SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE IN FALKIRK

[2019] FAI 29

FAL-B230-18

DETERMINATION

BY

SHERIFF J K MUNDY

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

into the death of

ROBERT WAGSTAFF

Falkirk, June 2019

DETERMINATION

The Sheriff, having considered the information presented at the inquiry, determines in terms of section 26 of the Act that:-

1. In terms of section 26(2)(a) Robert Wagstaff died in Cell 15, Level 3, Iona Hall, HM YOI Polmont either late on 20 January or in the early hours of 21 January 2017, life being pronounced extinct at 0753 hours.
2. In terms of section 26(2)(c) the cause of death was hanging.
3. In terms of section 26(2)(e) the following precautions, which could reasonably have been taken, and had they been taken might realistically have resulted in the death being avoided were: the reading and sharing by Scottish Prison Service

("SPS") staff of the contents of the Transitions Report for Robert Wagstaff compiled by William McKeown, Depute Head of Service, St Mary's Kenmure and received by the SPS at Polmont on 14 November 2016, and in particular the information that on 27 October 2016, at about the time he was under the influence of unknown substances, he was found with a ligature around his neck and required close supervision as a result.

4. In terms of section 26(2)(g), the failure to carry out a healthcare risk assessment by a healthcare professional under the SPS Prevention of Suicide Prison Strategy on Robert Wagstaff's return to Polmont from court following conviction on 19 January 2017 is a circumstance relevant to his death.

RECOMMENDATIONS

In terms of section 26(1)(b) the following recommendations are made:

1. That information in Transitions Reports and similar documents from other institutions, including secure accommodation, on the transfer of an individual to HM YOI Polmont should be thoroughly read by SPS staff within Polmont who are responsible for the transfer and placement of the person and that the information in such reports be shared with all relevant SPS, NHS and other staff within Polmont dealing with the person, including those involved in the management of the person in terms of risk both to himself or herself and to others.

2. That the guidance issued by the SPS in their Prevention of Suicide in Prison Strategy as to the circumstances in which a healthcare risk assessment is carried out by a healthcare professional upon an individual's reception into an institution be amended to clearly state all the circumstances in which such an assessment be carried out so that it is easily understood by SPS staff.
3. That regular training, including refresher training, be provided by the SPS to their staff, NHS staff and other relevant staff within Polmont in relation to the SPS Prevention of Suicide in Prison Strategy, with particular emphasis on the circumstances in which the strategy might be invoked in relation to an individual.

NOTE

Introduction

[1] This is a Fatal Accident Inquiry held into the death of Robert Wagstaff ("Robert"). Following a Notice of Inquiry being lodged by the Procurator Fiscal on 28 August 2018 this court ordered the inquiry. A preliminary hearing was held on 16 October 2018 with a further such hearing being held on 12 November 2018. The inquiry ran over 3 days of evidence: 26 November 2018, 15 January 2019 and 27 February 2019. A further hearing on submissions was assigned for 12 March 2019 but this was discharged on 11 March 2019 as being unnecessary in light of the written submissions that had been lodged shortly before it, and I made avizandum. At the inquiry the Procurator Fiscal was represented by Ms Cook. Also represented at the

inquiry were the following parties who had an interest in the matter: the Scottish Prison Service ("SPS") represented by Ms Thornton, solicitor; the Prison Officers Association ("POA") represented by Mr Phillips, solicitor; and NHS Forth Valley, represented by Ms McNeill, advocate.

[2] On the first day of the inquiry oral evidence of seven witnesses was led by the Procurator Fiscal: (1) Joanne Brogan, a mental health nurse at HM YOI Polmont; (2) Evelina Worobiej or Sneddon, of the NHS Addictions Team, Polmont; (3) Calum McCarthy, SPS, formerly a unit manager at Polmont; (4) Martin Troy, SPS, a prison officer; (5) Derek Watson, SPS, a prison officer; (6) Jill Morrison, SPS, an operations officer and (7) Donald Macpherson, a mental health nurse NHS at Polmont.

[3] In light of the nature of the evidence that had been led thus far the inquiry was continued until 15 January 2019 for, amongst other things the SPS to lodge written guidance relating to their Prevention of Suicide in Prison Strategy "Talk to Me" applying as at 19 January 2017, when Robert was received back at Polmont following a fresh conviction, and in particular relating to healthcare risk assessments on reception.

[4] In the event, on 15 January 2019 evidence was led on behalf of the SPS, and in particular the evidence of Lesley McDowall, SPS Health Strategy and Suicide Prevention Manager. Following her evidence the inquiry was further adjourned until 27 February 2019 for the SPS to produce records relating to audits of compliance with their Prevention of Suicide in Prison Strategy insofar as relevant to Robert's reception into Polmont following his transfer there and subsequent conviction and to consider whether any further evidence would be required.

[5] Following the adjournment and on consideration of the evidence it appeared to me that evidence in relation to another matter would be required. This arose from Crown production 7, the DIPLAR (Death in Prison Learning, Audit and Review) report following the death of Robert. It had been briefly referred to in evidence but only in relation to the fact that no reference had been made in it to the absence of a healthcare risk assessment on admission to Polmont following his conviction on 19 January 2017. Having reviewed the contents of that document it seemed to me that there was certain other important information within it which raised questions as to the knowledge of SPS and other staff within Polmont of the deceased's relevant previous history, and in particular an incident during his time in secure accommodation – St Mary's Kenmure – and the dissemination of that information to relevant staff within Polmont. I indicated to the parties through my clerk that further evidence would be required from witnesses who could speak to these matters, in addition to the question of audits of compliance referred to. That information was subsequently lodged and it was accordingly unnecessary to make a formal order in that regard.

[6] On 27 February 2019 the SPS led evidence from: (1) James Smith, SPS, Operations Unit Manager, Polmont; (2) Lesley McDowall, who was recalled and (3) Jeffrey Richardson, SPS, Community Placement Officer, Polmont. Following that evidence the inquiry was adjourned for submissions as already indicated.

The legal framework

[7] The inquiry was held under section 1 of the 2016 Act being a mandatory inquiry under section 2(4)(a) as Robert Wagstaff was in legal custody at HM YOI Polmont at the time of his death. In terms of section 1(3) the purpose of an inquiry is to: (a) establish the circumstances of the death and (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances. However, as stated in section 1(4) it is not the purpose of the inquiry to establish civil or criminal liability. The Procurator Fiscal represents the public interest and the inquiry differs from civil and criminal proceedings in that it is an inquisitorial, and not an adversarial, process.

[8] Section 26 sets out the matters which should be covered in the determination of the sheriff; in particular section 26(2) requires me to determine:

(a) when and where the death occurred

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

(c) the cause or causes of 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

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

[9] I am also entitled to make recommendations as to any of the matters set out in section 26(4), namely:

(a) the taking of reasonable precautions

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

(c) the introduction of a system of working or

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

SUMMARY

The Facts

[10] The background facts of this matter, which were not in dispute, can be gleaned from the evidence and I have briefly summarised the salient points in the opening paragraphs of the "Discussions and Conclusions" section of this Note, followed by the conclusions to be drawn.

Witness evidence

Joanne Brogan

[11] This witness was a mental health practitioner nurse at Polmont who saw prisoners on admission. She saw Robert at his reception to Polmont on 14 November 2016 and spoke to the Reception Risk Assessment under the SPS Prevention of Suicide in Prison Strategy known then as "Act to Care" and subsequently known as "Talk to Me". In particular she spoke to the third page of that document which is the Healthcare Risk

Assessment (at page 40 of Crown production 3). That document records questions asked of the prisoner to determine whether there is a risk of suicide or self-harm. The document indicates following assessment that there was no such risk. The document is dated 15 November 2016 although the assessment was the previous day and relevant information was put on to the "Vision System" (accessible by NHS staff) which is a computerised non-paper record the relevant record in this case being included in Crown production 4 (a subsequent fuller record being lodged on behalf of the NHS and forming their first production). That document disclosed that Robert was followed up by the Mental Health Team on 15 November 2016 at which time he had been moved to the Dunedin Hall for assessment. That information indicated that he was seen by Mr Paul Hartill and that he had previously been under the care of CAMHS Paisley and also a social worker there. A further consultation took place on 18 November 2016 with Joanne Brogan. Again there appeared to be no concerns in relation to Robert.

