SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

DETERMINATION

of

SHERIFF LINDA M RUXTON

FOLLOWING AN INQUIRY INTO THE DEATH OF ROBERT BUCK

Glasgow, 20 March 2006

The sheriff, having considered all the evidence adduced and the submissions made thereon at the Inquiry under the Fatal Accidents and Sudden Deaths (Scotland) Act 1976 **DETERMINES:-**

IN TERMS OF SECTION 6(1)(a) *(where and when the death and any accident resulting in the death occurred)* Robert Buck, born 3 May 1979, died in the early part of the afternoon of 5 March 2006 in cell 3/36, "E" Hall, Her Majesty's Prison, Barlinnie, 81 Lee Avenue, Glasgow while a prisoner there.

IN TERMS OF SECTION Section 6(1)(b) *(the cause of death and any accident resulting in the death)* The cause of death was hanging.

In terms of section 1(1)(a) of the above Act, an inquiry was held into the circumstances of the death of Robert Buck, born 3 May 1978. Mr Buck was in custody serving a prison sentence at the time of his death thus requiring an inquiry to be heard. Evidence was led on 18, 19, 20 and 22 February 2008. Miss Maria Kicinski, Procurator Fiscal Depute,

presented the Inquiry in the public interest; the Scottish Prison Service ("SPS") were represented by Miss Gillian Martin-Brown, solicitor; and Mr R Bruce, solicitor, appeared on behalf of Miss Sarah Matthews, Mr Buck's former girlfriend.

The followings facts were relevant to the circumstances of the death:-

Background

[1] On 2 February 2006, Robert Buck appeared at Arbroath Sheriff Court and was sentenced to a period of 2 years imprisonment in respect of a charge of assault. A further period of 376 days imprisonment was imposed consecutively, being the unexpired portion of a previous sentence on which he had been released on licence. Thus the total sentence was one of 3 years and 11 days. His estimated date of release was 9 August 2007.

[2] Mr Buck had been imprisoned in H M Prison, Perth since 14 January 2006, having been transferred there from H M Prison, Dorset where he had been serving a sentence. He was transferred to H M Prison, Barlinnie, Glasgow on 8 February 2006. He had never before been incarcerated in Barlinnie.

[3] Mr Buck had a lengthy criminal history and had previously served a number of custodial sentences. According to his mother, Mrs Sandra Buck, he had been in and out of jail since he was sixteen, mostly in Perth Prison. He was therefore accustomed to prison life and routine. He had served previous sentences without incident and had never before raised concerns that he might be at risk of suicide or self harm.

[4] Mr Buck had a history of mental illness. At the time of his transfer to Barlinnie, he was suffering from clinical depression for which he had been receiving psychiatric treatment in Perth Prison. He was prescribed two forms of anti-depressant medication. He had a significant psychiatric history: his father committed suicide by hanging when Robert Buck was a young child. Mr Buck himself had a history of self harm, having

previously been admitted to hospital following a deliberate overdose. He had a significant and long-standing alcohol problem and had, in the past abused drugs.

[5] In January 2006 when on remand in Perth Prison, Mr Buck had been referred to the mental health team there and was receiving on-going support for depression before he was transferred to Barlinnie. His prison records from Perth disclose longstanding mental health problems.

Admission and risk assessment

[6] As part of the general admissions procedure, Mr Buck was assessed in terms of risk of self harm and suicide in accordance with SPS practice and the "Act 2 Care" suicide risk management procedure in force (known as "ACT"). Reception risk assessment was carried out when Mr Buck arrived at Barlinnie from Perth prison on 8 February 2006. This assessment involved three separate interviews.

[7] The first interview was carried out by the prison officer Montgomery at the admission section. It was noted that Mr Buck was not currently subject to the ACT procedures, nor had he ever been assessed as a suicide risk during any previous period in custody. No information had been received from any other source to suggest that there were any concerns with regard to his at risk status. Office Montgomery carried out an assessment of Mr Buck's behaviour, attitude and risk by asking a number of pre-set questions the answers to which were recorded. Of note were three of Mr Buck's answers: he denied feeling suicidal, he denied that he might harm himself but he said that he felt the need to be protected. Nothing of concern was noted about his demeanour or behaviour at that time. In particular, Mr Buck did not appear anxious or low in mood. He was assessed as being at "no apparent risk of self harm or suicide". No mental health problems were suspected at that time.

