SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2023] FAI 26

GLW-B934-22

DETERMINATION

BY

SHERIFF M D JACKSON KC

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

JASON WATSON

GLASGOW, 26 June 2023

The sheriff, having resumed consideration of the cause, Finds and determines that in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (hereinafter referred to as "the 2016 Act") the following:

(1) In terms of section 26(2)(a) of the 2016 Act that Jason Watson, born 12 October 1986, died at some time between 22.00 hours on 26 February 2021 and 08.42 hours on 27 February 2021 within Cell 1/30, A Hall, HMP Barlinnie. He was pronounced dead at 08.42 hours on 27 February 2021. His death was not accidental. He committed suicide.

(2) In terms of section 26(2)(c) of the 2016 Act, that the cause of death was:

1(a) Hanging

(3) In term of section 26(2)(e) of the 2016 Act, there are no precautions which could reasonably have been taken that might realistically have resulted in the death being avoided.

(4) In terms of section 26(2)(f) of the 2016 Act, there was no defect in any system of working which contributed to the death.

(5) In terms of section 26(2)(b) and (d) of the 2016 Act, there was no accident on which to base any findings.

(6) In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death), that there are no other facts which are relevant to the circumstances of the death.

(7) In terms of section 26(1)(b) of the 2016 Act I have no recommendations which might realistically prevent other deaths in similar circumstances arising from the evidence.

(8) There are no observations I have to make about the system of working within HMP Barlinnie, Glasgow arising from the evidence or relevant to the death of Jason Watson.

NOTE:

Introduction

[1] This is a mandatory Inquiry into the death of Mr Jason Watson in terms of section 4(a) of the 2016 Act.

The proceedings and the parties

[2] Preliminary hearings took place at Glasgow Sheriff Court on a number of occasions before the Inquiry itself which was held on 27 and 28 February and 2 March 2023. Mr Abbas Ali, procurator fiscal depute, represented the Crown, Mr A Rodgers represented the Scottish Prison Officers' Association, Mr D Considine represented the Scottish Ministers for the Scottish Prison Service ("hereinafter referred to as SPS"), Ms Ayla Iridag, counsel, represented Greater Glasgow Health Board ("GGHB"). The family of Mr Watson chose not to be represented at the Inquiry.

The sources of evidence

[3] A joint minute of agreement was entered into by the parties. I heard oral evidence from the following witnesses who all gave evidence in person at Glasgow Sheriff Court;

1. Catherine Traynor
2. Dr Kalpana Sankey
3. Fiona Cruikshank
4. Lorraine Roughan
5. Allison Love
6. Jennifer Syme
7. Robert Rae
8. Gordon Crinean
9. Gary Hughes

10. Thomas Irvine
11. Stevie Sharpe
12. Thomas Allison
13. Amy Allan
14. Hannah Bowen
15. George Todd
16. Paul Bradford
17. Robert Luke
18. Dr Gordon Skilling
19. Nicola Earaker

The majority of these witnesses' evidence was supplemented by affidavit. A large number of productions were submitted in advance of the hearing. At the conclusion of the evidence all parties submitted full and detailed written submissions. Thereafter the SPS and GGHB each submitted a supplementary submission to address certain matters raised in the Crown's written submission. Parties did not wish to make any supplementary oral submissions. I am grateful to parties for their assistance in the preparation and conduct of the Inquiry.

The legal framework/the purpose of this Inquiry

[4] The Inquiry is held under section 1 of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016. The 2016 Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (hereinafter referred to as "the 2017 Rules") govern fatal accident inquiries.

The purpose of the Inquiry in terms of section 1(3) is to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. The purpose of the Inquiry is not to establish civil or criminal liability. The process is inquisitorial in character. The Procurator Fiscal represents the public interest at the Inquiry. This Inquiry was mandatory in terms of section 2(1) and (4) of the 2016 Act as Mr Watson was in legal custody at the time of his death.

[5] As regards the circumstances, the sheriff must make findings regarding:

(a) when and where the death occurred;

(b) when and where any accident resulting in the death occurred;

(c) the cause or causes of the death;

(d) the cause or causes of any accident resulting in the death;

(e) any precautions which –

(i) could reasonably have been taken, and

(ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided;

(f) any defects in any system of working which contributed to the death or any accident resulting in the death; and

(g) any other facts which are relevant to the circumstances of the death.

[6] In terms of section 26(4) the sheriff is entitled to make recommendations regarding:

(a) the taking of reasonable precautions;

(b) the making of improvements to any system of working;

(c) the introduction of a system of working; and

(d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

A summary of the parties' positions

[7] The Crown's primary submission was to invite the Court to make the mandatory formal findings, that is to determine when and where the death of Jason Watson occurred, and the cause of his death in terms of section 26(2)(a) and (c) of the 2016 Act. The Crown submits that this death was not the result of an accident and consequently, the Crown made no submissions in terms of section 26(2)(b) and (d) of the 2016 Act. Specifically in terms of section 26(2)(a) of the 2016 Act that the Court find that Mr Watson's death occurred at 08.42 on 27 February 2021 at HM Prison Barlinnie, Glasgow. This was consequent upon paragraph 4 of the Joint Minute. Alternatively, the Crown invited me to find that the death had occurred between 22.00 on 26 February 2021 when Mr Watson had contacted prison staff seeking Gaviscon and 08.42 on 27 February 2021 when Mr Watson's life was confirmed extinct by the attending medical personnel.

[8] I was invited to find, in terms of section 26(2)(c) of the 2016 Act that in terms of Crown production 1 (the post mortem report) the cause of Mr Watson's death was hanging.

[9] In terms of sections 26(2)(e) and (f) the Crown submitted that it was difficult to identify what precautions might reasonably be taken which might have "realistically"

avoided the death of Mr Watson, or to identify any defects in any system of working which contributed to the death. Ultimately, I was invited to make no findings in either of the latter-mentioned subsections

[10] In relation to section 26(2)(g), it was submitted by the Crown that certain issues are relevant to the circumstances of Mr Watson's death. I note these in the following paragraphs.

Actions of Prison Staff/Breakdown in Communication Following 999 Calls

[11] First Line Manager (FLM) Gary Hughes stated he had taken a radio call from the Electronic Control Room (ECR) within Barlinnie Prison that Mr Watson had been making nuisance phone calls to the emergency services. He then informed his colleagues (Thomas Irvine, Thomas Allison and Stevie Sharpe) and they proceeded to attend at Mr Watson's cell. The prison officers who attended Jason Watson's cell on the evening of 25 February 2021 following reports of him telephoning the emergency services all reported that he appeared fine, normal and they did not have any concerns.

[12] The Crown submits that there is an issue with the reliability of witnesses here. Robert Rae, police call handler confirmed he provided a synopsis to staff in the ECR regarding the nature of Mr Watson's calls and requested a welfare check. Both George Todd and Amy Allan, who were working in the ECR that evening, stated if they had taken a call from a third party such as the police for a welfare check then they would have contacted the relevant nightshift manager and conveyed the contents of the call to the manager. However, Gary Hughes stated that all that he was made aware of

was that Mr Watson was making nuisance calls. Gary Hughes was unable to recall who he spoke to in the ECR while Amy Allan and George Todd do not recall working that evening.

[13] The Crown submits that the observations of the prison officers were in stark contrast to Mr Watson's presentation during the telephone calls to emergency services earlier that evening. In the calls, which were played for the benefit of the Inquiry, Mr Watson appeared to be describing a traumatic flashback of having a gun put to his head and could be heard to be crying and becoming very emotional. The Inquiry heard from the three call handlers who took Mr Watson's telephone calls all of whom had concerns regarding the welfare of the caller and accordingly carried out risk assessments and logged the calls as incidents. Jennifer Syme considered he was erratic and upset and had concerns for his mental health. Similarly, Alison Love noted Mr Watson's speech was fast and frantic and felt he was having some mental health issues while breaking down at the end of the telephone call. Hannah Bowen also reported that Mr Watson sounded erratic and panicked, stating that she logged it as an incident due to concerns relating to the content of his telephone call.

[14] The prison officers attended Mr Watson's cell due to information that he was making nuisance calls to the emergency services. The making of such calls is against protocol, and the incident did not appear to be dealt with as a welfare check, as requested by Robert Rae. There was no exploration with Mr Watson as to why he was calling the emergency services or anything beyond a superficial assessment of his welfare and how he presented. None of the officers, for example, asked him how he was

or if there was anything troubling him which had caused him to contact the emergency services. From the evidence of Gary Hughes, nuisance calls in the prison to emergency services were occasional when the prison began issuing mobile phones, so it did not appear to be something that was happening constantly. Notwithstanding the prison officers stating they were not advised of the content of the calls, the Crown submit that I may wish to comment that even in the simple knowledge that Mr Watson had telephoned emergency services on multiple occasions, the prison officers ought to have probed the calls with Mr Watson and carried out a more comprehensive check on his welfare. I am also invited to make a finding or comment on the apparent breakdown in communication between staff in the ECR and FLM Gary Hughes.

Delay in 999 control room contacting Barlinnie ECR

[15] Mr Watson telephoned the emergency services on three occasions on 25 February 2021. Evidence was led from the police call handlers that he telephoned at 2036 hours, 2039 hours and 2056 hours (Crown Production 11, pages 627, 631 and 634). Following his final telephone call, police handlers were able to identify that he was a prisoner at Barlinnie. Thereafter, police staff attempted to contact Barlinnie on multiple occasions but were unable to get through as the line was repeatedly engaged. They were finally able to make contact at 2219 hours to request a welfare check on Mr Watson – a delay of almost 1 hour and 20 minutes (Crown Production 11, page 634-635).

[16] In evidence Amy Allan (a former SPS employee on duty that night) explained there were four desks in the ECR with two members of staff on the nightshift. If a call

was not attended to in the ECR it would transfer to another number in the ECR and if that was not attended to then the call would transfer to the gate manager's office, which is not occupied on the nightshift. There was no voicemail facility. Amy Allan and George Todd were surprised that the police were attempting to telephone the ECR for almost 1 hour and 20 minutes without success.