Evelina Worobiej or Sneddon

[12] Mrs Sneddon was a case worker with the NHS Addictions Team in Polmont which provided support in relation to drugs and alcohol through self-referral. Robert was a client. This witness met him in Dunedin Hall, a segregated unit and completed an assessment there. He appeared to be quiet at first but opened up. The witness spoke to Crown production 4 and in particular to her meeting with Robert on 18 November 2016. Page 5 of that production represents a care plan completed by this witness in which he is reported to be "struggling with mental health and sleep … denied any thoughts of

suicide or self-harm". The witness did not remember why the entry was there. Her evidence was that nothing gave her cause for concern. It would appear that this witness had a further meeting with Robert on 25 November 2016. Her last meeting with Robert was on 20 December 2016 where it is noted that Robert "reported to struggle with his mental health" but he "denied any thoughts of suicide or self-harm". There is a note that a mental health referral was completed during the session and the next appointment was scheduled for 4 January 2017. That meeting did not take place and a subsequent appointment for 20 January 2017 also did not take place as Robert was at work within the prison and the witness was unable to gain access to him. The witness could not remember why the appointment did not take place on 4 January 2017. Curiously the witness could not remember why there had been a referral to the Mental Health Team. The referral form was not produced at the inquiry although a sample of such a form was subsequently produced on behalf of the NHS. An Addictions Assessment Form had been completed on 18 November 2016 forming pages 12 to 18 of Crown production 4 in which it is reported that Robert suffered from anxiety, sleep problems and low mood although he denied any thoughts of suicide or self-harm.

Calum McCarthy

[13] This witness was a unit manager at Polmont in January 2017. He is now an Inspector of HM Prisons. At the relevant time he was in charge of the Iona and Dunedin Halls including the Separation and Reintegration Unit ("SRU"). There was a cross section of prisoners in both halls. He explained that each prisoner had the opportunity

to speak to him. Some did and some did not. He remembered Robert. He was in the SRU due to the violence that Robert had exhibited prior to his admission. He had been advised of that and Robert's impending arrival by Jeffrey Richardson of the SPS in Polmont. Robert arrived at Polmont on 14 November 2016 and placed in Dunedin Hall under "rule 95" (segregation). He had been kept in Dunedin until he was 18 (his 18th birthday being 18 December 2017). He had met Robert on 15 November as part of his rounds but had no real dealings with him. There was an attempt to integrate Robert into the mainstream prison and to attend Munro Hall for recreation. However, he was assaulted by a fellow prisoner. The witness had spoken with Robert the week before he died. He had said hello. Robert said he was fine. The witness explained the rule 95 procedure, in terms of which a prisoner could be kept on rule 95 for 72 hours. It could then be extended under rule 95(11) for up to 30 days, the effect of which was to remove the prisoner from the mainstream prison. The practical effect was that the prisoner would remain in Dunedin Hall. The witness indicated that Robert was unusually respectful and mannerly. He had been shocked to learn that he had taken his own life. There had been no indication to the witness that he was not coping. If he had had concerns he would have taken steps under the Prevention of Suicide in Prison Strategy ("Talk to Me"). The witness did not further elucidate as to what steps he might have taken.

Martin Troy

[14] This witness was an operations officer at Polmont and worked in the reception area in January 2017. He dealt with prisoners coming in and going out. In any given day there would be 30 to 40 people coming in. He remembered Robert Wagstaff but nothing specific. He explained that at the time the Suicide Prevention Strategy "Talk to Me" was new, the former strategy being called "Act to Care". However he said there was no difference between the two. He spoke to the Reception Risk Assessment Form completed by him in respect of Robert on his reception on 19 January 2017 following his conviction for the assault, being the matter which precipitated his transfer to Polmont in the first place. The document is pages 34 to 36 of Crown production 3. The document recorded that there were no concerns relating to mental health issues and no issues in relation to the formal questions including one which is "Do you feel suicidal?" The document recorded that Robert "seems in good spirits". Notably however the third page of the form which is the Healthcare Risk Assessment was not completed. The witness did not remember completing the reception form but did confirm that it was his writing. It was noted that Robert was due to return to court for sentence on 16 February 2017. The witness indicated that had he had concerns then he would have taken steps to refer him to the suicide prevention strategy and would have referred him to mental health services. He said there was no apparent risk. When asked why it was that a Healthcare Risk Assessment was not carried out he indicated that that would only occur when the prisoner was sentenced or on admission. He gave that evidence notwithstanding the clear guidance at the top of the form that the risk assessment was

"for admissions, transfers and those convicted at court". He confirmed that Robert would not have been seen by a nurse at the time (and there is no suggestion from any other witness that that occurred). When asked whether or not there was any training in the "Talk to Me" strategy the witness indicated that he had one classroom session and "e-learning packages". He indicated that as of early in 2018 the procedure changed and that all convicted prisoners would get a Healthcare Risk Assessment but he was unsure how it was he became aware of that requirement.

Derek Watson

[15] Derek Watson was a residential officer at Polmont in January 2017 and he remembered Robert. He was quiet. You could speak to him but he would not approach staff freely. He had no concern relating to risk of self-harm. He was on duty in the evening of 20 January 2017 on the 12 noon to 9.30pm shift. His last job would be to check and make sure the young offenders were alright. He spoke to Robert at approximately 9.00pm. He was watching TV. He was sitting in a chair by his bed. The witness said something like "Goodnight, see you tomorrow, got everything?" The response was something like "Aye fine". He had no concern. Another prisoner spoke to the witness the following day and told him what had happened. The other prisoner was a "passman" in other words a trusted prisoner. He indicated to Mr Watson that he had concerns about Robert at the time. This appeared to be on the basis that Robert did not have any tobacco and had been asking for that the previous evening. The witness said that he was not aware that Robert had been a smoker but that lots of the boys in

Polmont took tobacco. In cross-examination the witness indicated that he had had a conversation with Robert when he had come back from court at the back of 4.00pm on 19 January 2017. The conversation was about his case and about Robert's sister. The witness was leading the conversation. They were chatting. Robert indicated that he was expecting another sentence. The witness had no concerns about him. He indicated that he had training in "Act to Care" and "Talk to Me". He said that he had invoked the procedure under those strategies many times. This witness was asked about a document prepared by Paul Preston, an officer instructor within the bike workshop at Polmont. The document is dated 23 January 2017 and indicated that Robert gave Mr Preston no cause to suspect that there were any issues he was struggling with. To hear what had happened to Robert came as a shock. It was noted that his peers in the workshop had been subdued all morning. The witness explained that the cell in which Robert was living at the time was Cell 15 in Iona Hall on the top (third) level. He explained that Robert would have had a personal officer (first point of contact) but did not know who that was. He indicated however that any member of staff could fulfil that role. It was indicated at this point in the evidence by Ms Thornton (the solicitor for the SPS) that the relevant "Talk to Me" documentation would be lodged for the next calling of the inquiry.

