

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

DETERMINATION OF SHERIFF ALAYNE E SWANSON

In

FATAL ACCIDENT INQUIRY

into the deaths of

STUART JAMES ROSE and JAMES BELL

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

Glasgow January 2014

The Sheriff having resumed consideration determines as follows:

- **Section 6(1)(a)**

Stuart Rose died at 1855 on 15 April 2010 within HMP Barlinnie Glasgow. James Bell died at 2122 on 13 August 2010 within Glasgow Royal Infirmary, Glasgow.

- **Section 6(1)(b)**

The cause of death in relation to both Mr Rose and Mr Bell was hanging.

- **Section 6(1)(c)**

There were no reasonable precautions whereby the deaths might have been avoided.

- **Section 6(1) (d)**

No defect in any system of working contributed to the deaths.

- **Section 6(1) (e)**

The facts relevant to the circumstances of the deaths are as follows:

1. Stuart James Rose, date of birth 24 January 1984, was detained in HMP Barlinnie following sentence at Glasgow Sheriff Court on 14 April 2010.
2. James Bell, date of birth 29 June 1983, was detained in HMP Barlinnie following appearance on petition at Glasgow Sheriff Court on 13 August 2010.
3. Every prisoner who goes into the care of the Scottish Prison Service at HMP Barlinnie is subject to a two part assessment to determine their risk of suicide or self-harm.
4. At around 1414 on 14 April 2010 following the reception risk assessment Mr Rose was assessed as being at no apparent risk by Mr Alan Tolmie.
5. At around 1519 on 14 April 2010 following the health care risk assessment Mr Rose was assessed as being at no apparent risk by Nurse Linda Boardman
6. Dr Kay also assessed Mr Rose as being at no apparent risk at around 0900 on 15 April 2010
7. At around 1713 on 13 August 2010 following the reception risk assessment Mr Bell was assessed as being at no apparent risk by Mr Brian May.
8. At around 1805 on 13 August 2010 following the health care risk assessment Mr Bell was assessed as being at no apparent risk by Nurse Sarah Cooper
9. Following those assessments Dr Raman also assessed Mr Bell as being at no apparent risk on 13 August 2010.
10. Mr Tolmie and Nurse Boardman did not have available to them at the time of the risk assessment the prisoner escort record or additional information pertaining to Mr Rose.

11. Mr May and Nurse Cooper did not have available to them at the time of the risk assessment the prisoner escort record pertaining to Mr Bell.
12. This was contrary to the procedure envisaged by the Scottish Prison Service following the introduction of the personal escort record in or around 2004.
13. On 14 April 2012 at about 1622 and 1624 and on 15 April 2010 at about 1523 Mr Rose made telephone calls from HMP Barlinnie Glasgow. Also on 14 April 2010 at about 1626 and on 15 April 2010 at about 1511 Mr Rose telephoned and spoke to his wife Anna Larionova or Rose.
14. On 15 April 2010 at about 1720 the life of Mr Rose was pronounced extinct by Dr Usman Qureshi.
15. On 13 August 2010 at 2122 within the Accident & Emergency Department of Glasgow Royal Infirmary the life of Mr Bell was pronounced extinct by Dr Alistair Ireland.
16. On 13 August 2010 shortly after 2030 officers of Strathclyde Police seized a note from within Mr Bell's cell bearing to have been written by him to his partner.

NOTE:

The Fatal Accident Inquiry ("FAI") was a mandatory Inquiry in terms of section 1 (1) (a) (ii) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. It proceeded over the course of the following fifteen days: 28, 29, 30 and 31 January, 1 February, 1, 2, 3, 4, 8, 9, 10, 30 and 31 July and 20 November 2013. The Crown was represented by Mr Quither, Procurator Fiscal Depute. The other parties represented were as follows: Mr Adam for the Prison Officers Association Scotland; Mr Watt for the Scottish Prison Service, Ms Davies for Reliance Custodial Services (Scotland); Ms Craig for Dr Kay; Mr Nimmo for Mr Khan; Mr Ewing for Ms Cooper and Ms Boardman; Mr Pettigrew for the

family of Stuart Rose; Mr Cheyne, Advocate, for Mr Gibbons and Mr Yuill for Ms Hotchkiss.