[8] Mr Buck was then interviewed by two nurse practitioners attached to the admissions sections, one of whom was Margaret Mason. She, too, carried out an ACT assessment. Again, a series of standard questions was asked. It was noted that Mr Buck had received

treatment for mental health problems; that he had previously attempted self harm or suicide but that he had no current thoughts of that type. Nurse Mason noted that Mr Buck had a significant history (father committed suicide by hanging himself, previous attempted suicide, alcohol and drug abuse, mental illness and depression) that reflected four of the predisposing risk factors acknowledged in the ACT guidance and that, as a transferred prisoner, he was in a situation likewise identified in the guidance as a precipitating factor in terms of risk assessment. It was also noted that he was suffering from paranoia and depression. In this connection, he had last seen a psychiatrist two weeks before in Perth. It was again documented that he was on anti-depressant medication. During the assessment, however, he was able to sustain a conversation, maintain good eye contact and he denied any intention to do any harm to himself, all features that suggested he was not at risk of suicide. Again, he was formally assessed as at no apparent risk of self harm or suicide.

[9] The third stage of Mr Buck's admission assessment was carried out by one of the prison medical officers, Dr Sethu Raman. He, too, saw Mr Buck and likewise noted his previous and psychiatric history, diagnosis of depression, history of alcohol problems and prescribed medication. He also assessed him in terms of suicide risk. Dr Raman agreed with the previous assessments that Mr Buck constituted no apparent risk of suicide at that time.

[10] Because of his mental health problems as noted on admission, Nurse Mason referred Mr Buck to the multi-disciplinary mental health team for further support. No other action was taken in respect of Mr Buck's mental health. Although he was considered to be in need of further support for his mental health problems, no information about that was passed to the relevant residential staff responsible for his day to day care. His condition was not made the subject of a health care marker, a means by which nursing staff communicate to medical information about prisoners in need of extra support to residential officers.

[11] It was not clear whether the medical case notes from Perth Prison had been transferred with Mr Buck and were available to those carrying out the assessments. Usually the medical records accompany the prisoner on transfer but sometimes they have to be requested and are forwarded later.

[12] At his own request, because of feelings of paranoia, Mr Buck was placed on protection and allocated cell 3/36 in "E" Hall. This is the protection wing where prisoners are accommodated separately from the rest of the mainstream prison in what is considered to be a safer environment. Mr Buck shared a cell with one James Murray, also a prisoner on transfer from Perth Prison whom Mr Buck knew from outside and inside prison.

[13] While in prison, it was usual for Mr Buck to keep in contact with his mother and his erstwhile girlfriend, Sarah Matthews. When he was in Perth Prison, he was visited regularly by his family every two or three weeks. He was in telephone contact with his mother two or three times a week and also wrote to and phoned Miss Matthews.

[14] Mr Buck was finding transfer back to a Scottish prison difficult after having been in H M Prison Dorset. He was unhappy and unsettled in Perth Prison albeit he knew the institution well. Mrs Buck saw her son on the Sunday before his transfer to Barlinnie. That was the last time she saw him alive. He was in a very low mood and was weepy. He was crying and depressed and wishing that he were back in Dorset. He had expressed similar sentiments to Miss Matthews. He told her that he was not coping in Perth.

Period between admission and death

[15] Following his transfer to Barlinnie, Mr Buck did not contact his family for some time although Miss Matthews received a letter on 20 February. In that letter it was clear that Mr Buck was still coming to terms with his lengthy sentence. He wrote that his head was "a bit messed up" and that he did not feel up to writing. However, he appeared to have been looking ahead: he mentioned having put his name up for education and that he intended to go to the gym in the next few months to keep himself occupied.