Jill Morrison

[16] This witness was an Operations Officer at Polmont whose main purpose was security on patrol. She was on patrol between 10.00pm on Friday 20 January 2017

and 8.30am on Saturday 21 January 2017. She would check with the prisoners to meet any needs, for example medication. She was responsible for Iona Hall along with a colleague. On that night there were two cells which were the subject of special observations but not the cell of Robert Wagstaff. This witness did not know him. Robert was in Cell 15, Level 3. There was nothing unusual about the night. She conducted latch checks at 7.30am starting at Level 3; on checking Cell 15 nobody was in bed. Robert was facing towards her with something around his neck. He appeared to be dead. The witness activated a code blue being a radio message to alert other staff of this occurrence. She waited for other staff to arrive, got permission to open the cell and she along with two others entered the cell. Robert was clearly deceased. He had a ligature around his neck attached to the bed. She laid Robert on the floor. Paramedics arrived thereafter.

[17] At this point in the evidence the fuller version of the Vision Record was lodged by the NHS as their first production. The witness Evelina Worobiej or Sneddon was briefly recalled to speak to this. The document in fact contained the same information but in a slightly different order. No new matter was covered in her evidence at this point.

Donald Macpherson

[18] This witness was a bank nurse, part of the Mental Health Team at Polmont. He performed a similar role to Joanne Brogan. He gave evidence under reference to the NHS production – the Vision Record. He spoke to attending a Multi-Disciplinary

Mental Health Team (MDMHT) meeting on 16 November 2016, 2 days after Robert's admission. Robert would be discussed along with other prisoners. He referred to notes of that meeting, which were subsequently lodged as SPS production number 4. He referred to the fact that Robert had cognitive issues and was possibly on the autistic spectrum. He was fairly settled in Dunedin and would remain there for 3 weeks before moving to one of the halls. It was confirmed at the meeting that Robert would be visited by Charles Kelly, the Head of Psychology. He explained that the psychological service did not have access to the NHS Vision Record but had access to the PR2 (ie the SPS) record. He did not know why that was. At a subsequent meeting on 14 December 2016 it appears that Mr Kelly advised that Robert had settled in well and that some further investigations regarding risk factors were required as he felt the level of violence used (at St Mary's) was disproportionate. This appears therefore to have been a reference to the risk of violence to others (ie forensic psychology). There is mention that Joanne Brogan had met with Robert and that he could be seen by mental health services on an ad hoc basis. There appeared to be no concerns at that time. The witness indicated that many prisoners have anger issues which are addressed by the psychology team. He spoke to the meeting he had with Robert on 21 December 2016 and referred to this appointment as a "quick fire" of someone's mental state. It was not a full assessment. There is reference in the entry in the Vision Record that Robert stated he suffered from anxiety and depression but most importantly had anger issues which he felt were the most concerning of his "illness". He thought that there were mental health issues in the family. He felt that there had to be something wrong with him as "his

mood varies dramatically from very low to euphoric". He had no thoughts of self-harm or suicide but stated that he "only thinks of self-harm when under the influence of drugs/alcohol". The note then is that Mr Macpherson contacted psychology, who were in the process of assessing Robert for prisoner programmes regarding anger management. In his evidence the witness could not remember the references to anxiety, depression and anger. It seems that the main concern appeared to be anger management. There was another meeting of the MDMHT on 11 January 2017 which referred to the requirement of Robert being risk assessed by the psychology department. A further meeting was scheduled for 25 January 2017 but by that time Robert had died. This witness gave some evidence about what would happen if a prisoner were to be assessed as requiring to be the subject of the suicide prevention strategy. He explained that all staff are involved in what was "Act to Care", including the hall manager and the staff in the halls. Supervision would vary depending on the circumstances and included where appropriate regulating the type of clothing that the prisoner would wear. The witness indicated that when the strategy was replaced by "Talk to Me" the only real difference was in the paperwork. Other measures might include a safe cell and tear proof bedding and clothing. Checks could range from a regularity of every 15 minutes and if the risk was perceived to be less serious the checks would be less frequent. In a hall at any given time there would be four or five such cells and typically three or four in use. Some prisoners would be subject to the strategy for a couple of days. Others would be subject to the strategy for weeks. It depended upon the circumstances. With reference to the record that Robert only thought of self-harm when under the influence

of drugs/alcohol his evidence was that if such were not available within the prison then he would imagine Robert would be safe.

[19] The foregoing evidence concluded the first day of the inquiry. The inquiry was then adjourned, as indicated, until 15 January 2019, and in the meantime, as required, productions were lodged on behalf of the SPS which included the SPS guidance in relation to their Prevention of Suicide in Prison Strategy "Talk to Me". The guidance formed productions 1, 2 and 3 for the SPS.

Evidence led by the SPS on 15 January 2019

Lesley McDowall

[20] This witness was the Health Strategy and Suicide Prevention Manager. Her previous experience was as a nurse within the prison system. She was responsible for strategies and developments of policy. She was in that role in January 2017. The previous strategy "Act to Care" was in place between 1997 and 2016. On 5 December 2016 it was replaced by "Talk to Me" following a review of the strategy. The strategies were very similar but it was explained that "Talk to Me" was more holistic. All staff, including SPS, NHS and social work staff required to be familiar with the strategy. It was a question of identifying risk factors and devising a care plan within 24 hours of the first case conference identifying the need. Measures could include a safe cell and suitable fittings and bedding with observations at various intervals between 15 and 60 minutes depending on the circumstances. The care plan would be in place for a minimum period of 24 hours but could be varied. It was not designed to be a long-term

plan. It was designed to keep prisoners safe in a crisis. It involved the Mental Health Team and drugs misuse team within the establishment. It was considered appropriate that prisoners felt they could trust staff and therefore a person was not placed on such a plan if it was not appropriate. The witness spoke to the productions numbers 1 to 3 lodged by the SPS which dealt with the "Talk to Me" strategy. When it began, all staff had training. It was essential to look for "cues and clues", as in the previous strategy "Act to Care". When asked about when it was appropriate to undertake a Healthcare Risk Assessment in relation to a prisoner, her evidence differed from that of Prisoner Officer Troy. She said that such an assessment should be carried out not only when a prisoner had been sentenced but also when he had gone from remand to conviction. In that situation he should be seen by a healthcare professional for the purpose of the assessment. This witness did training for trainers in the strategy which lasted half a day. There was now 3 year refresher training which comprised a 2 hour class. This applied to all staff including NHS staff. When asked about the audit policy she indicated that there were line manager checks. There was a check once per week by a senior manager who would look at and open "Talk to Me" cases to make sure the documentation was completed correctly. There would also be a Suicide Prevention Coordinator within Polmont to ensure adherence to policy. There was oversight by way of audit from SPS HQ. Any concerns were reported to the chief executive of SPS. An independent audit of Polmont had an outcome of "reasonable assurance". There was also a National Suicide Prevention Management Group of which this witness was secretary. There were no concerns raised by the audit. When questioned in cross-examination about the

reception of Robert on 19 January 2017 under reference to Crown production pages 34 to 36 the witness indicated that the healthcare risk assessment should have been completed. When questioned about the meeting held for the purposes of the DIPLAR report at which this witness attended she could not remember if the "Talk to Me" documentation had been discussed. She assumed that the fact that the Healthcare Risk Assessment had not been completed was not disclosed at the meeting. That was a matter which should have been highlighted in the DIPLAR report (Crown production 7). The witness explained that it was important to complete such an assessment where there had been a change in circumstances which included a prisoner being received following sentence and also a prisoner convicted from remand. It was clear that Robert had been convicted on 19 January 2017 as appeared from the court production sheet at page 22 of Crown production 3. Sentence had been deferred until 16 February 2017 but a fresh warrant would be prepared when convicted of a new matter. The witness explained the purpose of the DIPLAR review was an internal learning process to see if improvements in processes could be made following the death of a prisoner.