[17] It is possible that if both Amy Allan and George Todd were on the telephone attending to other matters on every occasion the police telephoned, this could explain why the line was engaged. However, this would appear to be extremely unlikely given the officers agreed the nightshift is generally quiet, typically receiving only three calls per nightshift.

[18] The SPS was unable to offer any explanation as to why the telephone was not answered. Gordon Crinean (an SPS employee) expressed surprise that the phone was not answered and he appeared to be unaware of any efforts made by SPS to investigate this issue, having only been asked about this issue a few weeks prior to the FAI. He also stated he was not aware that an engineer was called at the time to investigate. It is the Crown submission that it is inappropriate that the SPS can offer no explanation, nor does much, if anything, appear to have been carried out to investigate the issue. The Crown submits that the delay in this case was not critical, however if this issue was to be repeated in the future it could be very problematic.

SPS/NHS Handover Note

[19] Crown Production Number 14 is a handover note utilised by SPS and NHS staff whereby NHS staff complete the handover with any relevant issues that SPS need to be aware of overnight. Utilising the same handover form, SPS staff may then handwrite any relevant information regarding what has occurred out of hours and hand over to health care the following day. The handover notes completed by SPS for 25 February 2021 make no mention of the incident regarding the deceased's calls to the emergency services.

[20] The fact the note is silent can be explained by the issue mentioned above; Gary Hughes states he was told that Mr Watson was making nuisance calls and was not provided with any further information from staff at ECR, whilst the officers working in the ECR were clear that they would have relayed the information provided by the police (the content of Mr Watson's calls) and that a welfare check had been requested by the police. Indeed, when Gary Hughes was asked if he had known the content of Mr Watson's calls he suggested he would have been concerned for his welfare and likely placed him on Talk to Me (being the SPS suicide and self-harm management protocol described more fully below), and would therefore have noted it on the handover note.

[21] Paul Bradford was a NHS nurse working within Barlinnie Prison when Mr Watson was an inmate there. He said he personally did not use the Handover Note referred to above but that if he had been made aware of the nature and content of the telephone calls, the outcome of a consultation between him and Mr Watson which took place on the 26 February 2021 would have been the same. However, he agreed that had

he known about the calls he would have probed Mr Watson about the telephone calls and asked him about any trauma or flashbacks he was experiencing. The Crown submits that if the form had been completed this could have prompted further probing of Mr Watson's denial of suicidal ideation. Further, they submit that it seems logical and sensible that if a prisoner contacts the emergency services reporting flashbacks of a traumatic event and is noted to be upset, emotional and erratic on the call, that this information should at least be communicated to healthcare staff in the prison, either through the handover note or some other method as this information would allow them to probe the incident with the prisoner and deliver care accordingly.

Death in Prison Learning, Audit Review (DIPLAR) Inconsistency

[22] There is a discrepancy in the Death in Prison, Learning, Audit Review (DIPLAR) produced following the death of Mr Watson in which it is stated that he made extensive use of his prison issued mobile telephone and last used it on 20 December 2020 (Crown Production 3, page 16). This is inconsistent with the evidence presented at the Inquiry which suggested that Mr Watson telephoned emergency services on the evening of 25 February 2021. These calls appear to have been made with an illicit SIM, rather than Mr Watson's prison issued SIM. However, the information should have been contained within the DIPLAR as conceded by Robert Luke and Lorraine Roughan in her affidavit (paragraph 7). Robert Luke indicated that Gary Hughes' incident report and Thomas Allison's statement were added to the DIPLAR box of documents after the DIPLAR meeting and this is perhaps the cause of the error. However, Lorraine Roughan

stated in her affidavit that her notes of the DIPLAR meeting include reference to Mr Watson possibly using his phone to contact the police, which indicates that it was discussed at the DIPLAR meeting (paragraph 6).

[23] This latter issue is submitted to be a minor one but the Crown submits that it is important the DIPLAR accurately records information, particularly relating to events which occur close to the death of any prisoner in order to be an effective review of a death.

[24] Submissions on behalf of all of the other parties were to the effect that I should make formal findings in respect of sections 26(2)(a) and (c) only.

Factual circumstances

Events leading to circumstances of the deceased and his death

[25] On 12 March 2020 Jason Watson was sentenced to 3 years and 4 months' imprisonment at the High Court at Glasgow. The sentence followed a plea of guilty to charges of attempting to defeat the ends of justice, a contravention of section 7(6) of the Road Traffic Act 1988, and assault to severe injury, permanent disfigurement and impairment. His earliest date of release was to have been 12 October 2021. Prior to being sentenced, the deceased had been remanded in custody within Barlinnie Prison since 13 February 2020. Mr Watson had a custodial history and on the date of his death he remained a prisoner within Barlinnie Prison and was accordingly in legal custody. At the date of his death he was accommodated in a single cell within A Hall.

Responsibility for Healthcare within Barlinnie Prison

[26] As of 1 November 2011, individual regional NHS health boards are responsible for the delivery of healthcare services within prisons in Scotland which fall within their geographical ambit for the provision of medical care. In relation to Barlinnie prison, the relevant health board is Greater Glasgow and Clyde Health Board (GGHB).

***SPS Suicide Risk Strategy* Talk To Me**

[27] Talk To Me (referred to in this determination as TTM) is the current Scottish Prison Service suicide risk management strategy. TTM is a multi-agency suicide prevention strategy for identifying and caring for those at risk of self-harm or suicide. Anyone who has escorted contact with prisoners is trained in TTM and is responsible for placing someone on the strategy if they identify a risk. If an immediate risk is identified, a member of staff can place somebody directly onto TTM. This would be done by completing an initiation form. An appropriate care plan will then be put in place. If a member of staff has a concern, they can complete a concern form and if there is indeed a risk, they can initiate TTM. This results in an assessment taking place to determine whether the prisoner is in the "at risk" of suicide category. If a prisoner is assessed as "at risk" following the assessment, an appropriate care plan would be put in place. The care plan will be individually tailored to that prisoner to appropriately manage the identified risk. This may include, for example, placing the prisoner in a safer cell, safer clothing or perhaps removing certain items. Everyone on TTM has a maximum contact level where staff must have interaction with the individual at risk within an agreed

timeframe. It became apparent in the course of the Inquiry that prison officers were well acquainted with the terms of the TTM protocols, and felt comfortable instigating them if they felt there was any requirement to do so.

[28] Jason Watson was not on TTM at the time of his death.

Medical History

[29] On arrival at the prison on 13 February 2020, Jason Watson underwent an assessment by healthcare staff as part of the prison admission process. Mr Watson presented as agitated and he disclosed previous mental health issues as well as a previous history of suicidal thoughts. Mr Watson denied current thoughts of self-harm and/or suicide. He was categorised as "No Apparent Risk".

[30] Thereafter, on 30 March 2020 Mr Watson stated that he felt like "throwing himself off the top landing". He also stated "I am suicidal". Mr Watson was placed on TTM. He was placed in a safer cell, on 15 minute observations from 30 March 2020 until 31 March 2020.

[31] A case conference was held on 31 March 2020. Mr Watson distanced himself from the comments made by him on 30 March 2020 and described them as a "fly away comment". He explained that he had made the comments on 30 March 2020 because his medication was not in place. He denied any thoughts of self-harm or suicide. He had positive body language and made good eye contact throughout the case conference. At the conclusion of the case conference, Mr Watson was classed as "At Risk" but downgraded to low risk and remained on TTM at hourly observation intervals.

[32] Four case conferences were held in respect of Mr Watson's referral to TTM. At the fourth and final case conference on 9 April 2020, Mr Watson was classed as "no apparent risk" at the conclusion of the conference. Mr Watson said that he was both sleeping better and feeling better since been moved to a single cell on 7 April 2020.

[33] Mr Watson was reviewed by the prison GP, Dr Daly, on 17 July 2020. Mr Watson had gone "cold turkey" from his prescribed methadone. He was offered a tapered withdrawal from methadone with the assistance of the addictions team as well as symptomatic relief for withdrawal. Mr Watson declined both.

[34] Mr Watson was not drug tested whilst in custody. However, he was known to addiction services in the prison. He last met with the addictions team on 26 February 2021, the day before his death. Mr Watson had requested help to "stop chasing Subby" (illicit Buprenorphine). He asked to re-commence on methadone to stabilise and stop him from accessing illicit drugs within the halls. He had stopped taking his prescribed methadone, without assistance, in July 2020. He had previously been prescribed 70 μg of methadone daily. Addictions nursing staff had no cause for concern upon interview of Mr Watson on 26 February 2021 and offered him reassurance, a drug diary and sleep hygiene information. Mr Watson ended the consultation with the addictions team on 26 February 2021 by leaving the consultation room before the consultation had properly ended.

Job within the Prison

[35] Jason Watson had worked as an industrial cleaner within the prison since June 2020. An enhanced cleaning regime was implemented in the health centre due to the Covid-19 pandemic. Mr Watson was deployed to the cleaning duty from November 2020. He was removed from this job and redeployed on 9 February 2021. It had been reported that Mr Watson had behaved inappropriately towards a health centre doctor, complaining about his medication and treatment. At that time, Mr Watson was described as being demanding, agitated and disruptive.

Relevant events prior to 27 February 2021

[36] At approximately 22.00 hours on 26 February 2021, Jason Watson pressed the emergency buzzer button in his cell. Thomas Irvine, operations officer, answered that cell call. Mr Watson said that he had not meant to press "that", meaning the emergency buzzer. He asked for Gaviscon for heartburn. Mr Irvine told him that he did not have any at that time. Mr Irvine went to Mr Watson's cell and cancelled the emergency buzzer. Thereafter, Mr Irvine had no further contact with Mr Watson throughout his period of duty as operations officer on night shift.