[16] Mrs Buck heard nothing from her son until she received a letter after about five weeks after his transfer. The absence of telephone calls was unusual. In his letter, Mr Buck said that he was all right and urged his mother not to worry about him. He said that he hated Barlinnie but he appeared happy to be sharing a cell with a friend whom he knew from Montrose.

[17] Neither Mrs Buck nor Miss Matthews had any concern that Mr Buck would have taken his own life. He gave no indication of that. A police statement taken shortly afterwards from his former cell mate, James Murray, indicated that at no time in the three weeks when they had shared a cell did Mr Buck give any indication that he intended to commit suicide. Mr Murray was aware that Mr Buck was taking anti-depressants but said that otherwise he was fine.

[18] During this time, Mr Buck was seen by the mental health team as a follow-up to the referral from his admission assessment. On 13 February 2006 he was seen by one of the mental health nurse practitioners, Donna Skelton. She carried out a detailed assessment of Mr Buck's mental health during which she had access to his medical records from Perth prison. He had been seen by a psychiatrist in Perth prison two weeks prior to his transfer. At that time it was noted that he should be reviewed.

[19] At interview on 13 February, it was noted that Mr Buck was trying to adjust to Barlinnie. He did not attend recreation or exercise because of feelings of paranoia and therefore spent most of his time in his cell, watching television. He reported having difficulty sleeping, poor appetite, feelings of paranoia, low mood and feeling depressed but not suicidal. He presented as facially flat and low in mood but was able to converse and maintain fair eye contact and was appropriate and co-operative throughout the interview. He was referred to the high dependency unit (a smaller, quieter unit better suited to accommodate more vulnerable prisoners) but apparently he later chose not to pursue this option. He was to be reviewed in two weeks time.

[20] Mr Buck's case was discussed at the following multi-disciplinary meeting of the mental health team on 17 February. As its name suggests, this is a meeting attended by representatives of various disciplines and agencies including health care staff (nurses, medical officers, psychiatrists, psychologists) social workers, the prison chaplain, addiction and other services. Deputy governors and, on occasion, hall managers are also present. Residential staff do not routinely attend these meetings. It is the hall manager's decision to pass on any relevant information to residential officers strictly on a "need to know" basis.

[21] It is not known what was discussed about Mr Buck at that meeting. The notes of that meeting were not produced in evidence and were not included in his medical records. However, from the brief entry in these records it would appear that he was considered in need of further support. His case was to be reviewed in two weeks time.

[22] As a follow-up to Nurse Skelton's session, Mr Buck was seen again on 28 February by Nurse Morrison, another of the nurses attached to the mental health team. On that occasion he appeared settled in mood though "a bit flat". He denied all thoughts of self-harm. He complained that he was bored. He was still not attending recreation or exercise but had enquired about work. Hs appetite remained poor. It was decided to refer him for relaxation classes and review in three weeks.

Events leading up to death

[23] Mrs Buck received a phone call from her son on Saturday 2 March which was the day before he died. He sounded down but told her he was all right and that she was not to worry about him. A transcript of the call confirmed that Mr Buck's mood was low: he said that he was "feeling really down just now" and was not in the mood to write. He complained about being locked up 23 hours a day. He hoped to be starting some afternoon work and discussed when his mother could arrange a visit.

[24] None of the residential staff who gave evidence remembered Mr Buck at all. They could not describe his daily routine, his mood or his behaviour or give any indication of

how he had been coping with his transfer. The most they could say about Mr Buck was that he had not caused any problems or come to their attention for any reason. Accordingly, his exact movements on the day of his death are unknown.

[25] What can be inferred is that he must have been alive in his cell when the first security numbers check of prisoners was carried out just before breakfast at about 0845 hours. Thereafter, it is not known whether Mr Buck left his cell to collect his breakfast or whether he chose simply to stay in his cell. There was evidence to suggest that Mr Buck's section was not scheduled for exercise that morning so it would appear that he spent the remainder of the morning locked in his cell. The next numbers check took place around 1245 hours, after prisoners' lunch and before hall staff were due to take their lunch break. Again, it is not known whether Robert Buck left his cell to collect his lunch (although autopsy findings confirmed that he had eaten shortly before death). It can safely be assumed, however, that all was in order when Mr Buck was checked shortly before one o'clock that afternoon.