[21] Following the evidence of this witness the inquiry was adjourned until 27 February 2017. As indicated, the SPS were to produce any records relating to audits of compliance with their Suicide in Prison Strategy insofar as relevant to Robert's reception into Polmont and to consider whether any further witness evidence was required. Subsequent to that, as previously noted, I indicated to parties through my clerk that having reviewed the DIPLAR documentation at Crown production 7, further evidence would be required given that there was certain information within the report raising

questions as to the knowledge of SPS and other staff within Polmont of the deceased's relevant previous history including his time at St Mary's Kenmure and the dissemination of that information to the relevant staff within Polmont. This was in addition to any evidence that could be bought forward in relation to audit of compliance with the Suicide in Prison Strategy.

Further evidence led on behalf of the SPS on 27 February 2019

James Smith

[22] This witness was the operations unit manager at Polmont responsible for the safety and security of the whole establishment. At the time of Robert's death in January 2017 he was the unit manager of Munro Hall. He had been employed by SPS for an excess of 23 years. He was currently the Local Suicide Prevention Coordinator for Polmont and in that capacity oversaw all issues relating to the SPS Suicide Prevention Risk Strategy. He had been in that post for the last 14 months (in other words from around the beginning of 2018). He spoke to the document "Governors and Managers: ACTION" dated 26 October 2018 ("GMA") representing additional guidance to establishments on "Talk to Me" processes to improve compliance and mitigate risks following a series of national audits which identified common issues. All employees had access to this guidance. The additional guidance enumerated six points to assist establishments to achieve "substantial assurance". The first point reads:

> "To ensure Reception Risk Assessments (RRA) are completed in line with policy, a daily reconciliation process must be invoked to cross-reference the number of

> movements with the number of completed RRAs. This must be subject to Management Assurance through local audit."

It was indicated that while not specifically mentioned in the guidance RRAs included Healthcare Risk Assessments. It was noted that this guidance was not applicable as at January 2017. The witness also indicated that there would be a weekly audit selecting a number of cases from a particular day but again this was not something that happened in January 2017. The witness also spoke to SPS production number 5 the Prisons Resource Library Audit in relation to "Talk to Me" relating to the period 2016/2017 completed by his predecessor as a "Talk to Me" coordinator. He explained that this audit was done on closed files, in other words when someone was removed from the strategy. Further it was only an audit in relation to cases where the process had been initiated and not generally RRAs. This document was signed off by the Deputy Governor and the result in meeting the standard set by the Prisons Resource Library was 97%. The following year 2017/2018 the result was 100%. This is evidenced by production 6 for the SPS. Because of the nature of the assessment Robert would not have been the subject of it. An independent audit and assurance team checked the audit results to ensure an accurate level of assurance. The witness spoke to SPS production 18 which related to the rule 95 case conference concerning Robert on 16 November 2016. The meeting was chaired by this witness. He explained that the rule was invoked where it was perceived that the prisoner presented a risk to others or to themselves and accordingly measures were taken so that the person concerned did not associate with other prisoners. This rule was invoked in relation to Robert because of the information

received from St Mary's. Generally persons that would be present at such a meeting were a youth worker, a social worker, a psychiatrist and possibly somebody from the Mental Health Team. At this particular meeting Stewart Nixon from St Mary's was present. Rule 95(1) could be invoked for up to 72 hours. Because of the information from St Mary's a further period under rule 95 was sought and obtained under rule 95(11). The result was that Robert would continue to be within the Separation and Reintegration Unit (SRU) in other words Dunedin Hall. It appears from the productions (number 21 for the SPS) that Robert was kept on the rule until 6 December 2016. It was indicated by the witness that the report by William McKeown, Deputy Head of Service at St Mary's, was explored and that the language therein being noted to be "strong" in relation to Robert's risk to others. This is the report that appears as SPS production 14a. It seems that the report was not circulated in advance of the meeting. When asked about the reference in the report to the incident on 27 October 2016 where Robert was found with the ligature around his neck as a result of which he required close supervision, the witness, rather surprisingly, could not recall whether this was discussed. He did not recall an explanation of the incident being given by Mr Nixon. According to Mr Smith he had attended very few case conferences when the young person had come straight from secure care so this was an unusual situation for him. When asked whether self-harm or suicide was considered in the discussion the witness could not say that it was a concern. He had spoken to Robert around six or seven times. Robert presented as quiet, mannered and very compliant. He did not recognise the person he spoke to from

the language used in the report to describe Robert. The report described the violence exhibited by Robert at St Mary's. It is worth noting the conclusion:

> "In conclusion it is our professional opinion that Robert is a very dangerous unremorseful and unpredictable young person. Thus staff will require to be ever vigilant with regards to how he will react in any given situation. It would also appear that there are no triggers to Robert's behaviours and staff note that he will conceal home- made weapons that he would use if the opportunity presents itself. It is very difficult to find any redeeming features in terms of Robert's personality; as no doubt he will continue to demonstrate bizarre and withdrawn behaviours throughout his life. In summary, staff will require to be very careful when working with Robert."

The report also states:

> "On 26 October, Robert assaulted a teacher by biting him on the chest. Later during that night, Robert appeared to be under the influence of an unknown substance and as a result he became agitated, wrecking his bedroom, urinating everywhere and flooding his bedroom.
>
> On 27th of October, Robert remained under the influence and required support. He was later found with a ligature around his neck and required close supervision as a result."

The witness accepted that the reference in the report to the incident on 27 October 2016 was "significant". He spoke to the subsequent rule 95 case conference on 6 December 2016. It was noted at the meeting that Robert had settled and there were no issues with him engaging with various services. The plan had been for Robert to experience recreation within Munro Hall which housed under 18s but the last time he was there he had been assaulted by another prisoner. His reintegration into Polmont mainstream was discussed. Interestingly, this witness indicated that he did not think that a healthcare risk assessment was required when Robert was received on 19 January 2017 as his circumstances had not changed.

Lesley McDowall (recalled)

[23] The witness was once again asked whether or not a Healthcare Risk Assessment was required for Robert on 19 January 2017. On this occasion, and contrary to her previous evidence, she indicated that as his earliest liberation date had not in fact changed then no healthcare check was required, this in spite of the "Talk to Me" guidance at page 7 of SPS production 3 indicating that:

> "A Healthcare Assessment should be carried out if the individual is an admission, transfer or has returned from court convicted from remand."

The point the witness was making was that he had already been convicted and was serving a sentence on another matter and had not yet been sentenced on the new matter. Therefore there was no change in the earliest liberation date as of 19 January 2017.

Jeffrey Richardson

[24] This witness was the Community Placement Officer for Polmont. He was previously residential officer and had worked for the SPS for some 29 years. He spoke to various email correspondence relating to the transfer of Robert from St Mary's secure unit to Polmont. The said correspondence is included in SPS productions 8 to 16. Generally a young person would be prepared for transfer from another unit to Polmont, preparations being instigated around 6 months beforehand. The proposed transfer was Robert's 18th birthday on 18 December 2016. The documentation includes a calculation that Robert's earliest date of release in relation to his existing sentence was 29 August

2017. The email correspondence dates from June 2016. As of 5 July 2017 there were no concerns. Following a sentence of 40 months detention imposed at Paisley Sheriff Court there was an outburst at Kenmure and the documentation indicates that he was suffering from "stress and anxiety". It seems that following that he was not due to be considered for parole until August 2019 at the earliest. Following this he requested an early move to Polmont. Following this there were various emails to which Mr Richardson was a party and also Mary Amos, the Children and Young Person's Placement Manager with the Scottish Government. However, Robert later confirmed that he wished to transfer on his 18th birthday rather than before. This was indicated to Mr Richardson in an email from Mary Amos dated 12 October 2016. A pre-admission visit was planned in November 2016. In an email exchange between Mr Richardson and Mary Amos on 10 and 11 November 2016 it seemed to be proposed that there would be a visit the following week. However this plan appears to have been overtaken by events. Robert was transferred to Polmont on 14 November 2016 following a serious assault upon another young person at St Mary's on 12 November which became the subject of his later conviction. It appears that the Transitions Report from St Mary's was sent to Mr Richardson from Mary Amos by email of 14 November 2016.