The Inquiry heard evidence from the following witnesses:

1. Sandra Devine (Reliance Officer)
2. Brian Connelly (Police Scotland)
3. Robert Grier (Police Scotland)
4. Dr Malcolm Pickard
5. John Gilchrist (Police Scotland)
6. David Fraser (Police Scotland)
7. Graham Westwater (Reliance Officer)
8. Colin Duffy (Reliance Officer)
9. Alan McDonald (Reliance Officer)
10. Gerard Penman (Prison Officer)
11. Charles Dickson (Prison Officer)
12. Alan Tolmie (Prison Officer)
13. Mahmood Khan (Prison Officer)
14. Brian May (Prison Officer)
15. Charles Horton (Reliance Officer)
16. Linda Boardman (Nurse)
17. Dr Peter Kay
18. Alan McKay (Prison Officer)

19. Adrian Buttle (Prison Officer)
20. Sarah Cooper (Nurse)
21. Patrick Duffy (Prison Officer)
22. William Hunter (Prison Officer)
23. Ian Carson (Prison Officer)
24. David Inverarity (Prison Manager)
25. Tony McPike (Prison Governor)
26. Frank Gibbons (Prison Health Care Manager)
27. Rhona Hotchkiss (Prison Governor)
28. Douglas Lawson

In addition the Inquiry considered the following affidavits:

1. Affidavit of Avelina Dainese
2. Affidavit of Agnes Miller
3. Affidavit of John O'Connell
4. Affidavit of Frank Main

The Determination is what is usually referred to as a formal Determination and contains no recommendations. In order to explain why I have concluded that recommendations were not appropriate in this case I think it will be helpful if I briefly recite the factual background relating to the admissions into HMP Barlinnie and the events of 15 April and 13 August 2010 as I found them to be established by the parole evidence, the affidavits and the contents of the two Minutes of Agreement entered into

by the parties. I have also set out briefly parties' submissions on the additional findings and recommendations proposed by them and my reasons for rejecting those.

THE EVIDENCE

[1] The Inquiries into the deaths of James Bell and Stuart Rose were conjoined. Both deaths were deaths in custody resulting in a mandatory FAI in terms of the Act. Both men committed suicide by hanging. There is a sophisticated system in place within the Scottish Prison Service to identify those prisoners at risk from suicide and self harm. Given the nature of the prison population the prisoners detained in HMP Barlinnie will include a number of individuals at risk of suicide and self-harm. This Inquiry was concerned with the system for identification of those prisoners who are at risk. As they pass through the system prisoners are handled by the police, the court, those escorting prisoners to prison and prison officers and medical staff within the prison. The interaction between these different agencies and the way in which information is passed from one to another were the central issues for the Inquiry.

[2] Prior to 2003 the Scottish Prison Service and the eight Scottish police forces were responsible for undertaking the prisoner escort and court custody services. The contract for the provision of prisoner escort and court custody services was won by Reliance Custodial Services (Scotland) ("Reliance") in 2003 with a phased commencement date between 11 October 2004 and 21 February 2005. One of the aims was to provide uniformity throughout Scotland. In terms of the contract Reliance had to create a standardised prisoner escort record ("PER") for use by the criminal justice agencies. This was done in conjunction with the Scottish Prison Service and the police forces and utilised an adaption of the form used by Reliance in England.

[3] The form used previously by the police only identified prisoners at risk of suicide. The PER is designed to provide more detailed information about prisoners including medical or psychiatric conditions and risk of violence or use of concealed weapons. Its purpose is to pass information between the different agencies who deal with a prisoner in the course of his involvement with the court and prison services.

[4] Within the Scottish Prison Service the system for identifying prisoners at risk is called the ACT2 Care System. It is mandatory for all members of staff to be trained in the system. All members of staff from the cleaners to the governor can “put someone on ACT” if they identify a prisoner at risk. This can be done at any stage of a prisoner’s detention. On admission to HMP Barlinnie there is a three stage process for identifying prisoners who should be highlighted as being at risk. A prisoner admitted to Barlinnie is interviewed firstly by a prison officer and then by two nurses and a doctor to ascertain whether it is appropriate to place him on the ACT2 Care Plan. A prisoner who is assessed as being at risk of suicide/ self-harm is fast tracked to the health centre and spends his first 24 hours in a safe cell with observations at 15 minute intervals. The prisoner remains on ACT2 Care until a case conference is held.

[5] The central question for the Inquiry was whether appropriate information about risk was passed down the line to those undertaking the ACT2 Care assessment by way of the PER and any additional information provided with it and whether having that information available would have prevented the deaths.

[6] Both Mr Rose and Mr Bell were in the care of Reliance at Glasgow Sheriff Court and en route for HMP Barlinnie.

[7] Mr Bell had been detained in police custody on 12 August 2010 following his arrest. DC Brian Connelly and Sergeant Robert Grier gave evidence about his demeanour in the police office. He had struck his head on the charge bar and tried to self-harm with a staple. As a result he had been put into an observation cell and was examined by Dr Pickard. The police had completed the first part of the PER as despatching agency. Although the form did identify Mr Bell to be at risk of suicide/ self-harm it did not record any of the detail about his demeanour in police custody, his attempt at self-harm, his examination by Dr Pickard or the fact that he had been on constant observation. The Record of Events attached to the PER detailed the observations made during his time in police custody. Sergeant John Gilchrist acknowledged that the information not contained in the PER might have been helpful. I also heard evidence from David Fraser who was the civilian officer who transferred Mr Bell to Reliance. Graham Westwater of Reliance said that he would expect additional information to include the information that Mr Bell had self-harmed within the last 24 hours. The PER did record that Mr Bell was a previously convicted sex offender.

