SHERIFFDOM OF NORTH STRATHCLYDE AT KILMARNOCK

B914/09

2010 FAI43

DETERMINATION

by

SHERIFF PETER G. L. HAMMOND

in Inquiry into the circumstances of the death of

THOMAS JAMES STRAIN

Under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

APPEARANCES:

For the Crown: Mr. McMillan, Procurator Fiscal Depute, Kilmarnock.

For SERCO : Mrs. Anwar, Solicitor.

For Scottish Prison Service ("SPS"): Mr. Chaffey, Solicitor

Kilmarnock, 28 September 2010.

The Sheriff, having considered all the evidence adduced and the submissions made thereon, determines in terms of section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 as follows:

Section 6 (1) (a)

1. Thomas James Strain, born 3 July 1962, died between about 13:30 and about 16:30 hours on 23 November 2008 at Cell 25, E Wing, House Block 2, H M Prison Bowhouse, Kilmarnock.

Section 6 (1) (b)

2. The cause of his death was hanging.

Section 6 (1) (c)

3. There were no reasonable precautions whereby his death might have been avoided.

Section 6 (1) (d)

4. There were no defects in any system of working which contributed to his death.

Section 6 (1) (e)

5. Other facts which are relevant to the circumstances of his death are set out in the following Note.

Sheriff

NOTE:

Introduction

[1] This inquiry was held following an application by the Procurator Fiscal for the District of North Strathclyde at Kilmarnock in respect of the death of Thomas James Strain. Mr. Strain was a 46 year old man serving a 22 month sentence of imprisonment for an offence under the Explosive Substances Act 1883 committed against a domestic background. He was found hanged in his cell at HM Prison Kilmarnock on 23 November 2008. HM Prison Kilmarnock is privately managed by SERCO.

[2] As Mr. Strain was serving a prison sentence at the time of his death, section 1(1) (a) (ii) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 applies. This provides that where a person dies in legal custody an Inquiry is mandatory.

[3] There was no dispute between any of the parties to the Inquiry that the death took place between approximately 13:30 and 16:30 on 23 November 2008 within cell E25 at HM Prison, Kilmarnock, and that the cause of death was

hanging. That is in accordance with the evidence, and is reflected in my formal findings.

[4] The Inquiry examined the circumstances leading up to his death; court procedures upon his committal to prison, his reception into prison, his mental health, his interactions with other inmates and staff, his supervision and suicide risk assessment, and the process for informing that assessment. The evidence also dealt with some aspects of cell design.

[5] The inquiry in this case was heard over five days: 27, 28, 29 and 30 April, and 15 June, 2010. The Procurator Fiscal called the following witnesses:

(a) Mrs. Rachel Strain, Mr. Strain's mother.

(b) Mrs. R** W**, Sheriff Clerk Depute, Kilmarnock.

(c) Ian Miller, Prison Custody Officer, Reliance.

(d) Leon Smith, Prison Custody Officer, HMP Kilmarnock.

(e) Kenneth Beaton, Reception Supervisor, HMP Kilmarnock.

(f) Alan Thornton, Staff Nurse, SERCO Health, HMP Kilmarnock.

(g) Brian Torbett, Prison Custody Officer, HMP Kilmarnock.

(h) Dr. Gary Walker, Police Casualty Surgeon, Strathclyde Police, Kilmarnock.

(i) Stephen Lorimer, Prison Custody Officer, HMP Kilmarnock.

(j) Mrs. Nicola Greig, Trainee Forensic Psychologist, HMP Kilmarnock.

(k) Dr. Iain Graham, Pathologist, Crosshouse Hospital, Kilmarnock.

(l) Russell Clark, Unit Supervisor, HMP Kilmarnock.

(m) Niamh Kennedy, Trainee Forensic Psychologist, HMP Kilmarnock.

(n) Patricia Howie, Trainee Forensic Psychologist, HMP Kilmarnock.

(o) Jillian McGinty, Psychologist, formerly HMP Kilmarnock.

(p) Dr. Norman Clark, Consultant Forensic Psychiatrist.

(q) Mrs. Joanne O'Donnell, Unit Supervisor, SERCO, HMP Kilmarnock.

(r) R** R** (aka ******), former inmate, HMP Kilmarnock.

(s) Gregory Docherty, Prison Custody Officer, HMP Kilmarnock.

(t) Ms. Alexandria Ross, Prison Custody Officer, HMP Kilmarnock.

(u) Mr. E** H**, Staff Nurse (Mental Health), HMP Kilmarnock.

(v) A** M**, inmate, HMP Kilmarnock.

(w) William Sinclair, Building Services Engineer, Scottish Prisons Directorate, Edinburgh.

(x) Stuart McLaren, Facilities Manager, HMP Kilmarnock.

The parties entered into an extensive joint minute agreeing a number of matters which were not in dispute.

In addition, I was referred to a number of documentary productions including prison custody, health, risk assessment and supervision records relating to Mr Strain.

Background

[6] Thomas James Strain was born on 3 July 1962. He was the second oldest of 6 siblings and lived in Ayrshire all his life. He had been employed latterly as a driver within the road haulage industry. In September 1991, he married Morag Hutchison. The marriage had initially been happy, and the couple had 3 children together; namely ****, **** and ****. He had a close bond with his

children, and they lived together as a family at 42 Turnberry Wynd Irvine until the marriage broke down. The couple separated in about 2003, and this eventually led to divorce.

[7] Mr Strain took the separation badly. For example, when he telephoned his mother to tell her that his wife had left him, he stated that he had no future, and was going to end his life. The family managed to talk him out of it, but the evidence suggests that he never really came to terms with the situation.

[8] Following the separation, all three children lived with their mother. Difficulties between the couple led to problems over Mr. Strain's access to the children. This came to a head when the children moved with their mother to another part of Irvine, and his contact with them was stopped contrary to his wishes. Mr Strain subsequently became involved in a number of civil court disputes; one of which was in relation to repossession of the matrimonial home.

[9] On 16 July 2007, Mr Strain was involved in a serious incident which led to his custodial sentence. On that date sheriff officers attended at the former matrimonial home in connection with repossession proceedings. Mr Strain had rigged up a "booby trap" explosive device in the house, which consisted of home made petrol bombs and a bag of nails. Fortunately this was not detonated. Mr. Strain gave unclear accounts of why he had done this, but appears to have been resentful of his former wife because of what he perceived to be an unfair financial settlement on divorce, and the denial of contact with his children. He also harboured a grudge that the "legal authorities" were to blame for what he saw as the disadvantageous divorce settlement leading to the loss of his house.

Kilmarnock Sheriff Court Disposal - 24 June 2008

[10] Mr. Strain appeared for sentence at Kilmarnock Sheriff Court on 24 June 2008. He had previously pled Guilty to an indictment containing a charge in the following terms :

on 16 July 2007 at 42 Turnberry Wynd, Irvine, he did make or have in his possession, or under his control an explosive substance, namely petrol, with intent by means thereof to endanger life, or cause serious injury to property and he did contaminate the water supply there with petrol, leave a bag of nails beside a cannister containing petrol, leave a number of candles lit and unattended and prepare 'petrol bombs' by filling empty bottles with petrol and replacing the bottle tops with rags pressed into the neck of said bottles; CONTRARY to the Explosive Substances Act 1883, Section 3.

[11] He was sentenced to 22 months imprisonment. His earliest date of release was 22 May 2009. This was his first period of imprisonment within an adult Prison. His only previous conviction was for assault to severe injury in 1981, which resulted in a three month sentence of detention as a young offender.