Mr Richardson's evidence was that he did not read the report but simply passed it on. The passing on appears to have occurred in an email by him to Stewart Mustard (prisoner officer in SRU) and Mhairi Kelso (social worker allocated to Robert), the email being dated 17 November 2016 (the day after the rule 95 meeting). The witness spoke to documents subsequently received by him relating to Robert containing information as to

his convictions and background reports. The witness also spoke to the "Standard Operating Procedure" dated January 2019 dealing with transition of persons from secure care to Polmont. The document sets forth procedure in relation to planned and unplanned transitions from secure to SPS care. There are a number of bullet points setting out the procedure. For example where there are planned transitions

> "Immediately prior to the transfer all updated information is shared with Placements Officer who will share this with appropriate colleagues, which will include Reception, to ensure appropriate risk assessments are carried out".

Again in relation to procedure for unplanned transitions there is provision for the Scottish Government to:

> "forward any relevant information to SPS which should include any immediate concerns or risks to the Duty Governor".

Further:

> "All relevant information should be shared with appropriate stakeholders (Reception, Healthcare, PBSW, Psychology, Hall Manager) to inform decision making in the immediate period."

Also

> "Any significant notes and information should be uploaded to PR2 in CIP".

Mr Richardson confirmed that any significant information including concerns relating to a prisoner should be put on record on the PR2 system. He accepted that in this case there had been an oversight in that regard in relation to the incident at St Mary's on 27 October 2016. He indicated that the procedures set forth in the Standard Operating Procedure document in SPS production 17 represented clarification of existing procedures which applied at the time of Robert's reception to Polmont. The only time

this witness met with Robert was early in the transition process on 5 July 2016. It was confirmed by the witness in cross-examination that had he read the Transitions Report he would have put the relevant information onto the PR2 system to which all SPS staff had access and he would have contacted NHS colleagues to check on Robert to ensure that he was safe. He accepted that the email forwarding on the Transitions Report to Mhairi Kelso and Stewart Mustard was one day after the initial rule 95 case conference. He did not attend that conference. He indicated that it was possible that copies had been made available for it but he did not recall. I would pause to observe that it would seem from SPS production 18 that the report was discussed at the case conference, so a paper copy must have been made available.

Joint minute and statements of witnesses

[25] Some formal factual background matters were agreed by the parties in a joint minute of agreement in which it was agreed that statements of 13 witnesses were to be considered to be equivalent to parole evidence. That evidence was largely formal in nature and need not be rehearsed.

Submissions of the parties

[26] There was no issue as to where and when the death occurred nor as to the cause of death (section 26(2)(a) and (c) of the Act). There was no question of any accident having occurred. The issues for the inquiry were whether any precautions could reasonably have been taken and had they been taken might realistically have resulted in

the death being avoided (section 26(2)(e)); whether any defects in any system of working contributed to the death (section 26(2)(f)); and whether there were any other facts which are relevant to the circumstances of the death (section 26(2)(g)). There was also the question of whether the court should make any recommendations as to the matters set out in section 26(4) of the act namely: (a) the taking of reasonable precautions; (b) the making of improvements to any system of working; (c) the introduction of the system of working or (d) the taking of any other steps which might realistically prevent other deaths in similar circumstances.

[27] Except for the Procurator Fiscal, all parties submitted that I should confine my determination to the formal matters as set out in section 26(2)(a) and (c). All parties submitted that there should be no findings as to reasonable precautions or defects in any system of working in terms of section 26(2)(e) and (f). The only party suggesting that there should be anything other than formal findings was the Procurator Fiscal, submitting that under section 26(2)(g) – "other facts relevant to circumstances of death" - the SPS "Talk to Me" guidance be updated and clarified as to when a prisoner requires to see healthcare at reception. I do not think this really falls to be regarded as a submission under section 26(2)(g), rather a suggestion for a recommendation under section 26(4). There was no suggestion from any of the other parties that there be any recommendation.

[28] The common thread to the submissions of the parties was that there was no evidence to suggest that Robert would take his own life, nor evidence to suggest that he was contemplating such an act in the period prior to his death. In the inquiry the main

areas of focus ultimately became the reception risk assessment carried out on 19 January 2017 and the information in the Transitions Report from St Mary's regarding the incident there on 27 October 2016.

[29] As regards to the reception on 19 January 2017 it was submitted on behalf of the Procurator Fiscal that regardless of the fact that Robert was serving a separate sentence at the time of his conviction he had returned from court convicted from remand according to his documentation and therefore under the SPS guidance he should have undergone a Healthcare Risk Assessment that day. Further, the DIPLAR review did not mention the failure of Mr Troy to complete the healthcare risk assessment. The contrast between Lesley McDowall's initial evidence and subsequent evidence on whether such an assessment ought to have been carried out was highlighted. In relation to this confusion it was submitted that I might consider an appropriate finding as noted above. However it was submitted that such a failure would not have avoided Robert's death as the procedure of remanding for reports and return to Polmont would not have been a surprise to Mr Wagstaff. He was already a serving prisoner and would have been returned to Polmont regardless of the outcome of court on 19 January 2017. Prisoner Officer Derek Watson had seen and spoken to Mr Wagstaff on the evening prior to his death and there was nothing that gave him any concern. In relation to the Transitions Report, it appears that this was available for the rule 95 case conference on 16 November 2016 and it was forwarded by Jeffrey Richardson to a residential prison officer and a social worker. It was submitted that the failure of any member of staff to fully consider the Transitions Report which clearly made reference

to an earlier attempt by Robert to take his own life was regrettable. However this was not a failing in the system of working but human error. It was not that the report was not made available more that no single person read it properly. On that basis it was submitted that there should be no formal finding under section 26(2)(g) in this regard.

[30] On behalf of the SPS the omission to refer Robert to the healthcare team following his return from court on 19 January 2017 was noted. However it was submitted that even had a healthcare assessment been carried out it would have made no difference given the evidence of those who had dealings with Robert that they had no concerns and that there was no evidence to suggest that he was presenting as suicidal when he returned from court. As to the Transitions Report it was likely that a hard copy had been passed to James Smith prior to the case conference on 16 November 2016 and that in any event there was no evidence to suggest that the report had not been read in more detail or circulated to more individuals could causally be linked to Robert's death. The evidence demonstrated that had Mr Smith or Mr Richardson been aware of the specific incident it may have been marked on the PR2 system and an officer would decide whether or not to place Robert on the suicide prevention strategy, refer him to the Mental Health Team or take no further action. There was evidence that he was appropriately assessed under the strategy upon his submission on 14 November 2016 and did not present a suicidal at that time. There was follow-up by the Mental Health Team and he was discussed during MDMHT meetings. He had given no members of healthcare staff any cause for concern during his time at Polmont. If they had been concerned they would have initiated the "Talk to Me" policy. It was submitted that it

would be speculative to say that had the incident at St Mary's been known about this would have changed their approach to his treatment.

[31] There had been evidence from Lesley McDowall that aspects of the "Talk to Me" policy would be clarified in the coming months including healthcare assessments following return from court. Further the new Standard Operating Procedure demonstrated that a formalised process was in place at Polmont to ensure sufficient information sharing during planned or unplanned transitions from secure care to Polmont.

[32] It was submitted on behalf of the SPS that there were no precautions that staff could reasonably have taken that would have prevented Mr Wagstaff's death and that no defects in the system of working contributed to his death.