Events of 27 February 2021

[37] On 27 February 2021 prison officers Allan Murray and Lavina Grierson were working on A wing of the prison. At approximately 08.05 hours during morning roll count Mr Murray unlocked the cell belonging to Mr Watson (A1/30). On opening the

cell, Jason Watson was found to be on his knees, facing his bed with a woollen hat over his face. A lace was tied around his neck, attached to a railing of the top bunk. A code blue was immediately called and the ligature was cut from the bed frame. Mr Watson was lowered to the floor. Another prison officer (Julie Morris) responded to the code blue and on checking for a pulse, she found none. At approximately 0818 hours two nurses arrived at the cell in response to the code blue. They found that Mr Watson presented as pulseless, making no respiratory effort with both pupils fixed and dilated. There were no signs of rigor mortis or lividity. The nurses started CPR that was then continued by paramedics who arrived shortly thereafter. No signs of life were identified and Mr Watson was pronounced life extinct by the ambulance technician and advanced paramedic at 0842 hours.

Summary of the witnesses' evidence to the Inquiry:

[38] I note below an outline of the evidence of each of the witnesses to the Inquiry. Where relevant, I will draw attention to their affidavit also.

Catherine Traynor

[39] Ms Traynor was a charge nurse who is currently working with the mental health team at Low Moss prison. At the time of this Inquiry she had been a nurse for 3 years and 3 months. She had worked previously at Barlinnie prison. She recognised the name of Jason Watson because she had been his mental health nurse when he was an inmate within that prison. She had worked with him because she had been referred to her team

as a result of problems with his mental health. She worked with him regularly and would see him on an ad hoc basis. She would see him at least monthly. Ms Traynor gave evidence that Mr Watson had issues with emotional regulation. If he got emotional he could not deal with it very well. A simple thing would cause a lot of stress for Mr Watson. His mood was labile. He had recently come off 70 mg of methadone per day. He was poor at coping with his emotions. He catastrophised and internalised everything. She would sometimes get calls from the hall that Mr Watson was resident in saying that he wanted to see them. Equally, at other times, she would not hear anything. He had a so-called "pass job" in the health centre. Ms Traynor would sometimes see him in passing. Sometimes he seemed fine and sometimes he seemed to be doing quite well.

[40] Ms Traynor was referred to the Vision records. These are the medical records used by the prison. She confirmed that any interaction with a prisoner was recorded in these records. She noted that there had been a number of consultations with Mr Watson prior to his death.[1] Ms Traynor was referred to an entry for 9 December 2020. She advised that she had been employed in Barlinnie prison as an addictions nurse. Mr Watson had self-referred to the mental health team and he did so due to his previous addiction issues. Ms Traynor was also a qualified mental health nurse. Consequently, she was able to provide mental health services to those with addiction issues. Ms Traynor described Mr Watson as an impulsive individual but someone who spoke

[1] Crown production 13, page 649.

about life after prison and who, until shortly before his death, held down a job in the prison. He had good insight into the positive effects of previous medication, and he was not hesitant to request mental health input as and when it was required. He could see if something had happened within the prison to cause him to be of low mood. At the time of her first meeting with him, Ms Traynor established from Mr Watson that he was not feeling suicidal at that time. She confirmed that she would ask the question "do you have thoughts of suicide or self-harm?" The witness was asked about other clues that might enable one to establish whether a prisoner was feeling suicidal. The witness said that such a person would have little future planning. There would be a sense of hopelessness, with little eye contact and closed body language. They would be quite guarded. They would give little information on their thoughts regarding suicide. At this consultation, however, there was evidence of future planning. Mr Watson spoke about being "outside". He enjoyed his job within the prison and he spoke of psychiatric help. The witness considered this all to be positive and indicative of future planning. Ms Traynor confirmed that if she thought a prisoner was suicidal, she would immediately put the prisoner on TTM via an SPS first line manager.

[41] Ms Traynor elaborated on TTM. She described it as a form of risk management. If someone explicitly said that they were feeling suicidal, she would speak to the FLM and she, together with the FLM, and the prisoner would meet. The prisoner would be placed on 15 minute observations within a safe cell and would wear anti-ligature clothing. She confirmed that a prisoner can be referred to TTM at any time, including out of hours. She confirmed that if someone was put on TTM overnight she would be

told the next day. The prisoner would be seen within 24 hours. The initial case conference would establish if the current risk is the same as the day before.

[42] As a result of this consultation, Mr Watson was referred for psychiatric input. This was to consider the possibility of a Depakote prescription. Nurse Traynor said that she should have seen Mr Watson for review on 16 December 2020 but that this review was cancelled because she was required to assist in a clinical setting within the prison. She said that this happened on a very regular basis. At one point during the Covid pandemic, she was called away from her mental health role three or four times a week. She would be called away from reviews to assist with primary care nursing.

[43] At a consultation on 7 January 2021 Mr Watson gave a varying self-report of his own mental health position at that time. Ultimately, however, he advised that he was feeling mildly better since starting the Depakote. She reported that Mr Watson had been vague in answer to questions put to him. She had asked him follow-up questions when he had referred to nightmares etcetera. She said that prison officers had been concerned because Mr Watson had lost his job as a pass man in the health centre due to behaviours that she could not remember. That job had been a great support and a distraction from the thoughts in his head. She remembered that Mr Watson was often on the buzzer within his cell speaking to staff, asking to see the mental health team. Ms Traynor spoke about trauma. The procurator fiscal depute put to the witness that part of the medical record (from 23 February 2021) when, in consultation with Mr Watson, she said that he was remembering a past traumatic event, namely that "A gun was placed in my mouth and my life was threatened". In that regard, the witness suggested that she was

building up trust and rapport. She felt it was encouraging that he was opening up in respect of his past trauma. He spoke also about his night terrors. Between them, they discussed the issue of ruminating as well as grounding techniques and breathing techniques. She made a referral to the psychology unit and she gave him a prescription of promethazine which was to help with his sleep. She confirmed that she would ask a direct question about self-harm and that, over and above that, she would be looking for any cues that might be indicative of self-harm. Although Mr Watson presented on occasion with his head in his hands, Ms Traynor confirmed that this was not unusual for him when he was recalling past events. She filled out the relevant form and sent it to the psychology department. This took place on 23 February 2021.

[44] Ms Traynor stated that at the end of the consultation with Mr Watson on 23 February 2021 she had no concerns relative to either self-harm or suicide. She also confirmed that Mr Watson was well known and well liked in the health centre and that he would have interactions with staff every day.

[45] In cross-examination by counsel for GGHB, Ms Traynor confirmed that as a consequence of the Covid pandemic only urgent mental health referrals were to be treated. The witness confirmed that this impacted upon the issue of reviewing a patient's condition from time to time. She did say, however, that she was still able to fix and sometimes hold reviews during this period.

[46] Ms Traynor confirmed, again in cross by counsel, that she had qualified as a nurse in November 2019. She had trained as a registered mental health nurse. She remembered Jason Watson very well. It so happened that she had been the first

responder upon him being found in his cell following his death. This was the first such death that she had encountered.

[47] I considered Ms Traynor to be a thoughtful and helpful witness who spoke very clearly from a combination of her own memory and from the notes to which she was referred. She recognised that she had been inexperienced when she first encountered Mr Watson but she built their rapport throughout her time of knowing him. This was, as she put it, her "first death" and so she remembers him well for all sorts of reasons.

Dr Kalpana Christine Sankey

[48] Dr Sankey is a consultant forensic psychiatrist for NHS greater Glasgow health board. She has been in post as a consultant since 2008, having qualified as a doctor in 1999. Her specific remit is to assess and manage mentally disordered offenders. She has been working in Barlinnie prison since 2008.

[49] Dr Sankey remembered working with Jason Watson. She saw him three times. She spoke with him on 11 December 2020 when she had been asked to see him due to his desire to be re started on Depakote. She interviewed him at length and considered that there was a mood disorder which was possibly a depressive disorder. During this interview, Mr Watson suggested that his main problems were low mood and poor sleep. He could not identify any triggers for a low mood. He also complained of poor concentration and fluctuating energy levels. He admitted to frequent passive thoughts of ending his life, such as hanging himself. He denied any suicidal thoughts, intent or plans at the time of this interview. He had a history of suicide attempts. He said that he

had taken overdoses in the past and that the last time he did this was in 2017. On waking up in hospital after that last attempt he said that, at the time, he was "glad" that the suicide attempt had been unsuccessful. Mr Watson also spoke of his plans for the future. He also planned to attend Alcoholics Anonymous whilst in prison and to try and maintain abstinence of both alcohol and illicit drugs after his release. He described a good relationship with his parents who live in Irvine. Due to the pandemic, it had not been possible for his family to visit him. Dr Sankey prescribed a course of Depakote, noting that he was already prescribed Duloxetine (generally prescribed as an anti-depressant) albeit for chronic pain reasons. This consultation was carried out via the Attend Anywhere platform, which was being used by Dr Sankey during the pandemic. This consultation had been arranged via the mental health team. Ordinarily, before the pandemic, all consultations were carried out face to face.

[50] Dr Sankey spoke of how she would ordinarily conduct a consultation. Her initial task was to establish if the patient was suffering from a mental illness. She would ask a list of questions to establish whether there was a mood disorder or psychotic illness such as schizophrenia. She noted that Mr Watson had denied experiencing psychotic symptoms. As part of her psychiatric enquiry she would ask about psychotic symptoms such as paranoia, hypersensitivity, vigilance, hearing voices or unusual thoughts. She asked him if he had suicidal thoughts. This was when he spoke of his previous attempts at suicide. She said it was common to see people who have had previous suicide attempts. Such attempts may relate to conduct at the time the attempt is made. This behaviour may be quite impulsive. This witness spoke of Mr Watson's difficulty with

sleep. She said that this was a common problem within prisons. She said that no prisoners seem to sleep well. It was, as she points out, a very noisy environment. She confirmed that this would not help his mood.

[51] Dr Sankey saw Mr Watson again on 8 January 2021. She recalled that he looked better, with a fresh haircut and having taken Depakote for four weeks. Nothing at that meeting caused her any concern. Mr Watson described unusual thoughts that he was having at the time relating to future plans. His mood seemed better than when she last saw him and she arranged to review him again in 4weeks' time.