Information before the Court relevant to risk assessment

[12] When Mr Strain appeared for sentence on 24 June 2008, there were available to the court a Social Enquiry Report ("SER") (production 4, Annex 2), and a psychiatric Report by Dr. Norman Clark (production 10).

[13] Dr. Clark's psychiatric report was obtained at the request of his defence solicitors at a relatively early stage of the court process. It is dated 23 October 2007. Dr. Clark's conclusions were that, at that time, there was no evidence of mental disorder within the meaning of the Mental Health (Care and Treatment) (Scotland) Act 2003, although Mr. Strain did have a paranoid personality. He found Mr Strain to be intelligent and articulate, but with paranoid projection in his thinking processes and a very rigid and uncompromising outlook. His ideas did not amount to delusions, and there was no clear evidence of psychosis. He told Dr Clark that he was not a heavy drinker and had no history of illicit drug use. He had no previous history of psychiatric involvement or treatment. His paranoid outlook appeared to be clearly linked to the way he perceived he had been treated in relation to his family situation and divorce settlement. Dr. Clark's

conclusion was that Mr Strain would benefit from psychological and psychiatric counselling to provide help, but that he might not be keen to avail himself of such help on a voluntary basis.

[14] The SER before the court was dated 12 June 2008. The author was D** H**, social worker. Under the heading "Health" the author comments that Mr Strain reported maintaining very good physical health. He told her about Dr. Clark's report, but refuted Dr. Clark's diagnosis of paranoia. He admitted that he was not coping with events, and said that he considered he had nothing to live for and wished daily that he was dead. He told her that the index offence was committed as a result of his intention to kill himself by setting himself on fire.

[15] The author of the SER narrates the outcome of two risk assessment tools she used. In relation to the first of these, the LSI:R assessment, he achieved a very low risk score of re-offending, based on the age of his previous offence, the circumstances presenting and a number of protective factors drawn from his employment history, family stability and otherwise pro-social behaviour. However in relation to the Risk of Harm Assessment RA3, he was assessed as being potentially at high risk of harm given the nature of the index offence and his minimisation of the possible harm and consequences to others.

Transmission of paperwork from the Court to the Prison

[16] When a convicted person is sentenced by a court to a period of imprisonment, a committal warrant is generated by the clerk of court. At Kilmarnock Sheriff Court, the clerk of court would associate any background reports with the committal warrant and pass them together to Reliance custodial staff to be conveyed, along with the prisoner, to the relevant prison. The process involves the reports being collated on a shelf within the cell area. This shelf is inspected at the end of each day to ensure that the reports have been sent to the prison.

[17] The committal warrant which accompanies the prisoner to the prison is printed out by the clerk on a template form. The form includes a section

which states: *"Copy Reports Attached: Social Enquiry/Community Service/Psychiatric/Medical."*

[18] On 24th June 2008 the clerk who dealt with the committal warrant and provided Reliance with the relevant documentation was Mrs R** W**. Mrs R** W** is an experienced clerk who dealt with Mr Strain on a number of occasions. Her practice was to indicate which of these kinds of reports were attached, by scoring through to delete reference to any which were not attached.

[19] In Mr Strain's case the Extract Warrant appears as printed, with no amendment, scoring out or circling of any of the possible reports which might or might not be attached. Mrs R** W**'s evidence was that because none of the options had been scored out, that meant that all the reports listed were available in respect of Mr. Strain. SERs are provided to the court with copies, but psychiatric reports are not routinely copied, so that the sheriff clerk has to copy these. Her practice was that the reports would not be stapled to the warrant, but would be bundled together and passed to the Reliance Officer in court. The court's copies would be stapled together and filed in a plastic folder.

[20] She went further and stated that she specifically recalled the day Mr. Strain was sentenced. She recalled the defence solicitor referring to Dr. Clark's report in court. She remembered having copies of it. She equated a psychiatric report with a medical report, and on receipt of a psychiatric report she would not score out the "medical report" option. She specifically recalled passing the SER and psychiatric report to the Reliance Officer in court. She had no knowledge of what happened to the paperwork after it was passed to Reliance.

[21] Ian Miller is a Reliance Custody Officer based at Kilmarnock Sheriff Court. He is the Bar Officer responsible for booking prisoners in and out of the cells and liaising with court officials over the escorting of prisoners between cells, courtrooms and on to custodial institutions. He described the procedure, from the Reliance point of view, for dealing with the paperwork

when a prisoner is committed to custody. The person bringing the warrant down from the court pairs it up with the day summary. Mr. Miller checks that the warrant corresponds with the information from the court, has a correct charge code, and has been signed by the clerk. Mr Miller confirmed that warrants often come down from court accompanied by reports such a SER or psychiatric report. He understood that the clerk would delete anything in the "copy Reports Attached" section of the warrant which did not apply.

[22] The practice of Reliance is to maintain a Prisoner Escort Record, which is a narrative log relating to every prisoner in their custody that day. Any reports are stapled together with the warrant and eventually given to the driver whose duty it is to take the prisoner to the prison. On arrival at the prison Reception, the Reliance driver takes the paperwork to staff there and prison staff check the documentation before accepting the prisoner into their custody.

[23] Mr. Miller remembered being on duty as the Bar Officer on 24 June 2008 and dealing with Mr Strain. However he did not recall what paperwork came with him when he was received into custody by Reliance. He did not recall if any reports were available. Because none of the "Copy Reports Attached" were scored out on the committal warrant relating to Mr. Strain, he believed that Reliance would have got all the Reports mentioned. He did not personally escort Mr Strain to prison and was not involved in handing over paperwork to the prison. Paperwork for prisoners is put on various shelves during the day, according to the cell where each prisoner is being held. He accepted that because the paperwork passes through a number of hands and sits on a busy shelf for a period of time before the prisoner leaves court, there is always the potential for documents to get mixed up and separated. However this is uncommon in his experience.

Reception into Custody and initial risk assessments

[24] Later that day, 24 June 2008, at approximately 16:00, Mr Strain arrived at HM Prison Kilmarnock and was received into custody there. He was

accompanied by the warrant of committal from the court. There is evidence that the SER was received at the prison, but there is no record of Dr. Clark's psychiatric report being received there.

[25] SERCO operate a High Risk Assessment (HRAT) procedure to identify and supervise prisoners considered to be at risk of self harm or suicide. All staff involved in the HRAT process are trained. They attend an HRAT training course of 1 ½ - 2 days, and refresher courses are available to them. An HRAT book is opened for any prisoner who is considered to be at risk, and this is maintained through out the period the prisoner remains at risk. The book is a record showing the reasons for identifying the risk in the first place, the level of supervision required, any special requirements relating to cell allocation, minutes of case conferences reviewing and monitoring the prisoner's situation, and any feedback from prison staff or follow up in respect of any treatment, investigations or other measures deemed to be in the prisoner's interests. The process of information gathering and monitoring involves input from the prisoner himself, Prison Custody Officers, Prison Social Workers, Health or Mental Health professionals and psychologists. The level of risk is kept under review and may be increased or decreased, or the prisoner might be taken off watch altogether, according to the circumstances. Every prisoner is assigned a supervision level. In accordance with the HRAT procedure, Mr. Strain's initial supervision level was prioritised as "High". Within this category of prisoner there are three levels of supervision, requiring observations on the prisoner at different intervals. Observations on those assessed as presenting the highest risk (Level 1) are to be carried out every 2 minutes. At the next highest level, Level 2, observations require to be carried out at 15 minute intervals.