[33] On behalf of the POA it was submitted that in spite of the fact that Robert was already a convicted prisoner serving a sentence, nevertheless, technically he was in remand in relation to the new matter. But irrespective of whether or not he ought to have been assessed by a nurse on 19 January 2017 there was no evidence to suggest that this in any way contributed to his death and reference was made to the submissions of the Crown in that respect. As regards to the Transitions Report, a hard copy appears to have been before the case conference on 16 November 2016. Stewart Nixon from St Mary's attended along with other agencies to provide more information to SPS about how Robert would progress. As to the incident at St Mary's on 27 October 2016 when Robert was found with a ligature around his neck, it was acknowledged that Mr Smith could not recall this entry in the report or any discussion regarding it. Nevertheless, the

evidence of Mr Smith was that he did not believe that he would have altered his course of action had he known. The report was also emailed to a social worker and prison officer after the case management conference. Mr Richardson did not read the report at the time but advised that he now reads all such reports. There was also a new Standard Operating Procedure which formalised and detailed the procedure to be followed where there were unplanned transitions such as Roberts. It was submitted therefore that the determination should be confined to formal findings.

[34] On behalf of NHS Forth Valley it was submitted that following his initial reception to Polmont he was assessed appropriately by the Mental Health Team, a Healthcare Risk Assessment having been completed and disclosing that there was no cause for concern and no apparent risk of self-harm identified. Witness Joanne Brogan had seen him on reception and also subsequently on 18 November 2016. Anger management was seen as the main issue. A further mental health consultation took place on 21 December 2016 in response to a referral by Mrs Sneddon and this was carried out by Donald Macpherson. Again this witness had no concerns. While this witness had recorded that Robert "states he only thinks about self-harm when under the influence of drugs/alcohol" his evidence was that given Robert was in Polmont the circumstances of his being located there meant that no drugs or alcohol were available to him and he imagined Robert would be safe. Had the witness had any concerns he would have placed Robert on "Talk to Me". His evidence also was that there were downsides to being on "Talk to Me" for young people who are not at risk of harm as the safe cell environment is not the nicest surroundings for young people to be in.

Notwithstanding the record indicating thoughts of self-harm, it was submitted that Mr Macpherson had the training skills and experience to make the assessment he did. It was submitted that even if Robert had been put on the strategy and subject to observations following the consultation on 21 December his positive presentation in the period after that date was supportive of the inference that he would have been removed from observations and would have found himself in the same environment on 21 January 2017 as he was in when he took his own life. In all the circumstances it was submitted that there were no reasonable precautions which could have been taken by NHS staff which could have avoided Robert's death. Further, it was submitted that insofar as the NHS Forth Valley were involved there were no defects in any system of work which contributed to his death. It was submitted that the risk assessments carried out in relation to Robert were thorough, appropriate and in accordance with procedures. The risk of self-harm was considered and assessed. The risk assessment process involved pro forma documentation designed for the purpose of assessing the risk that young people in custody present. That formal documentation was supplemented by SPS and NHS staff awareness. Robust procedures were in place to identify the risk of self-harm and to prevent it. It was submitted that the Scottish Government has recognised the difficulties of protecting young people in custody from harm and an independent review of mental health and other support for young people entering custody had been announced by the Justice Committee. This followed public and parliamentary concerns about the death of several young people in custody, one of whom was Robert. As part of this process NHS Forth Valley had engaged with SPS to

assess and augment provisions for the population living at Polmont. I was advised that HM Inspectorate of Prisons, Healthcare Improvement Scotland and other relevant agencies undertook a regular routine inspection of Polmont towards the end of 2018 and this included consideration of the provision of physical and mental health services. A report of the inspection was to be published. An Expert Review of Mental Health Assessment and Support was mentioned and this was due to report.

[35] It was submitted that it was not possible to eradicate the risk of self-harm. In this case, on the evidence, NHS staff, who followed the correct procedures and exercised their professional judgment, assessed Robert as not presenting an apparent risk of self-harm and this was supported by those who saw Robert most frequently in the days and hours before his death.

[36] In relation to the Transitions Report which referred to the earlier incident involving Robert on 27 October 2016 while a resident at St Mary's, it was submitted that a hard copy had been made available for the rule 95 case conference on 16 November 2016 and it had been emailed by Mr Richardson to social worker Mhairi Kelso and prison officer Stewart Mustard on 17 November 2016. It was acknowledged that Mr Smith could not recall reading the information about the ligature incident but his evidence was that he did not believe that, had he known about the incident, it would have altered the risk assessment at that time. Mr Richardson, when he emailed the Transitions Report to the said staff expected them to read it.

[37] In relation to the further evidence regarding healthcare risk assessment on reception reference was made to Lesley McDowall's evidence that only those who

returned from court convicted and who also had a change to their liberation date required to be seen by a healthcare professional. Lesley McDowall highlighted that resource constraints required that groups identified as highest risk were given healthcare assessments on return from court. Even now, if Mr Wagstaff returned from court convicted but with no change to his liberation date there would be no mandatory assessment carried out by a healthcare professional.

DISCUSSION AND CONCLUSIONS

[38] The essential facts are not in dispute. In summary, Robert was admitted to Polmont from St Mary's Kenmure where on 12 November 2016 he had been involved in an incident which led him to appearing on petition on 14 November 2016 on a charge of assault to severe injury and permanent disfigurement. He was remanded on that charge to Polmont although up to that point he had been serving a sentence at St Mary's in relation to another matter. Because of his age and perceived issues with those under 18 years he was placed initially in the Dunedin segregation unit (SRU) where Calum McCarthy was the unit manager. On arrival at Polmont, he was seen initially by SPS admission staff and as per the then "Act to Care" procedure he was assessed by a mental health practice nurse Joanne Brogan who carried out a healthcare risk assessment. At that stage Robert was assessed as presenting no apparent risk of self-harm. Joanne Brogan completed the healthcare risk assessment in paper form and also made an entry in the Vision System accessed by NHS staff. This is to be distinguished from the PR2 system accessible by SPS staff.

[39] There was a rule 95 case conference on 16 November 2016 at which a hard copy of the Transitions Report from St Mary's was available. It had been received by the SPS on 14 November and although seen by those at the rule 95 meeting was not forwarded on to prison officer Stewart Mustard within SRU and Robert's prison based social worker Mhairi Kelso until 17 November. It is not known, and not recorded, what, if anything, those recipients made of or did with that information. The report contained the following information:

> "On 26 October, Robert assaulted a teacher by biting him on the chest. Later during that night, Robert appeared to be under the influence of an unknown substance and as a result he became agitated, wrecking his bedroom, urinating everywhere and flooding his bedroom.
>
> On 27th of October, Robert remained under the influence and required support. He was later found with a ligature around his neck and required close supervision as a result."

That particular information is not mentioned in the report of the case conference nor any subsequent case conference. The report goes on to describe further violent behaviour and also the assault on 12 November 2016 and the focus is on such behaviour and the strong language of the Transitions Report in that regard. Following his admission to Polmont, Robert was seen by mental health services on an ad hoc basis and also the Addictions Team. During these assessments, he reported on at least two occasions that he was struggling with his mental health and on another occasion that he only thought of self-harm when under the influence of drugs or alcohol. He was also the subject of discussion at MDMHT (Multi–Disciplinary Health Team) meetings, the first one being held on 16 November 2016. He was never made subject to any measures under the SPS

Prevention of Suicide Strategy. He was, it appears, ultimately transferred to Iona Hall where he remained until his death, having been removed from rule 95(11) by decision of the case conference of 6 December 2016. On 19 January 2017, he was convicted of the assault arising out of the incident in St Mary's and sentence was deferred until 16 February 2017. No healthcare risk assessment was carried out on his return. The prevention of suicide strategy was now called "Talk to Me" which had replaced "Act to Care" as of 5 December 2016, but the essentials of the policy remained the same, including the requirement of a healthcare risk assessment. On his return from court Robert appeared to be in good spirits. However, he told Prison Officer Derek Watson that he expected another sentence.