Circumstances of death

[26] At approximately 1530 hours, cells were opened up to let those prisoners scheduled to receive medication go to the ground floor to see the nurse. Mr Buck listed as was due to receive his medication. Prison officer Neil Fraser went to cell 3/36 and on entering the cell discovered Mr Buck suspended from a ligature attached to the upper rail of the bunk bed approximately five-and-a-half feet above the floor. He was leaning forward in a crouched position with his head in a loosely fitting noose. The ligature was fashioned out of torn up bed linen. His feet were touching the floor with his knees bent. He was already dead.

[27] At the time of his death, Mr Buck was alone in his cell, James Murray with whom he had been sharing his cell having been transferred back to Perth Prison that morning.

[28] Officer Fraser immediately raised a "Code Blue" – an alarm that signifies an emergency associated with asphyxia (in other words, a hanging) and other staff promptly

arrived to assist. Emergency services were called. Within a matter of seconds, officers Steven Martin and Michael Mulholland arrived in the cell. Together they supported Mr Buck's weight, removed the ligature and laid him on the cell floor. Thomas Cringles, the duty line manager also attended as did practitioner nurse Mandy Woods who had been at the nursing station on the ground floor dispensing medication when she heard the alarm. She immediately commenced resuscitation, administering CPR with the assistance of officers Martin and Mulholland. CPR was continued for some thirty minutes until the arrival of ambulance paramedics who then took over. One of the prison medical officers, Dr Jai Kural, attended and having examined Mr Buck pronounced life extinct at 1712 hours.

Cause of death and time of death

[29] An autopsy examination carried out by Dr John Clark, Forensic Pathologist, confirmed that the cause of death was hanging. According to Dr Clark, the injuries caused by the ligature were typical of those found in prison hangings which were mostly the result of partial suspension. Pressure on the neck would have rendered Mr Buck unconscious within ten to fifteen seconds. Irreversible brain damage as a result of anoxia would have occurred within three to four minutes. Death would have supervined within about five minutes. Accordingly, to have survived, Mr Buck would need to have been discovered within that initial three or four minute period, the ligature slackened, oxygen given and his heart re-started if it had already stopped.

[30] From the condition of his body when found and from the presence of partly digested food in his stomach, it would appear that Mr Buck died a short time – an hour or so – after having eaten and probably about an hour or two before his body was discovered. An exact time of death cannot be determined but it appears that Mr Buck died in the early part of the afternoon, probably sometime between 1330 and 1430 hours.

NOTE

[31] In the course of the Inquiry, attention focused on four areas of the evidence: the provision of first aid; the system for checking prisoners in their cells; the suicide risk assessment; and communication between nursing staff and residential staff with particular reference to health care markers. The first two areas were of little significance to the circumstances of Mr Buck's death. The latter two merit more detailed consideration.

First aid

[30] As to the provision of first aid, none of the prison officers who were first on the scene was at the time qualified to deliver first aid. Officer Fraser had not been trained in first aid. Officer Martin had previously passed first aid training but his certificate had lapsed. In the event, both officers Martin and Mulholland chose to render immediate assistance by means of CPR. There was qualified assistance on hand within seconds of the alarm being raised as practitioner nurse Woods was on hand dispensing medication in "E" hall. She was thus able to commence CPR and supervise and instruct officers. Additional nursing and medical help together with resuscitative equipment arrived within a very short space of time and the emergency services were contacted and attended in accordance with SPS procedure. There can be no criticism in connection with the availability and provision of first aid. In the event, sadly, the matter is academic as Mr Buck was already dead when officer Fraser entered his cell and had been so for some time.

System for checking prisoners

[31] It would appear from the evidence that Mr Buck spent most of the day of his death locked in his cell. Accordingly, he would have been in his cell, unobserved and undisturbed, between the lunch time numbers check just before 1300 hours and 1530 hours when his body was discovered.