[52] Dr Sankey's final meeting with Mr Watson took place on 5 February 2021. At that meeting, Dr Sankey raised with Mr Watson some of the unusual thought patterns that she had noted at the previous meeting. Mr Watson seemed embarrassed by these ideas. Sleep was still a problem and as a result he might feel tired and require to take a day off from his pass man job but he did not particularly highlight sleeplessness as an intolerable problem. There was no report of suicidal thoughts at this interview and he felt that he was continuing to benefit from Depakote and wanted to remain on it. He felt that his mental health had improved as a result of this drug. He described himself as "fine" and "quite happy just now". It was agreed that regular reviews were no longer required as a result of his mental health improvement. Dr Sankey encouraged him to speak to nursing staff or prison officers if he was concerned about his mental health or anything else. She noted that his mental health was stable, unchanged from her last review of him. As a result of this stabilisation in Mr Watson's mood, Dr Sankey considered that he may be suffering from affective or mood disorder. She said that if he

had reported any suicidal thoughts she would have triggered the TTM protocol and would have passed her concerns onto the mental health team as well as requiring more regular input. Indeed, she would consider whether he required to be transferred to hospital for more therapeutic treatment. Ultimately, she described his mood at this final interview as "normal".

[53] In cross-examination, Dr Sankey confirmed that she would indeed ask blunt questions regarding suicidal ideation. She also said that not everyone who harms themselves will say that they are going to do so. She said it was very difficult to forecast or predict what an impulsive person might do and in what circumstances they may harm themselves. She said that doing something in the moment, then regretting it, is textbook impulsivity. She said that she could not forecast his successful suicide. She said that they do as much as they can to help in prison. They carry out thorough and complex risk assessments but sometimes, short of being able to read someone's mind, there is very little they can do to prevent a suicide. She also confirmed that Depakote has no side effects relative to this situation.

Jennifer Syme

[54] Jennifer Syme was a service adviser for Police Scotland. She takes calls from the public. They will be 999 calls and 101 calls which she will refer to the emergency services control room if necessary. She was asked about a telephone call made on 25 February 2021 at 8pm. She did not remember receiving an unusual call on that date. A recording of a call was played to her and a transcript of that call was presented to her

in court. On hearing a tape of the call she said that she thought the caller sounded erratic and perhaps had mental health problems. As a result of the call, she created an "incident". She said that she had concerns for his mental health and she also had concerns for other people standing the terms of what he had said in the call. I record here the terms of that transcript;

> "CH Police: What's the address of the emergency?
>
> J: His [sic] there no I'm just, I'm wondering is there any missing people, girls or eh women?
>
> CH: What, what do you mean?
>
> J: Listen I'm having flashbacks, I've been injected with this a truth stuff and then, line silent I keep getting flashbacks of horrible, horrible things. Can you please check the Galloway Forest for em bodies please.
>
> CH: You keep getting flashbacks of horrible things?
>
> J: Yeah, yeah em having a gun to the back of my head. Doing unspeakable things to somebody. Erm please just check it.
>
> CH: Right OK, what's your name…hello...hello…hello?
> (Call from Jason Watson ends)."

[55] The call handler treated this call as an abandoned 999 call. She said it was normal for them to get calls like that. She described the tone of the caller as shaky and upset. She obtained location details from the BT operator which enabled her to see roughly where the person was calling from. She carried out a THRV risk assessment. This is based on the threat, harm, risk and vulnerability of the caller. The witness also said that the emergency service control room carries out a risk assessment. The number

from which the call is made is entered into a vulnerable persons database and they will check for any other calls made from that number.

Alison Love

[56] Alison Love was also a call handler for police Scotland. She remembered a call received by her at 8.55 pm on 25 February 2021. The call was from a male. His speech was very frantic and fast. He confirmed his name and address and advised that he was phoning from the prison. The terms of the call are as follows;

> "CH Police: What's the address of the emergency?
>
> J: Listen is no an address it was me that just phoned two minutes ago. Erm listen if there is any bodies in the Galloway Forest in Ayr, Mr [redaction] fae erm Irvine, Ayrshire. Mr [redaction] his travelling name is, he said he's going to fuck off to Thailand with loads of money and leave everybody in the shit. He had a gun to my head, I don't know what's happened. I'm just getting flashbacks, please check for a missing girl, boy, child or whatever. Please, the Galloway Forest in Ayr or Maybole out that way."

Robert Rae

[57] Robert Rae is a controller at Police Scotland. He said that he gets incidents in from call takers which are transferred to them. They will then dispatch officers if appropriate. They keep an eye on the job and close down calls if necessary. Mr Rae started his shift at 10 pm on 25 February 2021. He had received a handover from colleagues who had worked on the earlier shift. He thought that his colleague Tracey referred to this call. (I take this to be the calls made by Jason Watson from Barlinnie prison of that evening). She said she had "tried a few times". Mr Rae understood that

colleagues had tried to get through to Barlinnie prison but had not been able to do so. Mr Rae thought that his colleague had tried phoning Barlinnie, phoning back to the mobile number that had made the earlier calls and had also tried to email Barlinnie prison. She did not get through to anyone. He was referred to Crown production 11 which was a STORM report. This is their contact and control system. The storm report listed 18 incidents of attempted telephone calls or email communications made by Police Scotland to Barlinnie prison on the evening of 25 February 2021. These ranged in time from 20.56 hours until 22.20 hours.

[58] Mr Rae said that his colleague Tracey had attempted on numerous occasions to telephone Barlinnie prison that night. He himself tried for the first time at 22.20 hours and was successful at his first attempt. He did not remember the conversation. He just said that they had had a call from a prisoner and he asked to make sure that he was well. At the Inquiry Mr Rae was asked the question "So, for Barlinnie to carry out a welfare check?" To which he answered "Yes".

[59] Mr Rae agreed with the proposition that it was unusual to have to wait that long to get through to an institution. He confirmed that if he had received intimation of a medical emergency from Barlinnie and could not get through to the prison, he would himself call for an ambulance rather than leaving it for too long. He did not know if there was any indication of his system being at fault. He thought that it was a case of Barlinnie prison not answering their phone. He was unaware of any fault *per se.*

[60] In cross-examination Mr Rae was asked what information he gave to the emergency control room at Barlinnie prison when he got through to them. He said he

would have asked if Jason was a prisoner and then given a brief synopsis. It would not be word for word. He would have asked them to give a welfare check. He would have given Barlinnie a synopsis of what was in the incident report, namely that there was a concern for a prisoner's mental health.

Gordon Crinean

[61] Gordon Crinean is a First Line Manager ("FLM") with the Scottish Prison Service. He has worked with them for 27 years, of which he has served 10 years as FLM. Mr Crinean adopted the terms of his affidavit. He was also asked about the apparent failure to answer the calls made by the emergency service control room to Barlinnie prison following the phone calls made by Jason Watson on the evening of 25 February 2021. Mr Crinean confirmed that there are always two members of staff on duty after 6.30 pm. He said there required to be that quota to comply with health and safety regulations. He said there were definitely two members of staff on, on the evening in question. He described this room as the priority area in the prison. He would take staff from elsewhere to ensure that there was the minimum required personnel within the electronic control room ("ECR") should that require to happen. He could not understand what had happened on the evening in question. Having said that, he personally had not carried out any enquiries to identify why these calls were not answered for this one and a half hour period. Mr Crinean had first heard about this two weeks before the Inquiry sat. He did, however, understand that the Barlinnie security people had been speaking to the police about this apparent failure to answer calls.

[62] Mr Crinean confirmed that staff within the ECR would be able to read emails sent to them. However, emails sent to the generic Barlinnie email address would stop being answered after 5 pm and they do not go through automatically to the ECR. Mr Crinean agreed that it is unacceptable that there be a 1½ hour delay in answering a call from the 999 control room staff. He stressed, however, that he found it difficult to believe that that had happened.

Gary Hughes

[63] GaryHughes was a night shift manager employed at Barlinnie by the SPS. He has been with the SPS since 1986. Mr Hughes remembered receiving information via a message on his radio, saying that Jason Watson had been making nuisance phone calls. He went to see what was causing this problem. He denied being asked to carry out a welfare check. Instead, he said that when the police contact them to advise of nuisance calls, he would go and see the prisoner involved to see what was happening.

[64] Mr Hughes was trained and up to date with knowledge of TTM. He described that protocol as the SPS provision for taking care of prisoners feeling vulnerable or suicidal. He had previously placed prisoners on TTM and described it as "no work for me". He said that, in any event, the care aspect is the most important thing. He confirmed that when he attended at Jason Watson's cell that evening he was left with no particular concerns from a TTM perspective.

[65] The SPS Production 10/1 – nightshift report- was read out by the witness. This was the handover report for A Hall. The relevant portion of that report reads as follows:

> "to enter a cell 1/30 151298 Watson. Police had phoned the prison to say that 151298 Watson had been making 999 calls. The phone was removed from the cell. Mr Watson would appear to have some mental health issues."

Mr Hughes said that he completed this report because, ordinarily, the misuse of a phone in a cell would result in disciplinary action. He felt that in this case however, there was possibly a learning difficulty. He said that he wrote "mental health issue because he could see that something was no' right". Mr Hughes said that normally senior management would read the handover note and he said that he would also give a verbal handover. He said that a lot goes on that is not written down.

[66] It was apparent from Crown production 14 (NHS handover sheet) that Mr Hughes had written "quiet night, no issues". He was asked why he mentioned the visit to Mr Watson's cell on the SPS sheet but not the NHS sheet. He responded that he did so because he did not have any concerns about Mr Watson that night. He also confirmed that if he had had any concerns about suicide he would have mentioned them.

[67] Under cross-examination by the Crown, Mr Hughes was asked about the content of the calls from the police and Mr Hughes' knowledge of that. He said that they were referred to as nuisance calls. He could not remember who had passed the message on to him. He said that his intentions in speaking to Mr Watson were to find out if it was true that he had made these calls and why. He asked Mr Watson if he had called the police and Mr Watson denied it initially. Mr Hughes did not remember asking Mr Watson if he was okay. He said that he would ask if he was okay had he been worried or if there was any reason to ask but on that occasion Mr Watson did not present as not being okay.