[40] Up to this point, the incident at St Mary's on 27 October 2016, when Robert had been found with a ligature around his neck, was not mentioned or discussed by anybody working within Polmont. There is no record of it within the PR2 or Vision systems. The first occasion in the SPS records where it was acknowledged is in the DIPLAR, (Death in Prison Learning, Audit & Review) report compiled after his death, the review being held on 9 March 2017. The report referred to the incident as "an attempted suicide".

[41] Given the evidence of Jeffrey Richardson I have concluded that it is likely, had he read the Transitions Report, and appreciated the nature and significance of the information in it, then he would have recorded this information on the SPS PR2 system accessible to all prison staff including those who would be dealing with Robert on a regular basis. James Smith accepted that the information was significant. If Mr Smith

did say, as was contended in submissions, that had he known of it, it would not have altered his risk assessment at the time (although I do not have a note of that evidence), I find that hard to accept given its nature and gravity. There is then the other staff, such as NHS staff, in relation to whom such information would be highly relevant. Mr Richardson's evidence was that he would have contacted NHS staff so that they would check on Robert. It was clearly highly relevant to anyone considering whether Robert was at risk of self-harm and whether he should be made the subject of the SPS Prevention of Suicide in Prison Strategy "Talk to Me". Ideally, the information ought to have been made available to NHS staff and accessible through the Vision System to which they had access. The focus of the Mental Health and Addiction Teams appears to have been on Robert's anger issues from the forensic psychology perspective with a view to assessing and addressing the risk he posed to others. None of the witnesses appear to recollect why entries relating to his mental health had been made. For example, Mrs Sneddon did not recollect why the entry on 18 November 2016 on the Vision System referring to Robert struggling with his mental health, although denying thoughts of suicide or self-harm, was there. Another example: Donald Macpherson could not remember why it was that references in the note of the meeting on 21 December 2016 to Robert's anxiety and depression were there. This was the last meeting that Robert had with the Mental Health Team and in it it was noted that he only thought of self-harm when under the influence of drink or alcohol. There was no evidence that this statement was given any weight at all by the witness who "imagined" he was going to be safe in the absence of drugs or alcohol. I would suggest that such

information taken along with the earlier report of the incident in St Mary's, had it been known about and appreciated, would have set alarm bells ringing for those staff who were dealing with Robert and who could, on the evidence, initiate the suicide prevention strategy at any time.

[42] I accept the evidence of all the witnesses that they had in fact no concerns that Robert was at risk of self-harm or suicide. That is quite a different thing from saying that they ought not to have had any concerns. In my view, had the information I have mentioned been made available, appreciated and disseminated then there ought to have been an immediate concern, and the subsequent disclosures that he was struggling with his mental health and had thoughts of self-harm could be seen with that history in mind. I have concluded that it would have been likely in those circumstances that those dealing with Robert, and in particular the mental health team, would have seriously considered the application of the suicide prevention strategy which could have resulted in measures being taken to secure his safety.

[43] There is then the question of the failure to undertake a healthcare risk assessment in relation to Robert following upon his conviction and return to Polmont on 19 January 2017. There appears to have been confusion as to whether or not Robert ought to be the subject of a healthcare risk assessment. Martin Troy, the operation officer who dealt with Robert's reception that day, thought at the time that only when a prisoner was sentenced or was a new admission could there be any requirement for a healthcare assessment. That is in spite of the terms of the guidance on "Talk to Me" which strategy had been in place from the end of the previous year that prisoners returning after

conviction following remand ought to have such an assessment (which is replicated at the top of the Healthcare Risk Assessment Form). He said things were different now and that since the early part of 2018 all convicted prisoners were assessed, but he did not know how he found out about that. Lesley McDowall's evidence was perplexing, particularly as she was speaking from a position of authority as Health Strategy and Suicide Prevention Manager within the SPS. When she gave evidence on the second day of the inquiry she said that, in accordance with the guidance, if a prisoner has gone from remand to conviction and also when a prisoner is sentenced then he is seen by a healthcare professional. She was responsible for training in the strategy. However when she gave further evidence on the third day of the inquiry her position seemed to change. She indicated that, in spite of what the guidance said, no healthcare assessment was required unless the earliest date of liberation of the prisoner had changed, in other words, unless there had been a change in circumstances.

[44] The guidance on the issue, where a prisoner is received following conviction from remand is at least clear, although in my view inadequate in other respects. The guidance, effective 5 December 2016, states (at Part 2, at page 7) :

> "Healthcare Risk Assessment
>
> It is imperative that this assessment is carried out by a healthcare professional who has been appropriately trained in the Talk to Me strategy. A Healthcare Assessment should be carried out if the individual is an admission, transfer, or has returned to court convicted from remand."

There was therefore a requirement for a healthcare assessment at the time Robert was received following his conviction when he had become a convicted prisoner from

remand, albeit he was already a convicted prisoner and serving a sentence on another matter. Curiously, and contrary to what the witnesses thought was the practice, the guidance does not refer to the requirement for a healthcare assessment on sentence. It simply refers to the requirement on a prisoner being admitted, transferred or convicted from remand. Further Lesley McDowall's view, at least as originally expressed, was at odds with the view of Martin Troy the operations officer who was directly involved in the reception system. It may be that a pragmatic approach has been developed given the resources available to the prison system and the number of prisoners received on any given day, priority being given to those perceived to be high risk. That was suggested in submissions to have been alluded to in the evidence of Lesley McDowall, although I have no note of that. However, if that is the case, then such a potentially arbitrary approach would in my view be unsatisfactory. There needs to be clear guidance.

[45] On its own, the lack of a healthcare risk assessment may not have been significant, particularly in light of the evidence of those dealing with Robert at the time of his reception indicating that they had no concerns and that he seemed to be in good spirits. However, if one also considers the failure to note and so appreciate the nature of the earlier incident at St Mary's, and the failure to share that information, then those dealing with Robert subsequently were at a serous disadvantage, and the lack of an assessment at this later stage assumes greater significance.

[46] The inevitable question arises as to whether or not precautions could reasonably have been taken which, had they been, might realistically have resulted in Robert's

death being avoided. It is explained in the Scottish Government's Policy Memorandum to the 2016 Act at the Bill stage that the

> "…reference to precautions which could 'reasonably' have been taken is intended to make it clear that it will not matter whether or not the death or accident was foreseeable. There is no intention to establish civil liability. Lord Cullen thought that there was considerable force in the view that the sheriff should employ hindsight when considering recommendations. The use of the word 'realistically' is intended to imply an actual rather than fanciful possibility that the recommendation might have prevented the death".

The Bill largely implemented the recommendations made in the 2009 Review of the Fatal Accident Inquiry Legislation led by Lord Cullen insofar as they had not already been implemented. Under the previous legislation which was in similar terms it was well accepted that the court's mind was directed at "lively possibilities" rather than "any chance at all no matter how slim". The new legislation reinforces that approach.

[47] Having considered the evidence very carefully, I have come to the conclusion that the reading of the Transitions Report and the sharing of the information relating to the prior incident in St Mary's represented reasonable precautions that could have been taken and further that had they been taken, they might realistically have prevented the death. Had the information been appreciated and shared on the systems available to both SPS and NHS staff, it is likely that serious consideration would have been given to making Robert the subject of the Prevention of Suicide in Prison Strategy "Talk to Me" and that he may therefore have been subject to appropriate measures depending on the perceived risk of self-harm including measures relating to clothing, furnishing and observation. That is not to say that such precautions would have prevented his death. They might on the balance of probabilities have prevented his death. There is not any

doubt in my mind that reading and disseminating the contents of the report represented a reasonable precaution for SPS staff to have taken. The failure was recognised by Mr Richardson, the Community Placement Officer, in his evidence. That information would have been highly relevant to those assessing Robert, including the mental health and addictions teams.