[26] On his arrival at the prison, Mr. Strain underwent a reception risk assessment. This was carried out by PCO Leon Smith. An HRAT Assessment book was opened at 16:30 on that day. Mr. Strain was assessed as being at risk and an intial decision was made to place him at Level 3, with observations every 30 minutes. Dr. Clark's report was not available to PCO Smith or any other officer involved in the reception risk assessment process. PCO Beaton had

seen the SER, but did not pass on to those involved in the risk assessment process that it referred to a psychiatic report concluding that Mr. Strain had been suffering from paranoia.

[27] Mr Strain was then interviewed by the Head of Operations. The record of that interview is timed 18:40, and records that he had thought about suicide the previous year. He stated that he had no current thoughts of self-harm or suicide, but it was his first experience of custody and he was "a little bit anxious about being here." A first case conference was arranged for later that evening.

[28] That evening a first case conference took place at 19:10. Although he had denied having any current thoughts of self harm or suicide, it was noted that he had stated that he was fed up with life and felt he had nothing to live for. As a result of this, he was assessed as being appropriate for a Level 3 watch, with observations every 30 minutes. He was allocated to a "normal" cell location within the prison, rather than to the segregation unit.

[29] A second case conference took place on 26 May 2008 to review the level of watch and its continuation. Present at this conference were Ms Kennedy (chair) Ms Greig (assessor) Mr Docherty (PCO) and Mr Machimbidza (nurse). Mr. Strain was not present. In particular Ms Greig, as the assessor, had carried out an evaluation of Mr Strain. She found him guarded and suspicious of her. Prior to this case conference, she attempted to obtain further information by reviewing his social work and prison records file. No records were held by the Social Work Office within the Prison relating to Mr. Strain. The only reference to Mr. Strain was in a fax received from the Court on 25th of June 2008. This provided a Risk Alert in relation to Mr. Strain but provided no further information. She was aware of Dr Clark's report as it was mentioned in the SER (which was available at the case conference). This itself referred to Dr Clark's report, but no efforts were made to obtain a copy so that the case conference could be satisfied what it actually said, and whether its conclusions were correctly represented by the author of the SER. The case conference concluded with the decision to continue the watch at the same Level 3 status with 30 minute observations.

[30] On 30 June 2008 a third case conference took place. Present at this case conference were Mr Strain himself, Miss McGinty (chair) Ms Howie (assessor) Ms Jones (PCO) and Mr H****(nurse). In particular Ms Howie, as the assessor, had reviewed the previous case conference notes and carried out an assessment of Mr Strain. Contrary to the apparent expectation, no copy of Dr. Clark's report was available at this case conference. It was open to all members of the HRAT process to request a copy of Dr Clark's report, and to take reasonable steps to obtain it. It is recorded that Mr. Strain appeared to be defensive and guarded in his responses, and he had failed to report his current mood state. He continued to express the view that he had been unfairly treated by the criminal justice system. He presented as hostile towards support services offered to him. Nevertheless he agreed to a social work referral being made, and denied any ideation of self harm or suicide. This case conference concluded with the assessment that Mr. Strain was at "No apparent risk". The watch was then closed, with the result that he was no longer subject to the observation and monitoring regime of prisoners considered to be at risk. Various items of follow-up work were identified and minuted. In particular, one action point was for a follow-up Registered Mental Health nurse assessment to be carried out. As stated by Mr H**** in his evidence, this assessment never took place. Mr H**** as the RMN Nurse, had a responsibility to follow up the action plan within the case conference. He could provide no reason as to why this follow up work was not carried out. No systems were in place to check that all matters identified in the action plan were actually correctly carried out.

Timeline: June – November 2008

[31] 24 June 2008: Mr. Strain sentenced and admitted to HM Prison, Kilmarnock. Placed on high level supervision (Level 3 with observations at 30 minute intervals).

[32] 26 June 2008: Second case conference took place. The HRAT watch was continued at the same level.

[33] 30 June 2008: Mr Strain removed from supervision.

[34] Beginning of July until late October 2008: Mr Strain was not observed to be having any difficulties within the prison. His mother saw him regularly in prison. At first she was concerned because of his apparent lack of interest in either his appearance or his visitors. However, she noted that he quickly "got his head down" and got on with his sentence. He was looking forward to the prospect of being released early on a Home Detention curfew. According to the daily narratives written contemporaneously by prison staff, he mixed well and posed no problems on the wing (Production 4 annex 11), although the narratives were sketchy, lacking in detail and incomplete. Nevertheless, he became an enhanced prisoner with the privileges this entailed.

[35] By letter dated 28 October 2008, Mr Strain was notified that he would not be released early under the Home Detention Curfew scheme due to the nature of his index offence. Mr Strain appealed against this decision.

[36] By letter dated 5 November 2008, Mr. Strain was advised that the appeal was refused. He subsequently told his mother that he would just have "sit out" his sentence. He seemed to her to be brighter, and she was pleased with his positive attitude to the situation.

[37] On 10 November 2008, Mr Strain made a complaint about the conduct of former PCO C**** while he was attending the computer room in the education department of the prison. He complained that PCO C***** had touched his hair. This complaint became public knowledge as a result of unwelcome coverage in the tabloid press. The reporting of the matter in newspaper articles came to the attention of other inmates in HM Prison Kilmarnock, and this led to difficulties for Mr Strain. PCO C***** was a popular officer who was well regarded by many prisoners. Furthermore, the press articles made reference to the circumstances of Mr Strain's index offence, and portrayed him in an unsympathetic light would not have been well received by the mainstream prison population.

[38] On 20 November 2008, as a result of concerns for Mr. Strain following the newspaper reporting of his index offence and complaint, management

relocated Mr. Strain to the Segregation Unit within the prison (the Arran Unit).

[39] On 21 November 2008, Mr. Strain requested that he be removed from protection and returned to the mainstream population of the establishment. He signed a disclaimer confirming that this move would be at his own risk. Prior to entering the Arran Unit he had been resident in F Wing. He would have been returned there but there was no available space on that Wing. Bryan Crossan, Unit Supervisor of the Arran Unit spoke to Mr Strain, and informed him that he would be going to E Wing. Mr. Strain stated that he was happy with that arrangement, and specifically, he was not under any threat. He just wanted to return to mainstream conditions. Following a risk assessment, later that day, Mr Strain was re-housed within E wing.

[40] Later on that evening, following this return to E wing, Mr Strain approached PCO Lorimer and advised him that he was having some difficulties on the wing. He told the officer that he had heard information from an un-named prisoner that he may be under threat. A further risk assessment was carried out, and Mr Strain was housed within a protection cell but on the mainstream wing (E Wing). This was because there was no accommodation available on the protection wing. The narrative in regard to Mr Strain was not sent onto the wing.

[41] Mr Strain was moved into a shared cell with another prisoner, R** R** This was cell E 25. During their time together, Mr Strain talked about his family and the complaint he had made about PCO C*****. He indicated to R** R** that he had concerns that he was getting "set up", and was being referred to as a "beast" by other prisoners. R** R** and Mr Strain remained cellmates until Mr Strain's death. At no time did R** R** become aware of Mr Strain's intentions.

[42] On 22 November 2008, according to R** R**, a number of mainstream prisoners came to their cell door during the day, saying to Mr Strain things like "You're a beast!" He would respond by saying "No!" Mr Strain and R** R** were allowed to go to the canteen while other mainstream

prisoners were within the communal areas. On one occasion, when the cell door had been unlocked, Mr Strain took papers with him to the canteen area, to show them to other prisoners. According to R** R** these related to the offence for which he was imprisoned. He wanted to demonstrate what he had been jailed for, so that other prisoners could see that was not a "beast" (a sex offender). R** R**'s evidence was that the other prisoners were not interested in what Mr Strain had to show them, and he simply put the papers down and left them in the canteen. This episode tends to show that Mr Strain was feeling under growing pressure.