[32] There was evidence that, as a direct result of Mr Buck's death, an additional numbers check had been introduced after the lunch break for those prisoners in the section not due to go to recreation. It is difficult to see why this was felt necessary. Nor

was it clear what this additional physical check on prisoners was designed to achieve. All that was said in that connection was that it might allow someone who had harmed himself to be found sooner. Almost certainly, it would not prevent someone determined to hang himself in his cell from doing so. Given that death follows very rapidly in such circumstances, a fatal outcome might only be prevented were the numbers check to be carried out at a random time which happened to coincide with the moment of suspension. Accordingly, it cannot be said that an additional check would have prevented Mr Buck's death or that its absence contributed to it in any way.

[33] Although the frequency of numbers checks had little relevance to the circumstances of Mr Buck's death, it perhaps is worth noting that he was alone in his cell at the time of his death, his cell mate having been transferred to Perth earlier that day. Obviously it would have been difficult, if not impossible, for Mr Buck to have hung himself in the presence of another prisoner.

Suicide risk management and assessment

[34] The SPS have in place an active risk management strategy known throughout the service as "ACT". This strategy was first introduced in 1999 as "*Act and Care*". The current strategy – "Act 2 Care" – was introduced in 2005 and was in force at the time of Mr Buck's death. ACT is not a suicide *prevention* strategy but is designed to manage the *risk* of suicide. It is accepted that those determined to take their own lives will find a way of doing so, even within the restrictions of a prison environment. It is likewise recognised that, to some extent, all prisoners are vulnerable to risk of suicide or self harm and that many already have predisposing factors such as mental health problems, drug addiction and the abuse of alcohol.

[35] The ACT policy aims to foster a culture of care and support for individual prisoners as part of the management of suicide risk in prison. The ethos is of a supportive regime with the emphasis on multidisciplinary team work, information-sharing and the maintenance of clear and effective communication. Within that setting, staff are encouraged to build good relationships with prisoners, to listen to them and promote an

environment in which prisoners themselves will feel able to approach officers if they are in difficulty and, particularly, if they feel at risk of self harm. Thus communication is regarded as a key part of the strategy. All SPS staff receive core training in ACT procedures which is supplemented by mandatory refresher courses every year. It was clear from the evidence that all of the SPS witnesses were fully aware of the ACT principles and felt comfortable applying them in practice.

[36] Assessing risk of suicide is no science. It depends on many factors, not least of which is the experience and skill of the assessor. It is, too, a fluid concept which can change rapidly. For that reason, all staff are trained to recognize certain "cues" and "clues", the most common if which are noted in the ACT documentation as a means of guidance. Suicide risk awareness clearly forms an integral and on-going feature of the work of all prison staff. However, of fundamental importance of the ACT procedure is the initial assessment process which begins whenever a prisoner is admitted to the prison, be it directly from court or on transfer from another establishment.

[37] An ACT risk assessment forms an important part of the admission process. These procedures are followed strictly and details of the assessment are recorded in pre-printed ACT documentation. The procedure involves three separate interviews during which set questions are asked with reference to the ACT documentation. Each interview concludes with an assessment as to the individual prisoner's current risk of self harm or suicide. Although interviews follow a set pattern and the questions asked are those noted on the pre-printed forms, in reality, of course, this process is supplemented by discussion, interaction and direct observation of the prisoner's presentation, demeanor and responsiveness.

[38] ACT assessment can produce three conclusions as to risk of suicide or self harm: high risk, low risk or no apparent risk. ACT procedures are "raised" in the first two categories and there are immediate and direct consequences of ACT status being imposed. High risk prisoners are placed in specially adapted "safe cells" designed with certain anti-ligature features. Prisoners are dressed in special anti-ligature clothing and

placed under fifteen minute observations. Inevitably, this involves a substantial encroachment on the prisoner's privacy and freedom and, quite properly, such a course requires to be justified. Those assessed at low risk of suicide are allowed to remain in their cells and to wear their own clothes but they are placed on hourly observations and may be subject to other restrictions.