[8] Mr Bell arrived at Glasgow Sheriff Court at 0816 and left at 1530. No issues of concern were noted about him whilst he was in the care of Reliance. I heard from Colin Duffy that the journey to HMP Barlinnie was uneventful. Neither he nor his colleague Alan McDonald remembered handing over the PER for Mr Bell to the staff at Barlinnie but Mr Duffy said it was his practice to advise staff verbally about any risk factors identified on the PER.

[9] Stuart Rose had started the process as a walk in to Glasgow Sheriff Court on 14 April 2010. He came under the care of Reliance at 1016 following sentence. He was very upset by his sentence. Officers reported that he had collapsed in the dock, was crying and upset and difficult to control. PC Kenneth Sloan assisted the Reliance officer Avelina Dainese to get Mr Rose into custody. Other Reliance officers also assisted. Whilst in the care of Reliance Mr Rose was on constant observations. The Record of

Events sheet attached to the back of the PER detailed Mr Rose's involvement with officers from Reliance, Social Work, his lawyer and the nurse. It also recorded the observations made.

[10] There were various factors which meant that Mr Rose had paperwork additional to the PER completed for him. The first was that he had received his first custodial sentence. Edward McMillan filled out the New Admissions Prisoner Risk Assessment Form. That form confirmed that he was a suicide/self-harm risk. Mr Rose was searched and placed in Cell 42 which is the observation cell. Alan Graham did the search with Edward McMillan and witnessed the New Admissions Prisoner Risk Assessment Form. Secondly, because of his distress Mr Rose was also seen by Steven Strang a Social Worker and examined by a nurse. That resulted in a Suicide Risk Identification Court Form and a Doctor/Nurse Report being completed and signed. The evidence was that these additional documents were attached to the PER for onward transmission to the prison. Mr Rose left for Barlinnie at 1227.

[11] Mr Graham told the Inquiry that the normal procedure is to send the paperwork in the van; it is not normally faxed. Officers might decide to make a courtesy call to Barlinnie. That was what happened here; Charles Horton had telephoned Barlinnie to tell them about Mr Rose's risk status. Mr Penman said that the information might be in a separate envelope, might be faxed or be sent in a later bus. Terry Crewe of Reliance put all the papers together. Sandra Devine who was in charge of the transport said that the documents were stapled in; sometimes they were in an envelope. She required to take the pink copies of the PER back from the prison. In her view staff at Barlinnie were alerted by what she said to them not by the information in the PER.

[12] A number of witnesses agreed that verbal communication was important. Sandra Devine said that she would mention if she had a first time prisoner or knew that one of

the prisoners was upset. Alan McDonald said that he would tell Barlinnie if a prisoner was on observation or was a suicide/ self-harm risk. Mr Khan said that he would expect a verbal communication about a suicide risk. Mr Duffy said that he would mention verbally if the prisoner had attempted to self-harm in the cells or with the police in the last 24 hours or was on constant obs. Mr Dickson said that he had never had cause to study a PER. Any information about risk would come verbally.

[13] The PER form is designed to alert its reader to the existence of risk by ticking a box in section 3 either confirming risk or no known risk. On neither of the PER forms with which the Inquiry was concerned was the middle section 3 ticked to confirm risk. Section 4 below that provides risk categories which are described as medical and security in the first two columns; in the third column under the heading of other categories there is a box called suicide/ self-harm. Below that again there is space to provide other information and advise whether the prisoner requires to be segregated. The form suggests that a report can be attached to that section if necessary. In both cases with which the Inquiry was concerned section 4 had been completed although the risk box in section 3 had not.

[14] There was a variety of opinion about the significance of that. Mr Khan, Mr Graham, Mr Westwater, Mr MacDonald, Mr Grier and Mr Duffy all said that this did not cause them concern. Section 4 had highlighted the risk. Mr Dickson said that it was obvious from the form that Reliance had concerns. Only Mr Tolmie expressed concern about section 3 not being ticked and suggested that this was a “poorly displayed” PER.

[15] There was some doubt in the evidence about whether all the documentation had reached the admissions staff at Barlinnie. Mr Duffy, Mr McDonald and Mr Penman all suggested that there was no chance that a prisoner could be processed without a PER. Mr Tolmie said that he was aware that additional documents could come in later. Mr

Dickson was of the view that a large bundle of papers as described would be unlikely to be missed. I am satisfied that on the balance of probabilities the PER for both prisoners and the additional information for Mr Rose all reached Barlinnie. On the evidence it is not possible to say that all the information for Mr Rose arrived at the same time but the issue about transfer of information does not seem to lie with transmission to Barlinnie.