[48] As for the failure to undertake a healthcare risk assessment on 19 January 2017, this can hardly be regarded as anything other than a reasonable precaution given that the guidance expressly states that it should be done in circumstances when a prisoner returns to the establishment following conviction from remand. It matters not in my view whether or not he is already a prisoner serving a sentence on another matter. His status on the new matter changed and a fresh warrant from court issued. He was going to be sentenced on that matter at a later date. While his date of liberation did not change as a result of the conviction there would at least be a realistic possibility, indeed a probability, that that would be so following sentence. That is something that Robert would undoubtedly know and appreciate and he said as much to prison officer Derek Watson following his return from court. If the pragmatic test of a "change of circumstances" was being applied (which is not in the guidance) then there was undoubtedly a material change of circumstances in his position. I cannot however conclude, in light of the short period of time between his reception and his death that any healthcare risk assessment at that time might realistically have resulted in his death being avoided. In this respect I have also had regard to the evidence as to his demeanour at the time and any lack of concern regarding him. However, as indicated,

taken along with the earlier failure to identify the significance of the incident at St Mary's the failure to carry out a healthcare assessment assumes greater significance and it is for that reason that I have concluded that this is a factor relevant to the circumstances of death to be included in the determination.

[49] I am unable to conclude that there were any defects in any system of working which contributed to the death. This would require me to be satisfied on the balance of probabilities that a failure in system contributed to the death. That is quite a different test than that concerning reasonable precautions where the question is a precaution might realistically have avoided a death. I have come to the view that the failure to read and share the Transitions Report was human error rather than a failure in the system of working. While there is now guidance in the form of the Standard Operating Procedure relating to inter alia the dissemination of information to staff, that guidance, on the evidence of Mr Richardson, simply reflected the expected practice at the time, and I heard no evidence to the contrary. Therefore, it is reasonable to assume that the practice at November 2016 was to read and share relevant information in such a report with other staff. The failure to do so was accordingly human error. I have accordingly come to the view that there was no failure in system in that respect. In relation to the healthcare risk assessment, it is tempting to think that this again was human error, given the wording of the guidance instructing an assessment in the circumstances of Robert's reception, which is replicated on the form itself. However, there seems to have been a genuine difference among the witnesses as to what was required and my impression is that there continues to be confusion. That is heavily suggestive of a failure in system

itself rather than merely enforcement of system. However, if there was such a failure in system in relation to the healthcare risk assessment, I could not have been satisfied, on the balance of probabilities, that it was causally linked to the death for the reasons already explained. The failure to carry out an assessment is nonetheless a factor relevant to the circumstances of the death as explained above.

[50] My conclusions are reflected in the determination under section 26(2) of the 2016 Act and also the recommendations I have made in terms of section 26(4). The first recommendation relates particularly to Polmont, and to the identification and sharing of relevant information in documents such as Transitions Reports in relation to young persons received there. It may be suggested that this recommendation has been implemented in light of the evidence of Jeffrey Richardson concerning his current practice of reading such reports and his reference to the Standard Operating Procedure concerning the sharing of relevant information. However, he also indicated that the practice at the time of Robert's reception would have been the same, and yet the information was not identified nor the relevant information shared. Hence I have decided that a recommendation is appropriate to reinforce the importance of identifying and sharing information, and for consideration of the practical ways in which the latter can be done. In that regard it seems to me to be relevant to consider the different systems on which information is held electronically. For example, SPS staff input and access information on the PR2 system and NHS staff input and access information on the Vision system, but as I understand it, neither has access to the other. That is something which could be addressed, in so far as it is practicable to do so, in order that both SPS

and NHS staff can be fully informed in their task of dealing with or assessing an individual.

[51] As regards the healthcare risk assessment process, I have limited my recommendation to seeking clarification in the guidance as to the circumstances in which such an assessment be carried out in light of the evident confusion on the issue. Aside from the difference of opinion on what was required as a matter of practice, I did not hear any evidence, expert or otherwise, as to the particular circumstances in which such an assessment *should* be carried out and accordingly I have been unable to make such a recommendation. However, it may be thought that it would be appropriate that such an assessment be carried out where an individual is received (1) on first admission, (2) on transfer from another institution, (3) on the individual having been convicted, whether from remand or not, and whether already serving a sentence or not, and (4) following sentence of detention or imprisonment. It seems to me that such criteria would be consistent with the current guidance taken along with the evidence of the practice that such an assessment is carried out on sentence. Further, each of the criteria would in my view represent a change in a prisoner's circumstances – a criterion relied upon by several of the witnesses. While the evidence related to the process at Polmont, given that the guidance appears to apply across the prison estate, this recommendation may be seen as of general application.

[52] Following on from that, my final recommendation is intended to bring home the importance of regular training within Polmont in relation to the SPS suicide prevention strategy and in particular the circumstances in which it can be invoked in relation to an

individual. Quite apart from the failure to read and appreciate the contents of the Transitions Report, I was struck by the witness evidence of either no recollection or lack of concern in spite of reports that Robert was struggling with his mental health and on one occasion reporting that he thought of self-harm when under the influence of alcohol or drugs. I accept that there was evidence of training in the strategy, and accept that those dealing with Robert should be allowed to exercise their professional judgment, but the evidence in this case does leave me wondering why such reports were not taken more seriously and suggests a focus for training.

FURTHER OBSERVATIONS

[53] I have made no findings or recommendations as regards the audit of the suicide prevention strategy. There is an audit procedure now in place in relation to Reception Risk Assessments (RRA's) – the GMA document dated 26 October 2018 – although there was not at 19 January 2017. However, there was no evidence upon which I could base a conclusion that an audit would realistically have avoided the outcome, particularly in light of the short time between Robert's reception on 19 January and his death on 20/21 January.

[54] As indicated, the content of the Transitions Report referring to the incident at St Mary's on 27 October 2016 (described in the review report as "an attempted suicide") was noted at the DIPLAR (Death in Prison Learning, Audit & Review), where it was observed that none attending the review were aware of it. However, it was accepted by Lesley McDowall, at least when she first gave evidence, that the review ought to have

picked up on the failure to carry out a healthcare risk assessment. While, as we have seen, the failure to carry out such an assessment cannot be causally connected to the death, the failure to note the omission must considered to be a learning point for future reviews.

FINAL COMMENTS

[55] I accept that it is not possible to eradicate the risk of self-harm and that mental health issues affect many young people which issues might have a relation to a multiplicity of factors. I accept that many of the staff did their best to follow the correct processes and procedures and to exercise their judgment. That judgment was that Robert presented as no apparent risk of self-harm. However that judgment was exercised in ignorance of highly relevant information from St Mary's and it is difficult not to conclude that their judgment might have been different had they been aware of it.

[56] In this Note to the Determination, I have attempted not only to explore the circumstances of Robert's death, but help the relevant authorities to identify steps that can be taken to prevent deaths in such circumstances in the future. I understood at the time of submissions that the issue of mental health in young people entering custody is being considered by the Scottish Government and relevant agencies following public and parliamentary concern. I can only express a sincere hope that improvements can be made which reduce the risk of suicide in prison. As will be apparent from this Determination, it is not just a question of formulating policy and practice. It is vitally important to ensure that whatever processes and practices have been or are to be put in

place, they are understood by staff, enforced in practice and reinforced by regular training.

[57] It appears that Robert was a young man who had had a difficult upbringing. He had complex issues including issues relating to his mental health. He had been prone to the use of violence prior to his reception at Polmont and had, it would appear, attempted self-harm. Whatever is thought of the crimes he committed, it is always tragic when someone so young takes his own life.

[58] It only remains for me to offer my condolences to his family and friends.