[39] There are no separate means of identifying those individuals who are *potentially* – as opposed to actually or currently – at risk of suicide or self harm. Notwithstanding the belief that all prisoners may be at potential risk of self harm given their incarcerated status, prisoners such a Robert Buck whose history, personal circumstances and current state of mental health predispose them to the risk of self harm must be considered to be particularly vulnerable. While exploring this issue during the Inquiry, it emerged from the evidence that there is a procedure currently in use throughout the prison service which might be of some assistance in the management of such prisoners. That is the procedure for producing health care markers, a means of communicating information between health care staff and residential officers.

Communication and health care markers

[40] In 1998, the SPS introduced a practice whereby health care markers can be raised in respect of a prisoner. This is a means of communication between nursing/medical staff and residential officers responsible for the day to day care of the prisoner. This arrangement was designed to highlight individual prisoners who might have need for additional support as a result of a medical condition. They are most often used in connection with physical illness where it is important for hall staff to be aware of the prisoner's condition in the event of an emergency (for example, where a person is diabetic, epileptic or asthmatic). A short care plan may be attached to the marker giving brief instructions, such as, to ensure that a diabetic prisoner takes regular meals. Health care markers are usually initiated (and cancelled) by nursing staff. They are delivered to the hall manager who is responsible for communicating the information to the appropriate hall staff. A copy of the marker and any associated care plan is kept with the prisoner's file and is confidential in that it can only be accessed by prison staff. Thus health care

markers provide a valuable communication tool to ensure that prisoners who are vulnerable on health grounds receive the extra support or vigilance that their condition requires.

[41] Less commonly, health care markers are raised in respect of mental illness. They are not, however, used in any sense associated with risk management of suicide and are entirely separate from the ACT procedure. Like physical health care markers, it would be appropriate to use a mental health marker to identify prisoners who are considered to be vulnerable and in need of extra support and vigilance because of mental ill health. In practice, they tend to be used to provide residential staff with explanation for behaviour which might otherwise be regarded as bizarre, disruptive or disobedient. As such they assist the officers in managing daily routine and maintaining discipline, while also providing the individual prisoner with the requisite additional support.

[42] It became clear during the evidence that not all staff were aware of the existence of mental health care markers. Those who were appeared in some doubt as to the circumstances in which such markers would be appropriate. They tended to use markers to identify and explain a prisoner's behaviour rather than identifying a particular mental illness and a need for additional support. While physical health care markers were used to provide a means of communication between nursing staff and hall officers to share information about a prisoner's medical condition where that prisoner was considered to be in need of additional support, there was a distinct reluctance to use mental health markers in that sense. Confidentiality was considered to be an obstacle and was an issue about which several of the health care staff appeared less than confident. Moreover, the stigma attached to mental illness was another reason repeatedly given for not using mental health markers in this way. Referral to the mental health team was seen as the most appropriate way of dealing with a prisoner such as Mr Buck. The fact that there was no routine exchange of information between the mental health team and hall officers was not considered to be a problem.

[43] Robert Buck's mental state was specifically assessed on no fewer than eight documented occasions. At no time was he considered to be a current risk of self harm or suicide and it's no time were ACT procedures raised as a result of any concerns by any member of staff. There was no suggestion during the Inquiry that Mr Buck should have been made the subject of ACT procedure at any time while he was in Barlinnie. Such decisions are matters of clinical and professional judgment and all those who dealt with Mr Buck carried out their enquiries diligently and professionally in the spirit of the ACT strategy. His mental health difficulties were noted, his need for further support appreciated and acted upon with a referral to the mental health team and appropriate follow-up. At the time of his death, he was in receipt of on-going mental health treatment and support from a specialist team and was in daily contact with nursing staff trained to watch for tell-tale signs which would indicate any deterioration in his condition. However, no information about his depression or about any input from the mental health team was communicated to the hall officers so that they might know that Mr Buck was someone who had been assessed as vulnerable and in need of extra support. A mental health marker would seem the appropriate means by which to communicate such information.