[16] There was a lengthy chapter of evidence in the Inquiry about the use of the PER during the admissions process at Barlinnie. I could not form a clear view about how the form was used. One body of evidence suggested that the main reason for the PER in April 2010 was to identify the prisoner's property and to confirm that it had been received from Reliance. It was clear from the evidence that the PER came in with the prisoner and was then passed to the Valuable Property Officer who checked that the number on the property tallied with the number on the PER. He signed the PER as a receipt for the property. The valuable property Officer then split the PER into copies. Some of the witnesses suggested that if there was a risk identified on the PER, then it would be copied and placed with the additional information. It was very difficult to ascertain from the evidence who was the person checking for risks.

[17] Mr Charles Dickson said it was the Movements Officer. His evidence was that the risk factors should be highlighted to him by Reliance or anyone else who notices it. Any verbal information received from Reliance is marked on the white board. In Mr Dickson's view risk identification mainly came from Reliance. He disagreed with other officers who said that the Property Officer checked for risks. That was the evidence of Mr Tolmie, Mr Khan and Mr May. Mr Khan's evidence was that whoever picked up the PER in the property section would pass on the risk of suicide/ self-harm.

[18] Of greater relevance perhaps was the chapter of evidence about what information was passed to the staff conducting the interview with the prisoners. Every prisoner

who comes into an establishment must be assessed for risk of suicide/self-harm. The ACT2Care document has four parts: a front page, guidance notes, Reception Risk Assessment and Health Care Risk Assessment. The Reception Risk Assessment is conducted by a prison officer; the Health Care Risk Assessment is conducted by two nurses. The prisoner is then seen by a doctor.

[19] The front page of the document poses two questions: "PER received: yes/no?" and "Additional information received: yes/no?" If additional information is received its source and nature are also to be recorded. In the guidance notes the following text appears: "PER: This form is used by escorting staff. A PER should always be available. It is important that the information contained be scrutinised by the person carrying out the Reception Risk Assessment and Health Care Assessment." "Any additional information could be anything at all that has been disclosed [verbal/written] from whatever source e.g.[escort staff, court staff, prisoner's family, another prisoner etc.]" On both the page where the Reception Risk Assessment is marked up and the one for the Health Care Risk Assessment the form instructs the interviewer to check the PER and any additional information and to state whether there has been any information received from the PER or other source that has raised concerns with regard to "At Risk" status. This question is asked whether the prisoner is being admitted, transferred or returned.

[20] Mr Penman, Mr Dickson and Mr Khan were agreed that the interviewer would have a copy of any PER which identified risk. He would also have the warrant and any additional information provided. Mr May agreed that the system at the time was that a PER containing risk should have been photocopied and passed to the assessment officers. The officers were clear that the PER itself remained at reception and was only copied when it identified a risk. An answer "Yes" on the front page when asked about whether the PER has been received related to the fact that the prisoner would have arrived with one. It did not confirm that the interviewer had it.

[21] In neither of the cases with which the Inquiry was concerned did the interviewer have before him the relevant PER form. Mr May, who dealt with James Bell, said that whether there was a PER or not the assessment of his mental state is done on the basis of what he says at the time. The interviewer would talk to the prisoner. He did suggest, however, that he would have questioned differently if he had seen the PER. However his judgement is based on the answers given at the time and on what he had he would have made the same decision. He recorded the following: "James says that he feels he could do with some support when in custody and wishes to speak to someone; said no thoughts of self-harm/suicide although needs extra support." He marked him as being at no apparent risk.

[22] Mr Tolmie, who dealt with Stuart Rose, had no concerns about him and found him to be responsible enough to be considered for a job as a passman. He recorded: "appears fine" and marked Mr Rose as being at no apparent risk. However, he said that if he had seen the PER he would have started ACT at least overnight and assessed again in the morning even if the prisoner had presented well and said that he was OK. He said that because Mr Rose was a first time prisoner he would have erred on the side of caution. In Mr Khan's view if someone had self-harmed that day his mind would have been pretty much made up to place him on ACT.

[23] Following the interview with the admissions officers both Mr Bell and Mr Rose were seen by nurses for a health care assessment. Mr Bell was seen by Nurse Cooper and Mr Rose was seen by Nurse Boardman. Neither of the nurses had the relevant PER or in Mr Rose's case the additional information available to them when conducting the interview.

[24] The decision whether to put a prisoner on ACT is a joint one. Two nurses conduct the interview to assess whether someone is at risk or at no apparent risk. The prisoner is

asked about his previous history of self-harm and his current thoughts. Nurse Boardman remembered spending a bit of time with Mr Rose asking about his thoughts. He had been open about his attempted suicide in 2004. He said he had no thoughts of self-harm. She assessed him as at no apparent risk. This was based on his interaction, engagement in conversation and his expressed feelings about his family, being in prison and visits. He made eye contact. He did not present as he had done in court. Nurse Boardman said that he was very positive. She was asked about how the information in the PER might have affected her assessment if she had seen it. She was clear that her assessment was based on how he presented at the time. If she had had the PER she would have discussed it with him but was clear that the man described in the PER was not the man she interviewed. She said it was not unusual for prisoners to be upset initially but calm later on. Nothing in the interview had given her cause for concern. She agreed that she could not put every prisoner who had previously self-harmed on ACT. On the Health Care Assessment for Mr Rose the nurses recorded the following: "2004 attempted O/D painkillers no cause for concern denies any thoughts suicide or self-harm"