There was some conflict within Mr Hughes evidence on the issue of whether he had considered Mr Watson to be presenting with mental health issues. He preferred, again, to suggest that "something was no' quite right".

[68] On being confronted, by the procurator fiscal depute, with the proposition that Jason Watson had been crying and upset when making these phone calls, Mr Hughes said that that information was not passed to him. He was simply told that Mr Watson was making nuisance calls. Mr Hughes' colleague noticed, from looking at Mr Watson's phone, that calls had indeed been made to the emergency services. Mr Hughes asked why he had done this and Mr Watson replied by saying "ma heid's up my arse". Mr Watson's demeanour was described as compliant and quite positive. Mr Hughes said that he was confiscating the phone because he should not be making such calls. Mr Hughes confirmed that, in the ordinary course of events, the phone would have been returned to Mr Watson in the morning by the hall manager.

[69] Mr Hughes said that he had felt, quite early in the conversation with Mr Watson, something wasn't quite right, he felt it might be learning difficulties or drug-related. It was hard to describe and it was something that you learn on the job. He did not, however, think that he had been taking drugs. He did not ask if he was going to self-harm. He would not ordinarily ask this question if somebody did not appear as though they were going to do so.

[70] Mr Hughes was confronted with the description that the call handlers had used of how Mr Watson had sounded 90 minutes earlier. They had described him as shaky, erratic, teary and upset on those calls. In contrast, Mr Hughes said that Mr Watson

presented as absolutely fine. There was no indication at all of this earlier presentation. He said that had that information been given to him it would have been a different conversation.

[71] Mr Hughes was asked, again, why he had written "mental health" in the handover note. He said that he had written mental health down because senior management would be asking why Mr Watson had not been placed on report. On the evening itself, Mr Hughes felt that this was not in fact bad behaviour, more something that had occurred due to a learning disability. He wrote "mental health" because he did not know what language properly to use to reflect his interpretation of the events of that evening. Under cross-examination by counsel for GGHB Mr Hughes was asked again about his use of the phrase "no' quite right." He said that he had not wanted to cause offence. He said that he was not clever enough to explain it in any other way. So far as he was concerned Mr Watson's actions did not constitute a disciplinary matter. Mr Hughes said that there are lots of slang words that he could have used but he did not want to write those down.

[72] Mr Hughes said that if he had been made aware of the content of the 999 calls he would have queried the content and asked why. He would also have asked if he needed help. Mr Hughes also said that it frequently happens that prisoners make nuisance calls to the police, to the ambulance service and indeed to takeaway restaurants.

[73] Mr Hughes said that he had entered the cell in the company of Stevie Sharp, Thomas Irvine, Tom Allison and Barry MacDougall.

[74] Mr Hughes also confirmed that he has dealt with nuisance calls on the one hand and requests for welfare checks on the other. He said that the police will call the prison to say that they have had a call from a prisoner and will ask the prison staff to carry out a welfare check.

Thomas Irvine

[75] Thomas Irvine had been a SPS operations officer for 26 years. He gave evidence by way of affidavit and parole evidence. He said that he had been present with Mr Hughes and others when they had attended at Mr Watson's cell on the evening of 25 February 2021. Mr Irvine said that Jason Watson was asked if he had been making calls. That question was asked in a neutral tone. Mr Watson did not appear angry at all. He looked the same as most would look at that time of night. He did not remember anybody asking him about the content of the calls. Mr Irvine was asked about his comment within his affidavit regarding Mr Watson saying that his meds were all over the place. Mr Irvine reported that it was commonplace to complain either of the wrong meds or not getting meds. Nothing could be done about that at night. Mr Irvine regarded this as a throw-away line. He said that Mr Watson threw himself onto the bed and said his meds were all fucked up. Mr Irvine considered this quite normal in a jail setting. Mr Irvine said that Mr Watson did appear to be disgruntled which he understood to be as a result of his phone being taken and because of his difficulties with his medication.

[76] Mr Irvine also gave evidence about a contact that occurred between him and Mr Watson on the evening of 26 February 2021. He said that at around 9.10 pm he had responded to Jason Watson pressing an emergency buzzer. Mr Irvine advised that the buzzer was supposed to be used for emergencies only. It seemed that Mr Watson had pressed the emergency buzzer inadvertently. Mr Watson asked whether Mr Irvine had any Gaviscon. Mr Irvine replied that there was no Gaviscon kept in A hall. Mr Watson had replied "Aye, okay then". His speech appeared to be normal and there was nothing to suggest that there was anything wrong with him. It was just a very "nothing" conversation. Mr Irvine did not look into the cell although he did require to attend at the cell to cancel the call.

Stephen Kenneth Sharp

[77] Stephen Sharp has worked in Barlinnie prison for 17 years. Mr Sharp advised that, at the time of this incident, mobile telephones had only recently been issued to prisoners as a result of the difficulties caused by the Covid pandemic. Mr Sharp said that he became aware that a prisoner had been making calls. In fact, he had been unaware that prisoners were able to telephone the police at the time of this incident. He said that he went to the cell (presumably with others) and opened the door. He was sure that Jason Watson had been on the top bunk. He was on his own. Mr Sharp asked if he had been using his phone to call the police and Mr Watson said no. Mr Sharp then asked to see his phone. None of this was argumentative. Mr Sharp opened the call log

and could see that on at least two occasions he had indeed called the police. Mr Sharp reported this to Mr Watson and Mr Hughes confiscated the phone.

[78] Mr Sharp accepted that there may have been other conversation taking place around this time, but he could not remember it as he had been focused on examining the phone. Mr Sharp gave evidence about the TTM programme. He said that it was a suicide and self-harm management protocol. He himself had previously put prisoners on TTM. He said this was especially so at night. It could be as a result of being in fear of a cell mate or other fears. Mr Sharp described it as the safest option which brought good results. Mr Sharp confirmed that Mr Watson had been calm and relaxed within the cell. He didn't move from the bed and he did not argue about his phone being taken.

Thomas Allison

[79] Thomas Allison had been a prison officer at Barlinnie for 27 years and he was able to remember his dealings with Jason Watson. Mr Allison spoke to attending at Mr Watson's cell on the evening of 25 February 2021. He had been told that Mr Watson had phoned the police multiple times. That was all that he and his colleagues knew. He did not even know it was the police, he just knew that it was the emergency services. On entering the cell, he found Mr Watson sitting on the top bunk. He said that his head was up his arse and they had fucked up his medication. Mr Allison had no interaction with Mr Watson within the cell either verbally or physically. Mr Watson's presentation did not give him any cause for concern. It was a common complaint to say that his meds

were fucked up. He did not appear upset in any way. Mr Allison was aware of the TTM protocols and had received the appropriate training and refresher training.

[80] Mr Allison understood that Gary Hughes had referred Mr Watson to the mental health nurse. He believed he did this to avoid an unnecessary disciplinary outcome for Jason Watson.

Amy Allan

[81] Amy Allan is 26 years old and now works as an engineer with a telecommunications company. She had previously worked at Barlinnie prison for perhaps 2 years and before that, had worked in Low Moss prison. She had started work with the SPS in 2017 and left in April 2021. At Barlinnie prison she had worked as an operations officer. She had been involved with the daily running of the prison. She was based in the ECR although she was sometimes asked to go elsewhere. She gave a detailed description of the layout of the ECR. It consisted of four desks and four main posts; radio, doors, vehicle lock and books. These positions managed the radio communication throughout the prison, the movement of prisoners, internal movements, controlled entry and exit of vehicles, and numbers of prisoners.

[82] Ms Allan did not specifically recall the evening of 25 February 2021. She did not recall receiving a call from a police call handler that evening. She could not recall whether she had received any calls from the police related to the welfare of a prisoner although she accepted that she potentially might have done. She said that if she had received such a call she might potentially contact a manager or staff in that area and

asked them to do a welfare check on the prisoner in question. Calls into the ECR were not recorded at that time. She believes there is a telephone log but she cannot remember if it was in use at that time.

[83] Ms Allan said that there were four phones in ECR. If one line was occupied the call would bounce to another phone in ECR and if that did not happen it would bounce to the gatehouse. She also said that there would not be anybody in the gatehouse on a night shift and there is no voicemail facility. She could not explain why that was the case. A member of the public trying to telephone Barlinnie in the evening would go through to the telephones in the ECR. She described phone traffic within the ECR in the evenings as relatively quiet. There might be the "odd couple of calls" it was usually a member of the public under the influence who wanted to speak to a prisoner which they cannot do. Ms Allan estimated receiving around three calls per night to ECR. She did say that they were at their busiest between 9 and 10.20 pm. She felt that the space in which they worked was able to do what it had to do and she confirmed that there were always a minimum of two people in that room at any one time.

Hannah Bowen

[84] Hanna Bowen had been a service advisor with Police Scotland for 3 years. She took one of the calls made by Mr Watson on evening of 25 February 2021 although she could not remember that call as they take a lot of similar calls from the public. The call was replayed to her and she described the caller's tone as quite erratic. She did have concerns for the caller due to his mention of having a gun put to his head and other

flashbacks. That is why she created an incident. She confirmed that the call was received at 20.39 pm on 25 February 2021.

George Todd

[85] George Todd has been an Operations Manager at Barlinnie Prison for 13 years. He had been working in the ECR on 25 February 2021. He believed that Amy Allan had been working with him that evening. He did not remember a call coming in from a call handler asking for a welfare check on Jason Watson. Indeed, he did not recall the name, Jason Watson. He confirmed that welfare checks do occasionally happen. He would pass them on to the night shift manager and that officer would take it on from there. He said there were four phones in ECR. He did not know what would happen to a call if all lines were busy. He said that phone calls are always answered.

[86] Mr Todd said that he would pass on the information given to him by the call handler seeking the welfare check. It surprised him to learn that the night shift manager testified that he had not received the contents of the calls made by Mr Watson.