[43] In the late evening of Saturday 22 November, and into the early hours of Sunday 23 November, both Mr Strain and R** R** watched television. There was a boxing match on. Mr. Strain went to bed and slept. R** R** stayed up after the boxing finished at 04:15. and played with his Play Station until about 08:00. He went for breakfast and then slept until the late afternoon.

Sunday 23 November 2008

[44] R** R** recalled that on Sunday 23 November Mr Strain did not want breakfast, but otherwise he seemed fine. He mentioned that his mother was coming to visit him at 16:00 that afternoon. R** R** was emphatic that Mr. Strain had given him no signs or warning that he was thinking of harming himself, and the tragic outcome of that afternoon came as a complete surprise and shock.

[45] At 16:15 Mr Strain's mother attended at the prison to visit her son. PCO Torbett went to cell E 25 at approximately 16:30 to escort him to his visit. He found the cell in darkness and noted R** R** to have been asleep prior to his attendance. He noted a knotted ligature above the toilet door and discovered Mr Strain to be suspended by a belt within the toilet area. He summoned help, and, along with colleagues, managed to recover Mr Strain from the toilet area. Medical personnel attended. They attempted unsuccessfully to resuscitate him, but he had already died. He was formally pronounced dead at 20:00 that evening.

Medical and Toxological evidence

[46] Dr. Iain Graham, Consultant Pathologist, carried out a post mortem examination on 25 November 2008. He found a ligature mark round the neck with bruising of the soft tissues below. The eye whites were suffused. His opinion was that the cause of death was hanging.

[47] Blood samples were sent for laboratory examination. They were tested for the presence of alcohol, acidic and basic drugs, benzodiazepines, paracetamol and drugs of abuse. All analyses gave negative results.

Cell Design issues

[48] The Inquiry heard technical evidence from William Sinclair, SPS Project Supervisor and Stuart McLaren, Facilities Manager, HMP Kilmarnock, about the design of the toilet door in the cell concerned, and its suitability for purpose in the context of suicide prevention.

[49] The door to the toilet in cell E25 is a standard "Taskmaster" door. The dimensions of the door are 1m 840mm (height), 585 mm (width) and 45mm (thickness). The doors are not capable of being locked, and have a magnetic hold on them for privacy purposes. The door is hung by means of a top pin inserted into the top of the door, and a bottom pin inserted into the bottom of the door. It is made of metal. It is fitted with a piano type hinge to make it more difficult for inmates to remove; for example, to use as a barricade or weapon. The door shape is rectangular.

[50] In some prison establishments, a revised form of the door is fitted to cell toilets. The modification consists of a diagonal cut across the top of the door, from the top at one side to a point approximately 10 cm below the top at the other side. This can be seen in photograph "P" in production 11. There are a number of possible suspension points in within every cell which can be used to suspend a ligature. Even if the design of the toilet door were altered as shown in production 11, a number of suspension points would still exist, including the toilet door. It would have been harder to secure the knotted ligature if the door was modified in this way, and would make it more

difficult for the "opportunist" suicide. However the witnesses accepted that this new design of door would not stop someone who was determined to take his own life. An altered design of cell toilet door also has implications for privacy, and the size of the cell floor space.

[51] The evidence was, that although SPS are now introducing the modified type of door as the standard in new establishments, there is no policy of retro-fitting. No private prison has been required to do so. In the view of these witnesses, the style of Taskmaster doors fitted to cell toilets at Bowhouse, including the one in cell E25, were fit for purpose.

Subsequent investigations

[52] Following Mr. Strain's death, SERCO carried out their own internal investigation into the circumstances. This resulted in a report dated 14 December 2008, which was produced as Crown production 4 at the Inquiry.

[53] The SERCO report includes a number of recommendations at page 33, and includes the following passage:

"The Daily Narratives… that were completed on Mr Strain are scant and lacking in detail, e.g. there is no comment as to how he reacted to the newspaper articles, how he reacted to the refusal and subsequent refusal of his appeal against not being comsidered for the Home Detention Curfew scheme and any negativity that may have surrounded these factors could have had a bearing on consideration whether Mr Strain should have been re-assessed via HRA.

I recommend that all staff are reminded of the importance of comprehensive comments in Wing Narratives and that they are required to make them more detailed. Should the Personal Officer not be available to their prisoner, i.e. on Annual Leave or Night Duty then a deputy should be appointed to complete the narrative.

I further recommend that the auditing of the Narratives should be the continual focus of the Wing Supervisors….."

The report thus contains a frank acknowledgment of the importance that Wing Narratives on prisoners can play in risk assessment, and a recognition that the quality of Narratives on Mr Strain was affected by the gaps and lack of attention to detail.

[54] In preparation for this Inquiry, the Crown obtained from Dr Clark a further (posthumous) psychiatric report relating to Mr Strain. His second report, dated 8 April 2010, was produced as Crown production 9.

[55] Dr. Clark's second report contains important conclusions, which he confirmed in his oral evidence. In the course of her submissions on behalf of SERCO, Mrs Anwar founded on Dr. Clark's conclusions and commended them to me. In particular, he states in the second report:

> *"I felt it unlikely that Mr Strain would voluntarily accept help as this would imply that he was, in some way, unwell or that his view of events was invalid. He was very keen to maintain control in the situation in which he found himself and his rigid and inflexible views would make it difficult for him to trust doctors or to accept help that might imply his view of events may, in some way, be incorrect".* (page 2) …..
>
> *"I felt the [HRAT case conferences] indicated a careful assessment of the position and that Mr Strain himself was present at these meetings. He appears to have settled over the course of the period of assessment and I note that the meetings were chaired by the Institution Psychiatrist. I am unsure whether my report of the previous October was available at those meetings or whether they were merely made aware of it. I am unsure as to the involvement of the Institution Psychiatrist at that time and it may be that more psychiatric input would have been helpful, including a copy of my report of 23 October 2007 or other psychiatric opinion available to the court prior to admission . . . . . Psychiatrist input might have been helpful, but I feel that it would not have altered the overall discussions and conclusions.. . . I feel that the overall assessment*

was satisfactory and the conclusion to move him to the wings was appropriate". (pages 3-4) …..

". . . I could find no evidence to suggest that he had developed any form of mental illness, such as a severe depressive illness or a paranoid psychosis. I feel it unlikely that psychological or psychiatric intervention at this point [November 2008] would have been either acceptable to Mr Strain or proved effective in altering the situation." (page 5*)* ….

"Overall, I feel that his assessment on admission to HMP Kilmarnock was adequate and the Risk Assessment and management were appropriate. The unfortunate chain of events leading to his death and in particular, the newspaper reports would, I feel, have had a major catastrophic impact on his feelings of self esteem and he would have great difficulty in being perceived by fellow inmates as a 'beast' and being the butt of their contempt. Despite the tragic outcome, I feel that he was appropriately managed, and it is difficult to see at what point the chain of events could be broken. In hindsight, it is likely that the staff would not have been aware of how sensitive and vulnerable Mr Strain actually was and I am sure that he made great attempts to hide this wherever possible". (page 6)…..