[25] Doctor Peter Kay saw Mr Rose the following day. He also had no concerns. He described Mr Rose as a pleasant young man who used open language and volunteered the information about 2004. He had good eye contact; he spoke well and clearly; there were no issues to follow up; indeed Dr Kay said that there was nothing remarkable about Mr Rose at all. When asked about the information in the PER he said that this might be relevant but his assessment is his assessment and he has to complete that regardless of what has happened in the last 24 hours. He thought that if he had seen the PER he might have asked why the presentation had changed but he would not have altered his view based on what he had seen and heard. When he had heard that Mr Rose was distraught at court he was surprised. He also was clear that that was not the person he saw. Doctor Kay recorded the following: " previous O/D nil risk apparent"

[26] Nurse Cooper gave similar evidence about Mr Bell. She was looking at his manner, how he was conversing, what eye contact he was making and whether he was guarded. She said that nothing gave her concern. Mr Bell's body language was relaxed and he presented in an open manner. She said that the information about his demeanour at the police station would have warranted further discussion. She was asked about the significance of recent self-harm and she said that that would depend on the answers given to the questions about it. She was aware that Mr Bell had been suicidal previously and that he had been on ACT on nineteen previous occasions. She stood by her assessment. She recorded the following: "previous ACT x 19—last 2010; previous O/D several occasion—last Feb 2010 att hanging last aged 15 yrs old SH arms last approx. 5 yrs ago adamantly denies any thoughts self-harm or suicide S/B psyche re depression last Dec 09"

[27] Dr Raman's evidence was a matter of agreement between parties in terms of a Joint Minute of Agreement. He had been aware of Mr Bell's history of depression from the conversation he had with him but Mr Bell had said that there was no problem and no apparent risk. He recorded the following: "no problems"

[28] The system involves four separate professional people, three of whom are medically qualified, assessing each prisoner on admission or shortly thereafter. Any one of those four individuals or indeed any other member of staff who has interaction with the prisoner can place that prisoner on ACT if it is thought appropriate. The system continues after the assessment process. Prisoners are placed on E Hall for their first night before being placed in their permanent hall. On the Hall self-referral forms to the health centre are available; each prisoner has a personal officer who reinforces the access to services; finally there are listeners on each hall who have received Samaritan training to deal with those at risk. Mr Hunter gave detailed evidence about the induction process and the information given to Mr Rose about the various services available to him. I was satisfied on the evidence I heard that a robust and caring

system is in place for prisoners' welfare. Mr Hunter had commented that Mr Rose seemed a little low but confirmed in his evidence that this did not cause concern and was a result of Mr Rose not being sure of what was happening.

[29] I heard evidence about the PSS1 form used to allocate a level of supervision to the prisoners. Unusually when Mr Carson filled this in for Mr Rose Mr Rose was present and he had a chat with him about home detention, visits and phone calls. I also heard evidence from Mr Duffy about his interactions with Mr Rose about phone calls. Neither of them had any cause for concern about Mr Rose.

[30] I heard evidence from the officers who dealt with both Mr Rose and Mr Bell on the Hall and I heard nothing that I considered should have alerted anyone to the intentions of these men. In short there was no evidence to suggest that the presentation of either man had altered from the presentation at assessment. Dr Kay attends the National Suicide Risk Management Group. His experience is that staff tend not to know about prisoners who are suicidal. Those who proclaim their intentions are unlikely to carry them out.

[31] Mr Rose was found in his cell at 1705 on 15 April 2010. Earlier that day he had enquired about phone calls and had been allowed by Mr Duffy to make a short call to his wife ostensibly in order to cancel an appointment. During the afternoon he tried to make three phone calls. Only one of these connected. This was at 1511 and it was a call to his wife. A tape and transcript of this call was available to the Inquiry. The conversation was an emotional one in which Mr Rose was told by his wife that their marriage was over and that she had moved out of the house. Mr Rose was distraught and said amongst other things that he was sorry for messing things up and that he couldn't cope by himself.

[32] Mr Bell wrote a letter to his partner which was found in his cell after he was taken to hospital. This was also in emotional terms. Mr Bell also said that he was sorry for messing things up and said that he couldn't live without his partner.