[87] Mr Todd agreed that the night shift was generally quiet and he said it was unusual for both people to be on the phone at the same time.

Paul Bradford

[88] Paul Bradford is a primary care nurse at NHS Lothian. He has worked as a nurse for 30 years and between April 2020 and July 2021 he was working as an addictions charge nurse at Barlinnie. That post involved looking after people with addiction

problems with methadone, Subutex and suchlike. Prior to that he had worked in the state hospital at Carstairs. His expertise there was centred more on mental health than addictions.

[89] Mr Bradford knew Jason Watson. He believed him to have been a prisoner serving a sentence at Barlinnie where he was employed as a pass man in A hall. This was the hall on which Mr Bradford worked.

[90] Together with a student nurse, Mr Bradford consulted with Mr Watson on 26 February 2021. Crown production 13 contained the record of that consultation which was read out in the course of the Inquiry. This had been Mr Bradford's first interview with Mr Watson. He advised that they had received a call from a prison officer saying that Jason wanted to see someone. Mr Bradford was going into the hall to see others and when he was there he was asked to see Jason. He was not told why he wanted to see a nurse. He was just told that he was asking to see a mental health or addictions nurse.

[91] Mr Bradford described that consultation. He said that Jason came into the room and conversed well. He was well kempt. Mr Bradford asked what the problem was and Jason said that he was on Subutex which he was "chasing" in the hall. Subutex is an opiate replacement similar to methadone. Jason had reported that he was buying it from prisoners. He said that he wanted to go back onto a methadone programme and Mr Bradford told him that it was not quite as easy as that. He said he would have to fill out a drug diary and then 3 or 4 days later he would collect that and give him a urine test. Jason did not mention his mental health. Mr Bradford asked if anything else was bothering him. He noted that he had previously been on a 70 mg methadone

prescription which he had stopped abruptly with no reduction program in place. Mr Bradford noted that that did not appear to have had any negative effect on Mr Watson. There was a discussion about the practicalities of a resumption of a methadone prescription and Mr Watson was told about the practical steps which would require to be taken.

[92] Mr Bradford was asked about the purpose of a drug diary. The function of the diary is to indicate how much and what type of drug a prisoner has been using or abusing. That gives a nurse the background to allow them to go to a doctor and narrate the drug history of the prisoner/patient. Mr Watson was not interested in this. He said "I'll not be doing that, I'm no' interested." Mr Bradford indicated his belief that when he had spoken of the process involved in a methadone prescription, Mr Watson was not happy. Mr Bradford confirmed that Mr Watson terminated the meeting. There was no follow-up to that meeting.

[93] Mr Bradford was asked about an extract from the entry relating to the consultation on 26 February 2021 where he had noted that the patient had been "struggling" with his mental and physical health. Mr Bradford said that Mr Watson reported he had been struggling, and could not sleep at night. Mr Bradford had asked him about his mental health and he would not elaborate and would not go into any detail. Mr Bradford asked if he wanted to tell him a bit more but he said no. Mr Bradford asked about suicidal thoughts. Mr Watson said that he had no suicidal thoughts or plan. Mr Bradford confirmed that that was an explicit question that he would always ask. He defined it as a constant question. He said that people will

sometimes skip round about it. Mr Bradford said that there were no clues that Mr Watson was struggling. He spoke about what the problem was and there were no flags raised with Mr Bradford.

[94] Mr Bradford confirmed that when he consulted with Mr Watson on 26 February 2021 he was unaware of the calls having been made the previous evening. The three calls were played to Mr Bradford and he was asked to offer his opinion, as an experienced mental health professional, on what, if anything, Mr Watson was experiencing. Mr Bradford asked why Jason had not elaborated on this with him. He pointed out that Jason did not say anything to him. In the calls, he says he is having flashbacks. Mr Bradford wondered if this might be some form of post-traumatic stress disorder. Mr Bradford said that one might imagine that if you were that upset the previous evening he had plenty of opportunity to raise those issues the next day. Mr Bradford said that there was nothing within those calls to say that he was going to commit suicide or harm himself.

[95] Mr Bradford was asked whether he might have dealt with that consultation differently had he known about the content of the calls. He found that question difficult to answer. Mr Watson had plenty of opportunity to tell him about the calls had he wished to do so. Mr Bradford said he would still ask the same questions, namely, trying to establish what was going on, and how he could help Mr Watson. He asked him directly about his mental health experience. He said that about 80% of prisoners will struggle with their mental health. He said that once there is rapport with an individual they are more likely to open up to you in their discussions about mental health.

Mr Bradford described it as like having the cold or the flu in the sense that it is now largely destigmatised – mental health is open now and prisoners are more open to speaking about it.

[96] Mr Bradford said that he had known Mr Watson from his job as a pass man on the hall. He knew him to speak to. He would come in and sweep the floor and tidy up. Mr Bradford was asked, again, whether he would have behaved differently had he known about the calls having been made. Mr Bradford said that in the calls Mr Watson describes flashbacks. They are still there the next day. He had asked him the next day; was there anything he wanted to discuss and he said no. He knew Mr Bradford and he had plenty of chance to tell him. Mr Bradford did say that, had he known about the calls, he would have asked about the flashbacks and other matters raised in those calls. He would have probed him on them.

[97] It was put to Mr Bradford by the procurator fiscal depute that the Crown expert, looking into the circumstances of this death, felt that after the consultation on 26 February 2021 arguably Jason Watson should have been referred to a psychiatrist or an addiction clinic. Mr Bradford's response was that he had referred him to the addictions clinic. There had been no referral to psychiatry because there is a procedure to go through. Mr Bradford said that there was nothing at all that he had seen at this consultation that merited a referral to psychiatry.

[98] Mr Bradford was shocked by Jason Watson's death. This was the first death that he had encountered in a long history of involvement in mental health and addiction in a forensic environment. He said that not everyone with mental health problems will

self-harm. He said he was shocked to get a telephone call on Saturday because the consultation had gone okay. There was nothing which he had required to discuss further with any colleague. Mr Bradford rehearsed some of the questions that you might ask regarding suicide. He would ask if you have any plans to end your life. Have you got a way that you would do it? Have you self-harmed before? Mr Bradford had previously taken part in a suicide awareness course at the University of the West of Scotland. He was also familiar with the TTM procedures.

Robert Luke

[99] Robert Luke had been employed by SPS as a unit manager for 25 years. He has worked within the Barlinnie prison in that role for 12 years. He was the duty manager on the date of Mr Watson's death and consequently, was responsible for collating information relating to that episode. He would collate all the relevant information which is then put into a box file and stored in the business manager's admin office. Mr Luke is also responsible for coordinating and arranging a date for the DIPLAR meeting. That acronym means "Deaths in Prisons Learning, Audit & Review". That meeting should take place within 12 weeks of any death if that is possible. He would thereafter create a draft DIPLAR document that would be made available to the chair in advance of the DIPLAR meeting.

[100] Mr Luke was not aware of the phone calls made by Jason Watson on 25 February 2021 and, consequently, those telephone calls were not discussed or considered at the

DIPLAR meeting. It seems that the statement by Officer Alison relating to events on 25 February 2021 made its way into the box file after the DIPLAR meeting took place.

[101] In cross-examination, Mr Luke said that it would not be possible to rectify the DIPLAR report once the meeting is concluded. By this time, the report has been signed off. Mr Luke did say that he was aware that a FAI would take place which would consider these events. He did confirm that he would have wanted to know about these events, albeit that it is not unusual for prisoners to call 999. He said it should have been included in an incident report. There should have been an intelligence report also, and Mr Watson should have been placed on report for the abuse of a phone.

Dr Gordon Skilling

[102] Dr Gordon Skilling is a consultant forensic psychiatrist at the state hospital, Carstairs. He has been a consultant for 13 years mostly at Carstairs, leading a team in assessment and management of high-risk and mentally disordered offenders. He is also a visiting psychiatrist to Glenochil prison. Dr Skilling had prepared a comprehensive report at the request of the procurator fiscal's office. This report (Crown production number 10) was referred to for its terms in the course of Dr Skilling's evidence.

[103] Dr Skilling gave his understanding of Mr Watson's medical background. He had had some limited contact with community-based services regarding mood and substance issues. Within Barlinnie prison he had had contact with the mental health and addiction teams. He did not have a major mental illness but probably had a mood

disorder of some sort which benefited from medication. He had self-harmed in the past and had attempted suicide on two or three previous occasions.

[104] Dr Skilling's report included a full note of Mr Watson's various interactions with the health services within Barlinnie prison during the period of his last prison sentence, prior to his death on 26 February 2021. Specifically, reference was made to the incident on 30 March 2020 when Mr Watson was placed on TTM after he told staff that he was suicidal and felt like "throwing himself off the top landing".

[105] Dr Skilling spoke of the huge alteration to the way in which services were delivered as a consequence of the Covid pandemic. There was much less face to face interaction and prisoners were locked up much more frequently.

[106] Dr Skilling notes that Mr Watson was seen at the prison health centre on 11 and 16 February 2021 for physical health issues. He also says that he was seen on 22 February 2021 by a member of prison nursing staff due to complaints of poor sleep and exhaustion. He was seen again on 23 February 2021 at the request of SPS staff when it was noted that Mr Watson appeared pale, unshaven and had food stains on his clothing. This was the interaction at which he referred to "remembering a past traumatic event when a gun was placed in his mouth and his life was threatened". He also spoke, at this consultation, of "flashbacks, night terrors and ruminating thoughts". He strongly denied any suicidal thoughts or plans. He was referred to the GP to consider a short-term prescription for a sedative. On 24 February 2021 administrative staff noted a referral to clinical psychology had been received and would be discussed at the next team meeting. Mr Watson's final engagement with health services was on

26 February 2021 when he was reviewed by a mental health nurse and the student mental health nurse. This is the meeting referred to above with Mr Paul Bradford.