CROWN SUBMISSIONS

S6 (1) (c)

[56] The Procurator Fiscal Depute invited me not to make any formal findings under section 6(1)(c). In his submission there were no reasonable precautions whereby the death might have been avoided.

[57] While SERCO staff failed to carry out a follow-up RMN assessment in accordance with the action plan identified at the case conference, it was not possible to say that there was a link between this failure and the tragic events

on the 23rd of November. While Dr Clark's report would have provided a map giving direction to the treatment which Mr Strain required, this seems to have been adequately identified having regard to the follow up work which was set down following the watch being closed. During the intervening period between the case conference on 30 June and being placed within segregation on 20 November 2008, it was clear that Mr Strain came into daily contact with a number of PCO's, none of whom noted any signs of low mood or indications that he was experiencing difficulties coping in the prison environment.

[58] It appears that there were a number of events which affected Mr. Strain and built up to a head over a period. These were in themselves not sufficient to raise concerns. If the RMN assessment had taken place, if Mr Strain had accepted help, and if this gave him coping mechanisms, it is possible that he might have been diverted form the course which he ultimately took. However, even with Mr Strain suffering from Paranoia, there was no direct causal link between this condition and his decision to take his own life.

[59] For a finding to be made under this sub section, there must be a precaution that was reasonable in the circumstances, and which would give a real possibility that the death might have been avoided if it had been taken. There were too many factors involved here. It could not be said that if the follow up RMN assessment had been carried out, there would have been a real possibility that the death might have been avoided. For these reasons, he submitted that no formal finding should be made under this sub section.

S6 (1)(d)

[60] While there was evidence that Dr Clark's report was issued from the court, but not received at the prison, the contents of this report would not have led to a material change in the actions taken in respect of Mr Strain. Nor for that matter would staff have known of his intentions. Accordingly there was no defect in any system of working which contributed to the death, and no formal finding under this subsection should be made.

S6 (1)(e)

[61] The Procurator Fiscal Depute submitted that there were a number of matters arising from the evidence which could be described as relevant to the circumstances of the death. He invited me to comment on the following matters:

Paperwork from court.

[62] There was a clear difference in practice from supervisor to supervisor regarding what documentation they would look for, and what steps they would take should it not be available. The possible interpretations of the relevant part of the committal warrant varied. This process should be standardised and clarified.

[63] Information contained within the SER, and any other available report, should be given to those on the "front line" conducting the relevant interviews and risk assessments.

Design of the cell

[64] Where appropriate consideration should be given to reducing the number of suspension points within all cells, especially where a protection prisoner is held on a mainstream wing.

Medical treatment

[65] All matters which have been flagged as action points or follow up work should be confirmed to have been carried out; and in particular, greater care and attention should be given to RMN assessments.

[66] Checks should be carried out to make sure that all identified medical treatment is actually given to the prisoner in question

[67] All reasonable steps should be taken to identify medical or other reports capable of containing information which could inform case conferences and risk assessments, and make these available to those concerned..

HRAT Process

[68] As a protected prisoner on a mainstream wing has a reduced amount of contact with PCO's, then a further system should be in place to provide further contact between PCO's and the prisoner.

[69] Narratives on prisoners should be completed with full details, and available to PCO's to establish an understanding of the "usual" prisoners conduct.

SUBMISSIONS ON BEHALF OF SERCO

Section 6(1)(c) - Reasonable Precautions, if any, whereby the death might have been avoided

Psychiatric and HRAT issues

[70] Mrs. Anwar submitted that no findings fall to made under section 6(1)(c). I was referred to Carmichael, 'Sudden Deaths and Fatal Accident Inquiries', 3rd edition para 5-75. What is envisaged under section 6(1)(c) is not a 'probability' but a real or live possibility that the death might have been avoided by the reasonable precaution.

[71] Dr Clark's position in his second report (production 9 dated 8 April 2010), and in his oral evidence, was that the availability of his earlier report dated 23 October 2007 "might have been helpful but would be unlikely to have effected the outcome". That was supported by those involved in the HRAT process. For example, Nicola Grieg stated that sight of the Psychiatric Report "would not have impacted upon the case management conference", as the conclusion was already referenced in the SER which was available to staff. According to Niamh Kennedy, sight of the Psychiatric Report would have "been helpful but not essential". Patricia Howie stated that "the content of Dr Clark's report would have confirmed my view but not changed it".

[72] There was accordingly no basis in fact for any finding that had the staff at HMP Kilmarnock been provided with, or seen, a copy of the Psychiatric

Report, they would have taken any particular course of action with a real or live possibility that Mr Strain's death might have been avoided.

[73] The same observation applied in relation to the failure to carry out a follow up assessment of Mr Strain by a registered mental health nurse after the closure of the HRAT process. Dr Clark stated in his evidence that had Mr Strain died within days of being received in Prison, perhaps the fact that he had not had a follow up assessment might have been relevant. However, as he had gone on to cope for 5 months in prison prior to his death, an initial follow up assessment would have been unlikely to have assisted is detecting any risk of self harm.

[74] There was clear evidence that those involved in the HRAT process were aware of the conclusions in Psychiatric Report (Crown Production Number 4, at page 73 - the HRAT book). Whilst it was suggested that the HRAT team or the Reception staff at the prison could have contacted either the Scottish Courts Service or Dr Clark for a copy of the Psychiatric Report, and there was a general acceptance among the prison staff involved in the HRAT process that ideally it is best to have all relevant information before them, there was no evidence that had they had sight of the Psychiatric Report in this case, those involved in the HRAT team would have taken any different course of action with regards to the care of Mr Strain. There was also evidence that Mr Strain would not have accepted any continuing assistance from the mental health staff. Moreover, the purpose of the follow up assessment was not in relation to the risk of self harm. Were that to have been the case, the evidence of Patricia Howie and Gillian McKenzie was that the HRAT process would not have been closed.

Cell design

[75] There was no evidence to suggest that the installation of a 'slanted toilet door' at the toilet in Cell E25 was a reasonable precaution whereby the death might have been avoided.

Section 6(1)(d) – defects, if any, in any system of working which contributed to the death

[76] Mrs. Anwar reminded me that there required to be a clear casual connection between the defect and the death. The submissions under section 6 (1) (c) were also relevant to section 6 (1) (d). There was no evidence that the absence of the Psychiatric Report upon admission of Mr Strain to HMP Kilmarnock, or subsequently, was attributable to any defect in any SERCO system of working. Neither was there any evidence that the absence of the report contributed to Mr Strain's death. Whilst no follow up assessment by a registered mental heath nurse took place in line with the action plan decided upon at the closure of the HRAT process, it cannot be concluded that this omission contributed to Mr Strain's death. There was no evidence that Mr Strain had developed any depressive illness or any delusional thinking of a psychotic nature, and Dr Clark was of the view that Mr Strain would not have accepted any further interventions or referrals. At the time of the closure of the HRAT process, Mr. Strain appeared to be coping with life in prison, and thus there is every possibility that the outcome of any follow up assessment (had one taken place or had Mr Strain agreed to participate) would simply have been that no further interventions were necessary.

Section 6(1)(e) – Any other facts which are relevant to the circumstances of the death

[77] In Mrs. Anwar's submission, the missing Psychiatric Report, and the omission to carry out a follow up mental health assessment, might be relevant to the circumstances surrounding Mr Strain's admission to prison and his mental health at that time, but not to the circumstances of his death.

[78] Although there was no basis for making any formal findings against SERCO in terms of the Act, Mrs Anwar suggested that the court might wish to take the opportunity to comment on a number of issues raised in the evidence:

(a) The need for clear and consistent completion of paperwork, and communication between the court and prisons, where committal warrants are accompanied by medical or psychiatric reports.