[33] There is a contingency plan for deaths in Barlinnie which came into play in relation to both of these deaths. Mr Inverarity explained it to the Inquiry. As Throughcare Manager and Duty Manager he prepared an incident report about the death of Mr Rose. That report contained the following: Mr Inverarity's initial report; an information paper from each member of staff who was involved; the log of events from B Hall and from the CCTV incident room; Mr Rose's prisoner phone system call file; the PSS1 and door card; a Social Enquiry Report; the PER and the additional information; the induction core screen folder. The report is submitted to the Governor. Mr Inverarity said everything in the prison's file would be included and the content could vary from prisoner to prisoner. This was borne out by the incident report into the death of Mr Bell prepared by Mr McPike the present Governor the contents of which were different to the report prepared by Mr Inverarity. His report contained the health care records for Mr Bell detailing his previous risk assessments. Mr McPike the present Governor explained that the purpose of this exercise is to collate data. It is not an investigation into the death.

[34] The investigation into the death is conducted by way of a critical incident review based on a process similar to those used in other public sector organisations. The stated aim of the Self Inflicted Death in Custody Audit Analysis and Review ("SIDCAAR") is to learn from the incident and to contribute to the development of national suicide risk management policies and procedures. It is also designed to ensure standardised practice when conducting such reviews. An informal discussion takes place between the Secretary and the Deputy Governor about who should attend the SIDCAAR. Invitations are then sent out but attendance at the review is voluntary. Certain documents will be available at the meeting but these are not standard. No SIDCAAR

review was held into Mr Bell's death. All of this suggests that the aim of standardisation has not been achieved by this system.

[35] The Inquiry heard evidence from Mr Frank Gibbons who in addition to being the Health Care Manager was the Local ACT Group Co-ordinator. His role was to act as Secretary to the review. I found Mr Gibbons to be an unsatisfactory witness. His evidence was unclear and he frequently shifted his position. His understanding of his role did not accord with Ms Hotchkiss's evidence about it. What was clear, however, is that until the SIDCAAR into the death of Mr Rose the management had understood that the transfer of information on the PERs was achieved by PERs being routinely provided to the admissions interviewing staff and to the nurses. Mr Gibbons said that it became clear at the SIDCAAR that PERs were in fact being filed with the warrants unless a risk was identified on them in which case they were passed to the interviewing staff and the nurses. This did not accord with the evidence the Inquiry heard from the staff involved.

[36] Neither Nurse Boardman nor Nurse Cooper had seen PER forms in 2010. Dr Kay had never seen a PER. Nurse Boardman had heard about them for the first time around the time when she became aware that there was to be an FAI. Neither remembered PERs being highlighted in training. Nurse Cooper expressed her shock when she found out from the Procurator Fiscal as a result of preparation for the FAI the significance placed on PER forms in the Guidance Notes to the ACT2Care form. Mr Tolmie also said that when he had discovered what the Guidance notes said about scrutinising the PER by the Procurator Fiscal he was shocked and had immediately raised the issue with his line manager. There was no evidence that the officers conducting admission interview had access to the PERs in all cases. Their evidence in the most part suggested that PERs identifying risk were passed to the reception officers. All of this was contrary to the system for PERs as understood by the management.

[37] It is clear from the evidence that the SIDCAAR Group was correct to highlight improved staff communication, better liaison between different internal services and better liaison between different external services as issues. I will discuss below why I do not agree with the Group's conclusion that such improved communication and liaison could have prevented the death. Mr Gibbons described that conclusion as a mistake. Ms Hotchkiss's explanation of the Group decision was that it was impossible for the Group to say whether the additional information would have made a difference but given there was no alternative answer they had answered yes.

[38] When Rhona Hotchkiss read the file on Stuart Rose after his death she was surprised that there was no mention in the admissions and health care assessments of the information which in her view highlighted a suicide risk. She immediately made enquiries and found out that the PER and the additional information were not routinely available to the interviewers. She issued a notice to staff in April 2010 advising officers that they must check the paperwork of all prisoners coming into reception for any indication of increased risk of suicide/self-harm. The notice specifically instructed officers to check the PER and additional information which might be with it. Although Ms Hotchkiss had already taken this action before the SIDCAAR meeting she purposely gave herself an action point to follow up namely to review the processes in reception /General Office for passing alerts and information from court to the admission staff. This was to be completed by 31 July 2010. Her interest was in the totality of the information not specifically what the PER said. She acknowledged that the PER in itself would not influence the decision re ACT2Care.

[39] Following the SIDCAAR meeting Ms Hotchkiss undertook a review of the statistical data about admissions for a two month period. She compared records from reception with records from the health care centre to identify any cases where relevant information was not recorded all the way through to the health care records. Her

conclusion from that was that there was an occasional problem where information did not get recorded on the ACT form.

[40] Given the evidence noted above from those conducting the interview I found that surprising. Having given the question some thought I conclude that the reason for that is that all issues of relevance to risk raised by the prisoner would be noted by staff on the ACT form. The two individuals the Inquiry was concerned with prove that point. In neither case was the full package of information from outside agencies available but staff still noted from the prisoners their histories of self-harm. Ms Hotchkiss did not speak to any staff involved in the process and so may have been unaware of that practice. Ms Hotchkiss concluded that the failure to pass on information was unusual. Her conclusion was that there was no systematic failure. When asked by me about the evidence which the Inquiry had heard about staff being shocked when the importance of the PER in the ACT documentation was pointed out to them she said that she found that difficult to accept. It was clear to her what should happen. In my view the evidence did not support the failure to transfer PERs being an unusual occurrence. Had Ms Hothchkiss spoken to the staff she might have formed the view that, regardless of her own position, it was not clear to staff what should happen.