[107] In his Summary and Conclusions, Dr Skilling made a number of observations which related to earlier incidents during Mr Watson's last prison sentence which are not relevant to the remit of this Inquiry. What is relevant, however, is the final paragraph on page 621 of the Crown bundle of documents. Here, Dr Skilling observes that, in his opinion, there was evidence of a deterioration in Mr Watson's mental health when he was seen by mental health staff on 23 and 26 February 2021, notably after being removed from his pass man job on 9 February 2020 (sic). On both of these occasions he had been referred for mental health review by SPS staff due to their concerns. The assessments performed on these occasions were of a reasonable standard and they noted Mr Watson's deterioration. Following the review on 23 February 2020 (sic), a referral to psychology was made. However, there was no planned documentation for further follow up or input from the mental health team following either the review on 23 February or the review on 26 February 2020 (sic). The review on 26 February 2020 (sic) ended with Mr Watson clearly dissatisfied and leaving the interview room abruptly. Dr Skilling opined, that with the benefit of hindsight it is easy to say there should have been more done at that time. He did not think, however, that Mr Watson's presentation on the 26 February 2021 warranted immediate intervention (such as being placed on TTM for example) but he would have expected there to have been some plan for further review of his mental health in the coming days and consideration of re-referral to the prison psychiatrist.

[108] Dr Skilling also considered the issue of suicide risk in prisoners. He said that a recent meta-analysis of 77 studies from 27 countries including 35,351 prison suicides concluded that the five strongest factors associated with suicide risk prisoners were: suicidal ideations during current period in prison, previous suicide attempt, history of self-harm, single cell occupancy and current psychiatric diagnosis. Other significant risk factors included being convicted of a violent offence, a history of alcohol misuse a depression diagnosis and the lack of social visits. Dr Skilling noted that Mr Watson had all of these risk factors which would have statistically increased his risk of completing suicide. The relevant services were aware of his history and his risk factors. However, the reality is that it remains extremely difficult to predict when individuals, who have these chronic, broad statistical risks, are at acute risk of actually attempting and/or completing suicide.

[109] Dr Skilling said that current systems rely heavily on prisoners volunteering active suicidal thoughts or plans that then trigger a risk management response (for example TTM). In the absence of such suicidal statements from prisoners, the system relies upon staff having concerns for other reasons, and enacting measures such as TTM can be difficult to justify when a prisoner is actively denying any plans to harm themselves. Mr Watson was maintained on TTM for a period of several days in April 2020 after he denied any suicidal ideation or intent. This was based upon his history of previous attempts and was good practice in the circumstances. Dr Skilling's report specifically stated that he was not critical of staff for not enacting TTM on 23 or 26 February 2021 but he did suggest that it may be for the SPS and NHS to review, and

be more sophisticated and individualised about, thresholds for activating TTM for prisoners.

[110] Ultimately, Dr Skilling found there to be no failings in individual clinical decisions that had a direct impact on the outcome of Mr Watson's case. The systems issues identified by him, most likely related to the interface between addictions, mental health and GP services in the prison, and how referrals that are made to more than one of these services at a time, are assessed, prioritised and scheduled. Further, the systems impact of Covid-19 should not be underestimated.

[111] Dr Skilling said that it was impossible to know which individual prisoner will act to complete suicide. He postulated on the possibility of amending the TTM protocol by suggesting that it could be triggered in the absence of self-reporting. He might favour a more individualised approach considering their history and individual stressors for them. One could create a safety plan for the prisoner and produce a plan to manage when that prisoner is at increased risk. Having said that, Dr Skilling could offer no concrete recommendation on how to improve things. TTM is, he said, as good as it can be. He noted that prisoners do not like being on TTM. Dr Skilling was reminded that Jason Watson had, himself, spoken of the impulsivity of his prior suicide attempt. He had reported waking up and being glad to be alive. In response to this, Dr Skilling said that it is only possible to say that Jason Watson was at increased risk of suicide over time. It is not possible to say that a certain person will commit suicide at a certain time. Having written a few of these reports over the last few years Dr Skilling reported that

there was almost no indication beforehand that this (ie suicide) might happen. He said that impulsive people can carry out very risky acts.

[112] In cross-examination by counsel for the GGHB, Dr Skilling confirmed that a prisoner will see a psychiatrist much more quickly in a prison setting than in the community. He said that he would see people in prison that he would never see in the community. He agreed that there was, in effect, a treatment plan in place for Mr Watson insofar as he had been referred to the psychology team, a GP and there was open access to medication. Separately, Dr Skilling also agreed that the consultation on the 26 February 2021 concerned Mr Watson's restarting of methadone and there were no signs of mental health crisis or any acute episode in that examination.

Nicola Earaker

[113] Mrs Earaker was a nurse deployed within Barlinnie prison during the time in question. She was a nursing team leader within the mental health unit. She gave evidence of the challenges of providing mental health treatment in the face of the COVID-19 induced challenges. She noted from Mr Watson's medical records (Crown production 13, at page 650) that on 9 November 2020, Mr Watson was uprated to the "urgent" category although this appears to have been done as a consequence of the length of time he had waited for treatment rather than any specific clinical presentation.

Discussions and Conclusions

The evidence as it related to medical and mental health matters

[114] The 3½ days of evidence presented at the Inquiry may be distilled as follows. Jason Watson was a prisoner in Barlinnie prison at a time when Covid-related restrictions were having an effect upon everybody's lives, everywhere. Prison was no different and the necessary arrangements and protocols ordinarily in place within the prison environment required to change in sometimes radical ways to accommodate the exigencies brought about by the Covid-19 pandemic.

[115] It is clear from the evidence presented at the Inquiry that the provision of mental health services within Barlinnie prison was significantly affected during the Covid pandemic. In particular, a decision was made to focus dwindling staff numbers within the medical provision at Barlinnie prison on clinical, rather than mental health, requirements. In practice, this meant that ongoing review of prisoners who were under the auspices of the prison mental health team (for whatever reason, be that an addiction or other mental health concern) would take place less frequently. It does appear, however, that while this had been the stated intention of GGHB (see the GGHB First Inventory of Productions which state that from 18 March 2020 *Mental Health services will be for emergencies only),* in practice ongoing review of those under the care of the mental health team, took place on an ad hoc basis whenever possible. The Notices within that First Inventory of Productions cover the period from 18 March 2020 up to and beyond 5 January 2021. It is abundantly clear from the medical records (Crown production number 13) that Mr Watson was seen on numerous occasions during the period of time

when access to mental health provision was supposedly restricted. Equally, it is apparent that a number of entries in those records show that a review could not take place because of the existing Covid protocols.

> "As a generality, in the course of the Inquiry there was no suggestion that the decision to prioritise nursing and general medical healthcare in the direction of clinical, rather than mental health provision was in any sense improper. As the GGHB say in their submissions: the pressures, restrictions and limitations brought about by Covid were unprecedented in modern times. The health board, like most public authorities, organisations and health providers, had to adapt to circumstances never seen before in modern times."

Nobody could disagree with that sentiment. In any event, it appears to me that notwithstanding the aspiration of GGHB to focus their resources on clinical rather than mental health provision, as a matter of fact the provision of mental health care offered to Jason Watson in the final weeks and months of his life were more than adequate. Mr Watson was seen by Nurse Catherine Traynor on 5 January 2021. His mental health care plan was reviewed by Nurse Traynor on 7 January 2021. He was next seen on 9 January 2021 by consultant forensic psychiatrist, Dr Kalpana Sankey who saw him again, by way of follow up, on 5 February 2021. The records of these various appointments with Mr Watson show that he was receiving what I consider to be a very competent and compassionate level of care, particularly standing the challenging circumstance in which that care required to be delivered.

[116] I note from the medical records that, as was suggested by various witnesses who knew Mr Watson, he was quite content to approach medical staff as and when he felt the need to do so. On 11 February 2021 he approached a doctor to raise a medical concern that he had. On 16 February 2021 he approached a nurse to complain about a stomach

upset following a curry he had eaten the previous night. I consider it significant that Mr Watson felt able to approach medical personnel when he required to do so and, further, I note that those individual staff were sufficiently diligent to enter the details of those passing conversations in Mr Watson's medical record.

[117] On 22 February Mr Watson asked to speak with a nurse regarding his difficulties with sleep. Then, on 23 February 2021 following a request by the hall staff where Mr Watson was located, he was seen again by Nurse Traynor. In the course of this consultation he made reference to past traumatic events including "a gun was placed in my mouth and my life was threatened". In the course of that consultation he strongly denied any thoughts or intent for suicide or self-harm. The record of that consultation provides that Mr Watson was given self-help literature in the meantime around flashbacks and nightmares. The following day Mr Watson was referred to the Clinical Psychology Intervention Service.

[118] On 26 February 2021 again, the mental health team was contacted by a member of the prison staff to ask if somebody could see Jason. Mental health nurse Paul Bradford, together with a student nurse, attended at A hall to see Mr Watson. Nurse Bradford, in evidence, said that Mr Watson reported to him that he had been abusing Subutex whilst in prison and he wanted to try to stop this. Nurse Bradford said that he would require Mr Watson to complete a "drug diary" which would enable the appropriate doctor to consider how best to assist Mr Watson. He did not seem best pleased with this suggestion. He told Nurse Bradford; "I'll no' be doing that". The record of this entry reports that Mr Watson had been "struggling" with his mental and

physical health but did not offer further explanation regarding this. He explicitly denied any suicidal ideation, plan or intent at present. Nurse Bradford explicitly asked Mr Watson if he had any mental health concerns. He asked Mr Watson to elaborate on any concerns that he might have and Mr Watson refused to do so. Nurse Bradford explained in evidence that he would always ask explicit questions about suicide and self-harm. He has been a primary care nurse for 30 years. He had specialist training in suicide and self-harm awareness.

[119] That final consultation involving Mr Watson, Nurse Bradford and the student nurse also present, appeared to end abruptly with Mr Watson leaving the consultation early. It appeared that he was in some way displeased with the protocol that Nurse Bradford explained to him about how he may be assisted in reducing and ceasing his Subutex abuse.

[120] The next entry in Mr Watson's medical records is of 27 February 2021 and records the tragic circumstances of him being found apparently lifeless within his cell at 08.25 hours.