(b) The need for secure physical attachment of reports to warrants, to avoid the risk of detachment or loss.

(c) Whether the HRAT process should have been closed.

(d) Whether Mr. Strain ought to have been placed back on HRAT supervision prior to his death, having regard to stress factors such as the refusal of his Home Detention Curfew appeal, the incident in the computer room, and the problems with other inmates which led to him seeking protection status.

(e) The design of the cell toilet door.

[79] In her submission, Mr Strain's decision to take his life could not have predicted, foreseen, prevented or managed by any risk management process by SERCO and the staff at the Prison. His decision, as Dr Clark stated in his evidence, appears to have been 'impulsive' and without any prior indication of his intentions.

SUBMISSIONS ON BEHALF OF SPS

[80] Mr. Chaffey, on behalf of SPS, submitted that much of the evidence and issues considered in the course of the Inquiry were not directly relevant to SPS, as HMP Kilmarnock is operated by SERCO and not SPS. He submitted that no relevant criticism can be made of SPS in terms of Section 6(1) of the 1976 Act. He had no submissions to make in relation to Sections 6(1) (a) and 6(1) (b), although he did not take issue with any of the formal findings proposed in submissions by others. There was no evidence which would justify any findings under Section 6(1) (c), (d) or (e) in relation to SPS.

[81] SPS is fitting the new internal toilet doors with cut-out slanted tops in new prison halls for which they are responsible. The new design is partly due to suicide risk management concerns, and also for practical ventilation purposes as new cells will have showers installed. There is no policy to retrofit internal toilet doors in SPS managed establishments. Although the new door design would make it harder to create a suspension point, it would

not be impossible for the reasons canvassed elsewhere in this determination. The internal toilet door in Thomas Strain's cell was fit for purpose.

SECTION 6(1) (c) (d) and (e) - DISCUSSION AND CONCLUSIONS

Credibility and Reliability

[82] I found all the witnesses credible and generally reliable.

Court paperwork, processes and communication – The missing psychiatric report

[83] It is clear from the evidence that the psychiatric report was in court when Mr. Strain was sentenced, but no staff at HMP Kilmarnock were aware of it having been received there. Reception Supervisor Kenneth Beaton stated that it would have stuck in his mind if he had received it. When shown it, he confirmed that he had "never seen this document". Staff were made aware of the existence of the SER by the Social Work department at Kilmarnock Sheriff Court. Paragraph 16 of the Joint Minute refers to a 'risk alert' received by fax. There was no evidence that the existence of any psychiatric report had been specifically brought to the attention of the staff at HMP Kilmarnock.

[84] Mrs R** W** indicated that it was her practice to score out on the committal warrant reports which were not attached. She explained that the fact that no reports were scored out meant that all reports were provided with the warrant. She accepted that there was no medical report in this case, but in her view, psychiatric and medical reports were 'the same thing'. This shows potential for further confusion. These may well be entirely separate kinds of reports. It is also worth noting that a Community Service Report will usually, if not always, be contained within an SER rather than existing as a separate document. Mrs R** W** was unable to say whether either the escorting officers of Reliance or prison staff were aware of her practice to score out reports which were not attached (rather than to circle or tick those which were attached). Mr Miller, Reliance officer, was of the view that as

no reports were scored out on the warrant, four reports should have been with the warrant. Mrs R** W** explained that in her view in fact there should only have been 2 reports. Kenneth Beaton explained that the fact that reference to the Psychiatric Report was not scored out would not alert him to the fact that one was attached (or should have been) to the warrant; nor would it cause him to contact the court for a copy. Russell Clark stated that as no reports were scored out, he would not expect any reports to be attached to the warrant. His expectation was that those reports which were attached would be 'circled' to indicate that they were in fact attached.

[85] Mrs R** W** explained that the Psychiatric Report was not physically stapled to the warrant. However she was clear in her evidence that the report was "attached" to the warrant when she passed it to Reliance Officers. She did not know what had happened to the report after it left her. Mr. Miller described the process for handing the warrant and any accompanying documents. He explained (a) that the Reliance officer in court would pass the documents to the bar officer based in the cell area in the sheriff court (b) that the bar officer would cross reference these documents with Prisoner Escort Records (c) that a third member of staff would copy the documents and input certain data on to a computer system (d) the documents are then passed to the staff known as 'turnkeys' (e) the turnkeys place the documents in a 'docquet' outside a cell - there are up to eight prisoners in a cell and thus the docquet might contain paperwork relating to up to eight prisoners (f) the paperwork is then moved to the bar area ready for the departure of prisoners (g) the van drivers are passed the paperwork. Mr Miller explained that after the cells are emptied, the docquets are checked for any remaining paperwork, but he also accepted that it was possible that some paperwork belonging to one prisoner could be passed to the wrong Reliance van driver. The Personal Escort Record in respect of an individual prisoner does not specify what reports, if any, are attached to the warrant accompanying the prisoner into the prison.

[86] There was evidence that such reports are rarely provided with committal warrants. Mrs R** W** stated that "99% of the time", she scored out

reference to medical and psychiatric reports on committal warrants as they were not provided. Kenneth Beaton, a Reception Supervisor of 3 years stated that whist receipt of SERs was common place, he had never come across a psychiatric report before. Russell Clark stated that he had only seen one in his years of experience as Reception Supervisor, and that had been the week before the Inquiry. He had in fact been alerted to it by a call from the Scottish Courts Service in advance because "it was out of the ordinary".

[87] There was conflicting evidence about whether potentially important medical and psychiatric reports do routinely accompany committal warrants to prison. Mrs. Anwar invited me to consider commenting on the need for the Scottish Court Service to contact prisons and alert them in advance to the fact that such reports in relation to any particular prisoner will be accompanying the prisoner on admission. She suggested it might also be appropriate to comment on the need for clarity and consistency of practice in the completion of committal warrants, their physical attachment to accompanying reports, and the need for the Scottish Court Service to communicate any practice as to how the warrants are completed to both Reliance and receiving prisons.

[88] I share the concerns of the Procurator Fiscal Depute and Mrs Anwar over this chapter of the evidence. We will never know at what exact point in the chain the missing psychiatric report went astray, and what became of it. The evidence suggests that the practice Mrs R** W** described is not universally followed, as some prison staff clearly regarded the receipt of such reports as a rarity. However, in relation to the psychiatric report on Mr Strain, I accept Mrs R** W**'s evidence that she passed this to Reliance. She was the only witness who specifically remembered dealing with psychiatric report. Mr. Miller did not remember what paperwork came to Reliance with Mr Strain that day, but thought that Reliance would have received the reports mentioned on the warrant as none were scored out.

[89] I accept that, in this particular case, the fact that Dr Clark's report was not received at the prison did not have a bearing on the circumstances of Mr. Strain's death. It might have been relevant if he had died shortly after

admission, but his actions in taking his life happened some 5 months after his admission to prison. During the intervening period he had been subject to HRAT supervision, and taken off it again as a result of a review of the risks involved by a case conference consisting of health care and welfare professionals. Although no-one at HMP Kilmarnock actually saw the psychiatric report, its salient features were repeated in the SER which was received at the prison. The case conference knew that Dr Clark had provided a report and that it referred to Mr Strain suffering paranoia.