[41] The final witness to the Inquiry was Mr Douglas Lawson a Prison Manager at the Prison College who had been responsible for ACT training since 2010. He was aware that there had been a change in the training regime when Reliance had taken over the escort service but was unable to give evidence about any training other than that of current recruits. The Inquiry therefore did not have evidence about what training those in service prior to that change had received. The evidence from the staff from which he Inquiry heard was that they had no recollection of the use of the PER being mentioned at training. There was no evidence to contradict this. This was despite Mr Lawson giving evidence to the effect that each employee has a training record in their personal file.

SUBMISSIONS

[42] The formal determinations to be made in terms of section 6 (1)(a) and (b) were matters of agreement in the Joint Minute of Admissions. The only parties who made submissions in support of other potential determinations were the Crown, Mr Pettigrew on behalf of Mr Rose's family and Mr Ewing for the two nurses.

[43] The Procurator Fiscal suggested that there was a defect in the system of working pertaining to admissions and assessments in HMP Barlinnie because the system as devised differed from the system in practice. Mr Ewing echoed this in suggesting that the practice of filtering the PERs to pass on those identifying risk was a defect. Mr Pettigrew suggested that there was a defect in that the failure to consider the PER prejudiced the assessment leading to Mr Rose being incorrectly assessed.

[44] Suggestions as to other facts relevant to the circumstances of the death were made by the Crown and Mr Pettigrew. The Procurator Fiscal's suggestions covered the wording of the ACT2 Care documentation, the way in which the SIDCAAR is set up and the sharing of police custody records. Mr Pettigrew submitted that housing a Schedule 1 sex offender in the general prison population was of concern.

[45] All other parties suggested that no determinations should be made in respect of section (1) (c), (d) and (e).

THE DETERMINATION

[46] I am charged in terms of the statute with considering (a)whether there were any reasonable precautions whereby the deaths might have been avoided (b)whether any defect in any system of working contributed to the deaths and (c)whether there are any other facts relevant to the circumstances of the death.

[47] The evidence about the admissions procedure and the reception area at HMP Barlinnie raised some concerns. The evidence did not establish that there were clearly defined roles. Whilst a certain flexibility has clear organisational advantages the fact that the officers could not agree on whose job it was to check the papers to identify risks was concerning. There is no doubt that the way in which the system worked in practice was not as envisaged by the management. It was not clear on the evidence whether some PERs were made available to the interviewers as a matter of routine or not. I was unable to form a clear view about how widespread the wrong practice was. What was not in dispute is that on the two occasions with which the Inquiry was concerned the interviewers did not have before them the PERs and additional information.

[48] The question for me is whether the system operating on the days in question contained a defect which contributed to the deaths. On the evidence which I heard management had intended that every PER together with any relevant additional information should have been passed to the interviewing prison staff and health care staff. There was a clear failure to pass on that information in these two cases. That does represent a defect in the system of working as proposed. However I am not persuaded that that defect contributed to the deaths. There is no doubt that in the cases of both Mr Rose and Mr Bell relevant information was not passed to those conducting the risk assessment interviews. However the evidence showed that the thorough and professional manner in which those involved went about their task meant that although

the risks highlighted in the PERs and additional information were missed the fact that these two individuals had a history of self-harm was not. The officers were agreed that being in receipt of the information would have provoked a discussion but I am not satisfied on the evidence that that would have produced a different outcome.

[49] Only Mr Tolmie and Mr Khan said that knowledge of recent self-harm would have changed their view. Mr Khan was speaking hypothetically as he was not involved in either of the assessments. I have to consider that evidence as unreliable against the background of the other evidence I heard. Both of these men were conscientious employees anxious to do their best at the Inquiry. Mr Tolmie expressed his shock at discovering that the system was not operating as it should. I consider their evidence that they would have acted differently as being understandably over-emphasised with the benefit of hindsight. The evidence showed that the face to face assessment was the most important factor. How the prisoner presented at the interview was the paramount consideration. I am satisfied that the presentation of both men merited the status of no apparent risk.

[50] I accept that in the case of an uncommunicative prisoner who was determined to withhold from the interviewers the fact that he had previously self-harmed the lack of information noting previous history might have more relevance. However, in these two cases both men were straightforward about their earlier attempts at suicide and self-harm. It was clear from the evidence that the only facts not known to the interviewers were the facts about their most recent behaviour: in court in Mr Rose's case and in police custody in Mr Bell's case. There was no evidence to suggest that either man was in the same state whilst in the care of those at HMP Barlinnie. I accepted the evidence that by the time people have been processed at HMP Barlinnie it is not unusual for them to have calmed down. I reject the submissions made by the Procurator Fiscal, Mr Ewing and Mr Pettigrew that there was a defect which

contributed to the death because of the failure in these two cases to pass on the information in the PERs.

