the note that Mark Smith wrote, makes it clear to me that the telephone call was the main influence for Mark Smith's decision to try to take his own life.

[79] CP7 is the note that was found in Mark Smith's cell, which is attributed to him and appears to be intended for Michaela Hunter to read. The note starts in organised handwriting and says that he doesn't remember what happened, suggests that this is due to having taken, "them stupid things", and beers, and says that he loves her to bits. This probably refers to the allegations that he was charged with. After that, the handwriting becomes less organised, is elongated and slanted and tells her that, "you won't need to worry no more cos I'm not gonnae be here I told ya once I loose you there's no point in me being here so that's me way go now." The latter part ties in with the content of his phone call with Michaela Hunter when she told him that she could not be with him anymore. I infer that the first part of the letter was written before that telephone call, and that the remainder was written afterwards.

[80] The evidence shows that the main trigger for Mark Smith's decision to attempt to take his own life was the telephone call with Michaela Hunter. I do not attribute any blame or responsibility to Michaela Hunter for Mark Smith's decision to do this. Mark Smith's reaction to the telephone call and consequent decision to try to take his own life was not something that could have been anticipated by SPS staff. I found David Anderson to be a credible and reliable witness, and his actions to comfort and settle Mark Smith after that telephone call were commendable. He is an experienced prison officer and his belief that he would see Mark Smith later that day was based on his observations and reasoned judgement.

[81] I do not therefore think that the precautions mentioned by Mr Gilmartin would, realistically, have prevented the death of Mark Smith.

[82] Even though Mark Smith's decision could not have been anticipated by the SPS, I will consider whether the SPS reception and ACT 2 Care (now "Talk To Me") systems were lacking in any way.

[83] The SPS deals with vulnerable men and women every day within the prison estate. There were various statistics quoted at the FAI. What is clear is that people still take their own lives within the prison estate and that using 'rolling' figures this remains at a – sadly – consistent rate. There was no psychiatric evidence led about the sort of symptoms that may be displayed by a person that may suggest that he or she is considering taking his or her own life. It is within judicial knowledge that on occasions people do take their own lives without having exhibited any obvious indications of that intention. There was, however, no evidence to demonstrate whether a greater level of

psychiatric assessment at reception would have prevented Mark Smith's death, or would prevent future deaths in custody, and that must therefore remain as an unknown.

[84] I doubt that it would be possible to construct a system or systems within the prison estate that would absolutely guarantee that no prisoner would be able to take his or her own life, unless there were some form of automated 24/7 monitoring combined with a very high staff to inmate numbers ratio. I doubt whether that could be reasonably practicable to achieve and it would raise questions about the human rights of prisoners within that regime. The fact that some prisoners continue to take their own lives within the prison estate does not, of itself, mean that the reception systems are deficient.

[85] In the current case I consider that the nursing and prison staff were credible and reliable. I found that Peter Lee and Elaine McAinsh had followed the ACT2 Care procedures properly, had used the 'cues and clues' advice properly and had made well-reasoned decisions about Mark Smith based upon their observations and professional experience.

[86] The ACT2 Care forms were well constructed and gave sensible pointers to the staff whilst they carried out their assessments of new prisoners. The availability of the Personal Escort Record (PER) to the staff at the prison enabled them to consider information from the police and court staff. The existence and use of the First Night In Custody Suite enabled staff to spend additional time with new prisoners and to give them details about the prison regime, carry out their own assessment of the prisoner and provide them with information about their welfare. The system is robust and effective,

and benefits from at least five staff having the chance to assess the prisoner as he progresses through the reception procedure.

[87] The SPS decision not to adopt a points style of assessment is based on information from focus groups as well as the Mental Welfare Commission and, in the absence of research to the contrary, cannot be faulted.

[88] I agree with Mr Gilmartin that it could not be said with any certainty whether the recommendations he suggests would have prevented Mark Smith trying to take his own life. His suggested recommendations are designed to fix what he asserts are failings that contributed to Mark Smith's death. However, I have not found that there were failings that realistically contributed to, or could have prevented, Mark Smith's death and I do not therefore adopt as formal recommendations any of his well thought-out suggestions. I return to his suggestions under the "Observations" section below.

Observations

[89] There are several factors that could perhaps have led to Mark Smith attempting to take his own life. These include; a history that suggested some mental health difficulties such as depression, no access while in custody to his prescribed medication, unhappiness at being remanded in custody, finding himself at a low point in his life and upset following a telephone call with Michaela Hunter. Other than the telephone call – when Mark Smith's distress was observed along with his note – it is not possible to say which, if any, of these factors contributed to his decision to attempt to take his own life.

Equally, it is not possible to say what sort of precautions could most likely have prevented him from doing this. The recommendations that were suggested by Mr Gilmartin are sensible, but they are predicated on the basis that such precautions would realistically have prevented Mark Smith from trying to take his own life. On the evidence that I heard, I cannot come to that conclusion.

[90] Whilst I have no formal recommendations to make, I do have some observations that I hope the SPS and THB/NHS will consider. The assessment, gathering and dissemination of information at, and between, the reception process and the FNICS could benefit from a review of the following three areas.

(1) I heard evidence that a prisoner's medical records (or at least a good part of them) are available electronically on the VISION system to nursing staff when they carry out a prisoner's assessment in reception. In this case the nurse did not check for Mark Smith's medical records, and was of the view that even if she had done so her decision not to mark him as 'at risk' would not have been different. I accept that. However, on the basis that more information allows for a greater ability to make a good decision, the SPS and THB/NHS should consider whether to make it a mandatory requirement for nursing staff to check medical records (if they are available) for a prisoner at the reception assessment.

(2) Mr Gilmartin has suggested that more information should be physically transferred (hard copy) from the reception process to the officers in the FNICS. This includes information about any mental health history, any

> known current mental health problems, if the prisoner has been prescribed medication and whether he has taken the required dosages, previous markers for suicide/self-harm and what charges he faces. I agree with this. I do not think that if the FNICS staff had this information that they could realistically have prevented Mark Smith's death. However, again on the basis that more information allows for a greater ability to make a good decision, I hope that the SPS and THB/NHS will consider putting this arrangement in place if it is reasonably practicable to do so.

[91] I heard evidence that over half of prisoners have some sort of mental health history and I heard evidence that prisoners continue to take their own lives while in the care of the SPS. It is self-evident that if such a high percentage of prisoners have a mental health history, then SPS must be properly equipped to deal with this. I do not think that the lack of a nurse who was qualified in mental health nursing contributed to Mark Smith's death. However, I strongly encourage SPS/NHS to redouble their efforts to recruit nurses who are qualified in the treatment of mental health, and to provide specific training in mental health to nurses who are in the SPS and who are not so qualified.