[90] Although the absence of the psychiatric report was not material to the outcome in the particular circumstances of this case, I am concerned that in other cases it could be vital for the purpose of assessing the risk of self harm or suicide that the prison receive any psychiatric report from the court immediately. It must be regarded as unacceptable that the system for flagging up the existence of such important reports, and transmitting them to receiving establishments, is so informal and susceptible to breakdown, misinterpretation or indifference. Some witnesses thought that all the reports mentioned ought to have been with the warrant, but no-one saw fit to query why only an SER had been provided. Other witnesses, on their interpretation of the failure to score out any options, would have assumed that there were none. Again, no-one checked to enquire whether these assumptions were justified.

[91] It seems to me that the wording of the "reports" section of the committal warrant allows scope for confusion and this should be clarified. This could easily be resolved by changing the printed wording on the warrant form. I recommend that the wording of the form be changed to read: "The following reports are attached. … (circle/tick as appropriate)…".

[92] At present, the warrant, and any reports accompanying it, are passed by the clerk of court to Reliance at the same time; but not securely attached together. These documents then pass through a number of hands and lie on a shelf with other paperwork in the cells area during the court day. This system carries the obvious risk of important reports becoming detached from the warrant and mislaid. This could, in my view, be easily addressed if a

standard procedure were introduced for attaching any report to the warrant physically. I recommend that clerks of court be instructed to ensure that any reports accompanying a committal warrant to prison are either securely stapled to it, or put together in a folder or file containing all the documents relevant to each prisoner.

[93] One matter which arises from the evidence and the submissions is whether the prison should be alerted in advance that a prisoner being admitted from court will be accompanied by a particular type of report. On 25 June 2008, the day after Mr Strain's admission, the prison received a fax from the court providing a "Risk Alert" but no other details. As noted above, Russell Clark's evidence was that, on one occasion, he was alerted to the existence of a psychiatric report by a call from the court. Given the potential importance of a psychiatric report to the initial risk assessment process, it is obvious that the prison authorities require to be aware of it as early as possible. There seems to me to be merit in the suggestion that there should be a standardised practice whereby court staff contact the prison in advance to alert them that an incoming prisoner will be accompanied by such a report. I recommend that this practice be introduced.

HRAT – better information for those tasked with assessing risk

[94] The case conferences dealing with Mr Strain's risk assessment were attended by a number of mental health professionals. They had the SER and were aware that it referred to Dr Clark's psychiatric report. The case conference minutes record that Dr Clark had diagnosed paranoia. However, it is of concern that no-one made any efforts to try to obtain the psychiatric report itself. In deciding how to factor Dr Clark's assessment into their own risk assessment, they relied on the Social Worker's understanding of what his views were. There is no suggestion that the Social Worker relayed any misinformation or failed to pass on anything of significance in the SER. However, it strikes me as surprisingly casual for mental health professionals to appraise themselves of the conclusions in a consultant psychiatrist's written report on the basis of a non-medical third party's interpretation of what was significant, without attempting to obtain the actual report itself. I

recommend that staff charged with carrying out risk assessments and case conferences should be instructed to take all reasonable steps to obtain copies of any potentially relevant medical or psychiatric report which is identified in respect of a prisoner.

[95] The Case Conference care plan arising from the 3rd Case Conference on Mr Strain listed a number of action points. One of these was "Follow up RMN assessment – E** H**". No Follow up RMN assessment took place. E** H**, Registered Mental Health Nurse, was at a loss to explain why this was not done. There was no system in place to check that follow up work indentified at the case conference as being necessary was actually carried out. I am of the opinion that this is a weakness which ought to be corrected. I recommend that there should be a routine system of review of case conference minutes by management to ensure that items identified in the action plan are in fact carried out.

[96] As noted above, the report of SERCO's internal investigation recognised that the daily narratives prepared by PCO's on Mr Strain were incomplete. The report of that investigation was lodged as a production. It was recognised in the evidence, and in the SERCO report, that the daily narratives prepared by PCO's on Mr Strain were incomplete. SERCO are to be commended for taking the initiative in addressing this issue through the recommendation they have made. That seems to me to be entirely appropriate, and I have nothing to add on that matter.

Should the HRAT process have been closed?

[97] Dr Clark described the HRAT process as "quite impressive". Mr Strain was repeatedly interviewed; by a PCO, a nurse, the Head of Operations, a doctor and psychologists. There was a case review, followed by further interviews and further case reviews, and he was kept on 30 minute irregular observations (Crown Production 4 pages 83 to 89 and evidence of PCO Leon Smith). I accept that the approach of the multi-disciplinary HRAT team was to err of the side of caution when assessing risk of self harm to

prisoners. I accept that the HRAT process would not be brought to an end where any member of staff had continuing concerns in this regard.

[98] The missing Psychiatric Report did not assess Mr Strain's risk of self harm or suicide, although it did mention paranoia. The psychologists involved in the HRAT process, and in particular Niamh Kennedy, explained that someone suffering from paranoia would not of itself be sufficient to indicate that the person was at risk of self harm or suicide. I accept the psychological evidence that fact that a prisoner suffered from paranoia would not be sufficient cause, of itself, to keep the HRAT process open.

Should Mr Strain have been placed back on HRAT prior to his death?

[99] My impression was that the PCO's who gave evidence appeared to be well versed in the HRAT process. They had undergone training to identify the kinds of signs to look out for which might indicate that a prisoner was at risk of self harm. It is significant that neither the PCO's who had contact with Mr Strain in the days leading up to death, nor his cell mate, R** R** observed anything to lead them to think that he might take his life.

[100] It was clear from the evidence that Mr Strain knew how to ask for medical or other assistance. On 18 and 21 August 2008 he had referred himself to medical staff (Crown Production number 4, pages 95 & 96; evidence of Nurse Alan Thornton). On 21 November 2008 he had requested being placed on protection. Although he was placed on protection, he had numerous interactions with PCO's. He did not raise any issues with any of these PCO's, nor did they pick up on any indicators of risk of self harm or suicide.

[101] Dr Clark was of the opinion that Mr. Strain's decision to take his life was likely to have been impulsive, and acted upon quickly. Dr Graham's evidence confirmed that it would have taken Mr Strain perhaps only 2 to 3 minutes to end his life once the decision had been taken. He was sharing accommodation with a cell mate. He was due to receive a visit from his mother on the day he died cell. These were described as protective factors, making it less likely that he would attempt suicide. Mr Strain's attempt thus

could only have been discovered and prevented had he been placed on constant observations or held in anti-ligature conditions. For the reasons given above, I accept that such measures were not warranted on the information staff had at the relevant time.

The loss of his appeal for release under the Home Detention Curfew Scheme

[102] Mrs Strain gave evidence that she had spoken to Mr Strain since the loss of his appeal, and that he had resolved to 'just sit out his sentence'. He wanted to 'just get his head down' and get on with it. After the refusal of his appeal, her concerns were allayed, and she was pleased with what she saw as his positive response. She described how "Tommy appeared to be picking himself up". He had not said anything about hurting himself, and she had not picked up from their conversations anything to give her concern in that regard. In fact, he was talking about attending education in prison, and he was 'settling down'.

[103] PCO Docherty, Mr Strain's personal officer, discussed the refusal of the appeal with him. That discussion gave him no cause for concern.

[104] I am therefore satisfied, on the evidence, that Mr Strain's response to the refusal of his Home Detention Curfew appeal did not reveal any grounds for placing him back on HRAT supervision.

The complaint, the newspaper articles and difficulties with other inmates**.**

[105] In my view, SERCO cannot be criticised for their handling of the complaint by Mr Strain against PCO C*****, and the subsequent unfortunate newspaper coverage. PCO Torbett stated that such allegations by a prisoner are taken seriously by the prison authorities. This is borne out by their action in suspending the Officer concerned.