[121] I make no criticism whatsoever of the provision of mental health care to Mr Watson in the course of his prison sentence and, specifically, in the period of months and weeks before his tragic death. On the contrary, it was readily apparent from the evidence of those nurses and the forensic consultant psychiatrist who engaged directly with Mr Watson that he was treated competently and with compassion in that time. He was seen on a number of occasions shortly before he took his own life. It seems to me

that he had considerably greater access to mental health care as an incarcerated prisoner than he would have had, had he been at liberty.

The evidence relating to telephone calls made by Mr Watson

[122] Evidence was led at the Inquiry of three telephone calls made by Mr Watson from his cell on the evening of 25 February 2021 (at 2036, 2039 and 2056 hours respectively). It appears that those calls were made using a telephone handset commonly provided to prisoners during the Covid pandemic, to enable them to communicate with friends and family in circumstances where face-to-face visits were not taking place because of Covid restrictions. The calls were made using an illicit SIM card.

[123] The content of those telephone calls is set out in Crown production 12 as three distinct transcripts. The telephone calls were played in open court. It was clear from their content that Mr Watson was expressing paranoid and delusional thoughts. He sounded upset and worried in those calls. While it seems that the making of this type of call is far from unusual so far as the authorities are concerned, nonetheless, all three of these calls merited heightened attention on the part of the emergency call handlers who took them. Robert Rae was a controller at Police Scotland, who said that he and his colleagues had tried to contact Barlinnie prison to let them know that they had received calls from a prisoner there. They tried to call Mr Watson on his mobile telephone and they tried email and direct telephone to Barlinnie prison. It took approximately 1 hour and 20 minutes before the 999 control room was able to effectively contact the electronic

control room at Barlinnie prison (at 2219 hours). It appears that whenever the 999 control room tried to telephone Barlinnie prison, they were met with an engaged tone.

[124] When staff in the ECR did, eventually, receive intimation from the police that three concerning telephone calls had been made by Mr Watson from the prison, staff on the night shift proceeded to Mr Watson's cell to investigate what they understood to have been "nuisance calls". The submissions on behalf of the Crown submit that "there is an issue with the reliability of witnesses here. Robert Rae, police call handler confirmed he provided a synopsis to staff in the ECR regarding the nature of Mr Watson's calls and requested a welfare check." I agree with that characterisation. I consider that the police call handler did intimate to Barlinnie ECR that calls had been made and that a welfare check should be carried out. It appears that the welfare concerns behind that intimation were not communicated to the prison staff who went to see Mr Watson in his cell. First line manager ("FLM") Gary Hughes said in evidence that he had taken a radio call from the ECR that Mr Watson had been making nuisance phone calls to the emergency services. Thereafter the FLM and four colleagues attended at the cell. The four officers who gave evidence to the Inquiry, said that Mr Watson appeared fine, normal and they did not have any concerns for his well-being. (Note that Barry McDougall was said to be present by Gary Hughes. Mr McDougall was not called as a witness). There were certain differences in the accounts given of that visit by the respective officers who were there that night. I consider it unsurprising that, at this

remove, different people have differing memories of what will have seemed at the time, a matter of little moment.

[125] The FLM, Gary Hughes explained to the court that he felt that the making of these calls by Jason Watson was not, of itself, a disciplinary matter. He had considerable difficulty explaining to the court exactly how he would characterise Mr Watson's demeanour. Ultimately, he considered that "something was no quite right" about Mr Watson's presentation. If Mr Hughes had escalated this matter as might have been expected by his superiors then Mr Watson would have been put on report. Mr Hughes indicated that he felt that that would be inappropriate in the circumstances. Accordingly, Mr Hughes reported this to his superiors as a mental health issue so that he could avoid an escalation of the situation.

[126] Ultimately, while there were some differences regarding precisely what was said by Mr Watson whilst the prison officers were present, it was common ground that Mr Watson appeared to be fine and, despite an initial denial that he had made calls, he then accepted that he had done and readily handed over his phone to prison staff so that it was confiscated for the night.

[127] Finally, on this point, it is worthy of note that all of those members of SPS staff called as witnesses who engaged with Mr Watson that night are fully conversant with the TTM protocols and have all, at some time in the past, placed a prisoner on that scheme when they have had concerns in respect of possible suicide or self-harm.

[128] Within Barlinnie prison, there is provision for a SPS/NHS handover note. This would allow SPS staff to handwrite any relevant information regarding what may have

occurred out of hours for the benefit of healthcare staff the following day. The handover notes completed by SPS for 25 February 2021 make no mention of the incident regarding Mr Watson's telephone calls to the emergency services. In his evidence, Nurse Bradford who saw Mr Watson in the course of the day following the making of those calls, said that the outcome of his consultation would have been the same had there been reference to the specific content of the telephone calls made on the previous evening. Accordingly, while I note that the handover note is silent on the issue of calls having been made, it is apparent that that has no relevance to the decision by Mr Watson to take his own life during the night of 26/27 February 2021.

The DIPLAR process

[129] It seems unarguable that the DIPLAR process relating to Mr Watson's death has been at least partially flawed. It appears that through inadvertency, the relevant file was not updated to reflect the fact that Mr Watson had made telephone calls from his cell on the evening of 25 February 2021. The Crown, in their submissions to me, describe this omission as "minor". I would agree with that characterisation. Certainly, I do not consider that it has any relevance to the circumstances of Mr Watson's death.

The Application of Section 26(2)(g), Fatal Accidents and Sudden Deaths Etc (Scotland) Act 2016

[130] The only party to the Inquiry which sought to suggest that there be anything other than formal findings in my determination was the Crown. I have already listed (at

paras [10] to [23] above) the areas brought to my attention within the Crown's submissions which the Crown invite me to include under this subsection.

[131] I do not consider that any of the matters raised by the Crown under this subsection merit inclusion therein. I find that the level of mental health care provision offered to Mr Watson, and accepted by him was more than adequate. This is especially so given the background of a Covid pandemic. I consider it highly likely that Mr Watson had quicker and more comprehensive access to mental health care than he would have had were he at liberty. I find that the care provided to him was both competent and compassionate.

[132] While it is self-evident that the contents of the telephone calls made by Mr Watson on the evening of 25 February 2021 were concerning, at no point did Mr Watson hint at any suggestion of self-harm, much less suicide. I note that Nurse Traynor, during her consultation with Mr Watson on 23 February 2021, had already encountered the type of paranoid and probably delusional history reported by Mr Watson in the course of the telephone calls made by him on 25 February 2021. Accordingly, this state of mind was already known to the mental health team at Barlinnie prison before those calls were made on 25 February 2021. Indeed, the entries of 9 January and 5 February 2021 recording the consultations between Mr Watson and Dr Sankey also report a degree of unusual thinking when Mr Watson reported his plans to create a new app, invent a new TV aerial and reported that his grandfather was a serial killer about whom he wished to write a book.

[133] Notwithstanding these increasingly unusual presentations on the part of Mr Watson, at no time did he indicate any thoughts of self-harm or suicide. It is to be remembered that Mr Watson was somebody who would voice such a concern if he had one. He had been placed on the TTM protocol for just this reason on 30 March 2020 when Mr Watson stated that he felt like "throwing himself off the top landing". He had also stated; "I am suicidal". This indicates to me that perhaps more than others, Mr Watson was an individual capable of expressing candid concern about his own mental health and the possibility that he may self-harm or attempt suicide.

[134] In his evidence to the Inquiry, Dr Gordon Skilling said that it is impossible to know which individual prisoner will act to complete suicide. In referring to his own previous attempt at suicide, Mr Watson had spoken of being glad to have failed in that attempt. Commenting on that outcome, Dr Skilling said that it was only possible to say that Jason Watson was an increased risk of suicide over time. He made the perhaps obvious point that it is not possible to say that a person will commit suicide at a certain time. Dr Skilling also said that, having written a few of these reports over the last few years, there was almost no indication beforehand that this might happen. He gave the example of a prisoner who had been speaking to his partner moments before taking his own life. Dr Skilling made the point that impulsive people can carry out very risky acts.

[135] I consider that between the hours of 2200 hours on 26 February 2021 and 0842 hours on 27 February 2021 Jason Watson chose to take his own life. Earlier during the day of 26 February 2021 he had told an experienced mental health practitioner that he had no intention of self-harm or suicide. It is difficult to see what more could have

been done to protect Mr Watson from taking the impulsive decision that he took to take his own life.

[136] As noted by Sheriff Shead in his determination following the Inquiry into the death of Garry Munro,

> "There is a material difference between a prisoner at demonstrable risk of suicide and one with mental health difficulties when there is no indication that those difficulties are severe and in any event indicative of a desire to commit suicide."

[137] Unfortunately, whilst it was clear that Mr Watson suffered from mental health issues and may have had a number of other ongoing concerns, he did not, at or around the 26 February 2021 give any reason to believe that he was at risk of suicide. On the contrary; he indicated that he was not at risk. I am satisfied on the evidence that there was no basis on which the SPS should have treated him as being at risk of suicide. Accordingly, I am of the view that, on the evidence before the Inquiry, there are no identifiable precautions which could reasonably have been taken that might realistically have resulted in his death being avoided.

[138] I am satisfied that I should make formal findings of the time, place and cause of Mr Watson's death in terms of section 26(2)(a) and (c) of the 2016 Act and that I should make no findings in terms of sections 26(2)(b), (d), (e), (f) and (g). Likewise, I have no recommendations to make in terms of section 26(4) of the Act.

[139] I should add, by way of observation rather than recommendation, that it is surprising that the police 999 control room was unable to contact anyone within the Barlinnie prison for a period of 1 hour and 20 minutes during the evening of 25 February

2021. I have already indicated that I do not consider this failure of communication to justify inclusion within a section 26(2)(g) finding. I am mindful, however, that this determination will be considered by those authorities responsible for such channels of communication and I am hopeful that they will reflect upon the desirability of ensuring that this particular channel of communication remains open and accessible at all times.

[140] Finally, I join with all parties in offering my sincere condolences to the family of Mr Watson.