[44] While the idea of using mental health markers in these situations met with the approval of some of the health care staff who gave evidence, it elicited little support from the hall officers themselves. They were not convinced that having this information would assist. On the contrary, given the high number of prisoners who might fall into that category, there was a fear of information overload. Prison officers preferred to rely on using their daily interactions with the prisoners as the most reliable method of providing support and being able to detect warning signs and changes that might alert them to the fact that a prisoner was in difficulty. Such reliance assumes that the officers are able to interact with all prisoners in their care and establish the necessary rapport.

[45] Some prisons operate a system whereby prisoners are allocated a personal officer. There was evidence that this system is not operated in Barlinnie. There were, however, other sources of support available to prisoners including the prison chaplain and prison

listeners who are prisoners who are trained by The Samaritans to talk to prisoners in distress. But the residential staff and the nursing staff remain of primary significance in recognizing a prisoner in difficulty.

[46] A stark feature of this Inquiry was that not one of the prison staff remembered Robert Buck. That is so even though it might be thought that the circumstances of his death and the surrounding investigations at the time might have triggered some recollection of him as an individual. Nurse Skelton recognised him from a photograph as someone she had seen, but otherwise no-one knew him, remembered him or could give any information to the Inquiry about him except from documented facts in the prison records. It is, of course, accepted that prison staff deal with substantial numbers of prisoners and that there is a rapid turnover and throughput. It is unrealistic to expect that they remember all those who pass through their care. That is the reality of the situation. It is also the real context in which the ACT procedures operate. These procedures rely on communication, the building up of good relationships between staff and prisoners, the promotion of a caring and sympathetic environment where prisoners can approach staff with their problems, and importantly, staff knowing prisoners so that they can identify changes in routine, behaviour or mood so that they can be alert to difficulties and intervene. This is central to the ACT procedures. It is difficult to see how all this was put into practice as far as Mr Buck was concerned.

[47] A mental health care marker might provide a means whereby nursing staff can communicate concerns about a prisoner's mental health to residential staff where it is considered that the prisoner is struggling and would benefit from additional support. Residential staff could then act accordingly and be more alert to the need to watch for signs that might suggest that the prisoner is in particular difficulty. It would alert the officers to watch particularly for the clues and cues referred to in ACT. Such a system might be helpful in the context of an over-crowded prison where it is difficult to develop a relationship with every prisoner and impossible to be alert to all but the most obvious changes in behaviour.

Submissions

[48] Neither the procurator fiscal depute nor Miss Martin-Brown invited me to make any findings other than formal ones in terms of section 6(1)(a) and 6(1)(b). Mr Bruce invited me to make a findings in terms of section 6(1)(c) that highlighting Mr Buck's mental health difficulties by means of mental health marker was something which might have prevented his death. However, having regard to the information before the court, such a finding would be entirely speculative and unsupported by the evidence.

Comment

[49] However, the evidence did highlight some confusion amongst staff as to the use of health care markers in respect of mental illness and identified some misconceptions about issues of confidentiality and stigma. Although it was not referred to in evidence, it is of interest to note that a mental health marker had in the past been raised by health care staff in Perth prison in January 2005. That marker (page 24 Crown Production No 3) was headed "Health Care Marker: History of Psychiatric Illness" and noted care plan in the following terms: "If the prisoner's mental health is causing concern contact Health Centre or complete referral documentation." No doubt that information would have alerted residential staff of the need for extra vigilance on their part.

[50] Given that there was a degree of confusion surrounding the existence and use of health care markers, that some staff appeared unsure about the issue of confidentiality and were reluctant to use such markers because of concerns about the perceived stigma associated with mental illness, the SPS may wish to review the current training needs of staff in this connection. Furthermore, given the circumstances of Robert Buck's death, the SPS may also wish to consider whether such markers should routinely be used where health care staff have identified a prisoner as vulnerable and in need of extra support by reason of mental illness. As a means of communicating these concerns to residential staff, such markers might provide hall staff with valuable information alerting them to potential risks of self harm as well as ensuring that these prisoners receive the additional support they require.