[106] Having become aware of the newspaper coverage, the prison staff took the decision to place Mr Strain in the Segregation Unit on 20 November. PCO Torbett accompanied Mr Strain to the segregation unit and explained the process to him. He understood the situation, and his concern was about

whether he would be transferred to another establishment which would be more difficult for his mother to visit. PCO Torbett did not gain the impression that he was at risk of self harm. He confirmed that a number of experienced officers would have been involved with Mr Strain while he was in the segregation unit, and, had any of them had concerns, they would have placed Mr Strain on an HRAT process. The daily narratives completed by officers in the segregation unit clearly indicated that they had discussions with Mr Strain, and that Mr Strain was pleased to be returning to mainstream population on 21 November 2008.

[107] Mr Strain asked to be placed on protection when he returned to the mainstream prison population. He was aware of the support which could be offered to him and he knew to contact a PCO if he had any issues of concern. He approached PCO Lorimer, and told him that he was "having issues on the hall", but did he did not state to the officer that he was being threatened. PCO Lorimer was trained in the HRAT process. Neither on 21 November 2008, nor on seeing Mr Strain on the day of his death, did PCO Lorimer form the view that there was risk of self harm, or that Mr Strain should be placed on the HRAT process again.

[108] The Crown, in their submissions, pointed out that prisoners on protection would have more limited contact with PCOs than would mainstream prisoners. It was submitted that this might make the HRAT monitoring process, which relies on personal contact with PCO's, less effective for protection prisoners. However, prison staff remained in contact with him throughout. He obviously knew how to ask for help. He had had extensive dealings with prison staff between 20 November and 21 November, when he was placed in segregation, returned to the mainstream population and then put on protection on a mainstream wing. He was placed in a cell with a sympathetic cell-mate. There was no evidence that anyone in contact with Mr Strain in the days immediately before his death was or ought to have been alerted to a risk of self harm. Russell Clark gave evidence of the number of times during a day a prisoner on protection would have contact with a PCO (during unlock, roll counts, mealtimes etc). Each cell is fitted

with a cell call alarm, which would allow a prisoner on protection to seek help from staff. Each prisoner is allocated a Personal Officer, and there is a "Listener" scheme involving peer support from a fellow prisoner.

[109] There was thus no evidence to justify a conclusion that at any point between the complaint by Mr Strain on 10 November and the date of his death, he ought to have been placed back on the HRAT process.

Design of the cell toilet door

[110] Mr Sinclair, a Project Sponsor for SPS gave evidence that the toilet door in Cell E25 was 'fit for purpose'. The new toilet doors with a 10mm diagonal cut were being fitted to cells in new SPS prisons, or during refurbishments in new facilities. However, SPS were not applying this policy retrospectively in public prisons. As far as he was aware, no requirement or request had been made by SPS to private prisons to retrospectively fit such doors to toilets within cells.

[111] The diagonal cutout door serves two purposes namely (a) it reduces the risk of hanging and (b) it allows ventilation of those toilet areas fitted with showers. Cell E 25 did not have a shower in the toilet area. Mr Sinclair accepted that it was not impossible to commit suicide even if the new doors are fitted. He accepted that a prisoner could place something at the slanted end to create a suspension point. He agreed that a prisoner could use a lamp (commonly found in cells) as a ligature and the lamp could hang from the slanted door to create a suspension point. He accepted that the piano hinge which attached the door to the wall did not attach to the ceiling thus leaving a gap at the longer end of the door which could still be used as a suspension point, if something such as a belt were to pushed into that gap.

[112] Issues of privacy, safety and costs all required to be considered when considering making such changes in any prison. Although Mr Sinclair accepted that he was not an expert in safety, or the prevention of self harm in prisons, he thought the use of the new slanted door would not stop someone from hanging themselves, but might make it harder. If there was any indication of the risk of self harm, the most appropriate means of preventing

self harm would be to place a prisoner in an anti-ligature room in anti-ligature conditions.

[113] Having regard to the evidence, I am not satisfied that fitting the new design of toilet door with a slanted top would have been a reasonable precaution whereby Mr Strain's death might have been avoided. Design innovations are inevitable in any field of building design and construction over a period of time, but whether it is reasonable to adopt any changes prospectively or retrospectively must be a matter for the prison authorities taking into account the factors noted above. The authorities have decided not to embark on a programme of retro-fitting the new cell toilet door. The evidence is that the existing design of cell toilet door is fit for purpose. Accordingly I have no recommendations to make in this regard.

Summary of Recommendations

[114] I recommend that the wording of the committal warrant form be changed to read: "The following reports are attached. … (circle/tick as appropriate)…".

[115] I recommend that clerks of court be instructed to ensure that any reports accompanying a committal warrant are either securely stapled to it, or put together in a folder or file containing all the documents relevant to each prisoner.

[116] I recommend that there should be a standardised practice whereby court staff contact the prison in advance to alert them when an incoming prisoner will be accompanied by a psychiatric report.

[117] I recommend that staff charged with carrying out risk assessments and case conferences should be instructed to take all reasonable steps to obtain copies of any potentially relevant medical or psychiatric report which is identified in respect of a prisoner.

[118] I recommend that there should be a routine system of review of case conference minutes by management to ensure that items identified in the action plan are in fact carried out.

Concluding Remarks

[119] My responsibility is to make a determination on this matter pursuant to section 6 of the 1976 Act, which I have done. It is not the function of an Inquiry to make any findings of fault or to apportion blame. Questions of what might or might not have been reasonably foreseeable are for consideration elsewhere and are not appropriate to this forum. The statutory provisions are widely drawn and are intended to permit retrospective consideration of matters with the benefit of hindsight. Causation is relevant in determining what findings can be made under section 6 (1)(c) or (d), but section 6(1)(e) permits consideration of any other facts which are relevant to the circumstances of the death, even though a causal link has not been established.

[120] Although the Inquiry has highlighted some communication and procedural failings which have led to confusion or inactivity, it is not possible to say that any of these played a role in this tragic death. The case conferences were aware of the salient conclusion of the missing psychiatric report, and were able to take this into account in their assessment of risk. The death occurred some 5 months after Mr Strain was admitted to prison, during which time prison staff and mental health professionals had the benefit of their own observations. SERCO's own report made recommendations to improve the quality of daily narratives on prisoners. There is no evidence that any redesign of the cell door would have been likely to divert Mr. Strain from the course which he ultimately took. There was no evidence of any warning signs that Mr Strain was contemplating taking his own life, and prison staff and his cell mate were taken completely by surprise. In relation to the HRAT process, all the signs seem to have been that Mr Strain was coping with life in prison. For the reasons given, I have concluded that Mr Strain took his life impulsively and there were no reasonable precautions by which it might have been prevented. Although I have identified some defects in systems of working which ought to be addressed, it is not possible to conclude that these contributed to the death.

[121] It is not the function of this Inquiry to review general working practices within the prison system. However, I was invited to make observations by way of general comment on a number of matters which may be relevant to the circumstances of Mr Strain's death; or at least to procedures for helping prevent other deaths. I have accordingly made recommendations to improve procedures where it has appeared appropriate to do so in the light of evidence and submissions presented to the Inquiry.

[122] I wish to express my thanks to the Procurator Fiscal Depute, and to agents appearing at the Inquiry for their assistance in taking the evidence, and for their clear, careful and helpful submissions.

Sheriff Peter G. L. Hammond