[51] From what I heard about it in evidence I think that the ACT2 Care system is a good one. Every member of SPS Staff who gave evidence was aware of the system, had been trained on it and knew about the cues and clues to look out for in handling prisoners who might be at risk. Of course in theory every single prisoner could be placed on ACT but the impracticalities of that approach are obvious. It was accepted in evidence that it would not be appropriate to place even all those with a history of self-harm on ACT. A system therefore has to be developed to identify those most at risk to single them out for increased observation and special facilities. The system in place seems to be more than adequate for the purpose.

[52] I heard no evidence on which I could base any criticism of the professionals involved in the risk assessment process. The assessments made were based on considerable experience and expertise. There was no evidence to suggest that they were anything other than entirely reasonable. I reject Mr Pettigrew's submission that Mr Rose was not correctly assessed. There was no evidence to support his contention that the failure to consider the PER prejudiced the assessment made. His suggestion that all paperwork including medical reports and other previous assessments should be made available to the interviewers is not reasonable. As he himself acknowledges this would involve staff studying tiresome details. The evidence from those doing the assessments was that additional information only informs the process and talking to the prisoners is far more valuable. Ms Hotchkiss who had a background in health care and was also ACT trained also said that the face to face assessment was more important.

[53] I am not satisfied that the precaution of putting either of these men on ACT would have prevented the deaths. There was no evidence to suggest that if Mr Rose had been placed on ACT that would have avoided his suicide. I cannot determine the impact on him of the phone call which we heard but there can be no doubt that it was significant. His distress at being separated from his wife and her assertion that their relationship was over was evident. Significantly Ms Hotchkiss said that being on ACT would not have prevented Mr Rose from accessing the telephone. In addition, being on ACT would not have meant that his reaction to any phone call made was monitored. There was no evidence at all about Mr Bell's situation after admission. His note to his partner was in evidence. His distress at being separated from his partner is also evident from the terms of that note. I cannot conclude that being put on ACT would have prevented his death either.

[54] Any facts which I find established have to be relevant to the circumstances of the death. I reject the Procurator Fiscal's suggestion that my role allows me to get involved in the wording of documentation or the way in which internal review procedures are put in place. There was no evidence to suggest that had either of these matters been dealt with differently that would have had a relevance to the deaths. Neither was there evidence to suggest that the sharing of police custody records would have any significant benefit. Mr Pettigrew submitted that housing a Schedule 1 sex offender in the general prison population was of concern but there was no evidence to suggest that that factor had any bearing on the deaths.

[55] I note that, on the basis of the evidence, there was a lack of training when the new system for PERs was introduced. All of the witnesses who gave evidence at the Inquiry had joined the service before 2010. Mr Lawson's evidence was therefore of limited assistance. There was evidence about an e-learning course but no specifics were given in evidence and witnesses' recollections of what had been specifically covered in that training were poor. However, whilst I have criticisms of the admissions system in

Barlinnie in 2010 and the training for existing members of staff at that time, I cannot on the evidence determine that these areas of criticism are relevant to the circumstances of the death.

[56] The evidence also showed that since these deaths the system has changed. Dr Kay and Nurses Boardman and Cooper all said that they now always get the PER whether it identifies risk or not. In Ms Hotchkiss's view this new practice commenced after preparation for the FAI commenced. Prior to that and after April 2010 any PER with risk identified was being passed to those conducting the interviews.

[57] As Carmichael points out in his book on Sudden Deaths and Fatal Accident Inquiries Third Edition at p175: " the whole object of impartial public inquiry---in all cases [is] to see to it so far as humanly possible that the same mistake, whether it arises through fault or any other reason, is not made in the future. The public interest, in whose name inquiries are held, requires and deserves no more."

[58] The evidence clearly showed that the PER and additional information was not available to either those conducting the reception risk assessment or those conducting the health care risk assessment. Clearly that was a mistake in terms of the policy expressed in the guidance notes and in the system as envisaged by management. However that was now been remedied and so I am satisfied that so far as humanly possible that mistake relating to the transfer of information between agencies will not be made again in the future. Exposure to the Procurator Fiscal's investigations and wider preparation for the FAI has produced a considerable benefit. The overall awareness of the importance of transferring information between agencies has been significantly heightened as a result. To that extent the Inquiry has served its proper purpose.

[59] I express my condolences to both the family of Mr Rose and the family of Mr Bell. I would like to thank the legal representatives for the manner in which this lengthy Inquiry was conducted and for their helpful submissions.

Sheriff Alayne E Swanson

Sheriff of Glasgow and Strathkelvin at Glasgow

January 2014