SHERIFFDOM OF GRAMPIAN, HIGHLANDS AND ISLANDS AT INVERNESS

[2020] FAI 18

INV-B341-19

DETERMINATION

BY

SHERIFF CHRISTOPHER DICKSON

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

into the death of

ZACH AARON BANNER

Inverness, 22 April 2020

Determination

The sheriff, having considered the information presented at the inquiry, determines 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"):

1. **In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred):**

   That the late Zach Aaron Banner, born 11 March 1995, died at 10.00 hours on 3 January 2018 at Raigmore Hospital, Inverness.

2. **In terms of section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred):**

   No finding is made as the death did not result from an accident.

3. In terms of section 26(2)(c) of the 2016 Act (the cause or causes of death):

That the cause of death was:

(a) Hypoxic brain injury

due to (or as a consequence of):

(b) Hanging.

4. In terms of section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in death):

No finding is made as the death did not result from an accident.

5. In terms of section 26(2)(e) of the 2016 Act (any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided):

There are no precautions which could reasonably have been taken that might realistically have resulted in the death being avoided.

6. In terms of section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or the accident resulting in death):

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

7. In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death):

The other facts relevant to the circumstances of the death are:

1. When a detained person is being transferred from the police custody suite to court the police custody staff complete a Personal Escort Record. The Personal Escort Record is the primary document used to transfer information

between agencies. It is completed by the dispatching agency (the Police Service of Scotland), passed to the transporting agency (at the relevant time G4s) and then on to the receiving agency (usually the Scottish Prison Service). The purpose of the Personal Escort Record is, amongst other things, for the dispatching agency to pass on any current information about risk factors to both the transporting and receiving agency.

2. Mr Banner's Personal Escort Record included the following additional risk information:

> "PAVA sprayed - Doused himself and 2 police with petrol and brandished naked flame."

3. Mr Banner's Personal Escort Record did not fully reflect all the relevant information obtained from and about Mr Banner during his time in police custody. In particular, Mr Banner had: (i) stated to police officers in the police yard that he had doused himself in petrol in an effort to set himself on fire to kill himself; (ii) stated that he was suicidal on arrival at the police station; and (iii) stated to the mental health nurse that assessed him in police custody that he would attempt to hang himself if he was remanded. The Personal Escort Record ought to have included a summary of this information, which would have resulted in it being passed on to the prison staff.

4. That information would have been used by the prison staff to assess Mr Banner under the "Talk to Me" strategy and would have resulted in him

being questioned about that information. Mr Banner's answers to those questions would have informed the overall risk assessment undertaken under the "Talk to Me" strategy. However, the fact that the said information was not passed on to the prison staff did not result in a different assessment being reached when he was initially assessed by the prison staff under the "Talk to Me" strategy on 29 December 2017. Had the prison staff been aware of the said information it is highly likely that Mr Banner would have been considered to be "At Risk" of suicide and managed under the "Talk to Me" strategy. However, in any event, the prison staff had sufficient information before them, when conducting the initial assessment of Mr Banner, to assess him as being "At Risk" of suicide and placed him on the "Talk to Me" strategy.

Recommendations

1. **In terms of section 26(1)(b) of the 2016 Act (recommendations (if any) as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances):**

   The following recommendations are made:

   1. That once normality has resumed following the Covid-19 pandemic, the Police Service of Scotland, in consultation with the current transporting

agency, local Health Boards and the Scottish Prison Service, should review the contents and layout of the current Personal Escort Record in light of this determination and consider whether any improvements could be made to ensure, as far as reasonably practicable, that all relevant information, including, in particular, information in relation to: (i) the risk of suicide or self-harm; and (ii) the risk of harm to others, is included on the Personal Escort Record.

2. That once normality has resumed following the Covid-19 pandemic, the Police Service of Scotland should consult with local Health Boards and the Scottish Prison Service as regards the system or systems of sharing medical information between police custody suites and local prisons with a view to considering whether a system, based on the Highland Health Board pilot, ought be rolled out in other parts of the country.

NOTE

Introduction

[1] This inquiry was held into the death of Zach Aaron Banner. Mr Banner used a torn duvet to hang himself from the top bunk in cell 2/3 of B Hall, HM Prison Inverness, in the early hours on 1 January 2018. On being discovered he was transferred to Raigmore Hospital, Inverness, however, he was unable to recover and sadly passed away in that hospital on 3 January 2018. The death of Mr Banner was reported to the Procurator Fiscal (hereinafter referred to as "PF") on 4 January 2018. After a number of preliminary hearings the inquiry took place over 7 days on 18 and 19 November 2019, 16 and 18 December 2019 and 10 to 12 February 2020.

[2] The parties were represented as follows:

(1) Mr Main, PF Depute, represented the Crown;

(2) Mr Gilbride, Advocate, represented the family of Mr Banner;

(3) Mr Mulgrew, solicitor, represented Sheila Neil, police custody nurse;

(4) Mrs Leslie, solicitor, represented the Chief Constable of the Police Service of Scotland;

(5) Mr Rogers, solicitor, represented Margaret Balfour, mental health nurse;

(6) Mr Smith, solicitor, represented the Scottish Prison Service (hereinafter referred to as "SPS");

(7) Mr Gillies, solicitor, represented Prison Officers' Association Scotland; and

(8) Mr MacSporran, Advocate, represented the Highland Health Board (hereinafter referred to as "HHB").

[3] The representatives had conscientiously agreed a significant amount of evidence in two joint minutes of agreement which ran to a total of 25 paragraphs. That resulted in the need for oral evidence to be reduced. I heard oral evidence from the following witnesses:

1. Margaret Balfour, mental health nurse, who, together with Colin Fieldsend, assessed Mr Banner, whilst in police custody at Burnett Road Police Station, Inverness on 29 December 2017;
2. Colin Fieldsend, mental health team leader, who, together with Margaret Balfour, assessed Mr Banner, whilst in police custody on 29 December 2017;
3. Sheila Neil, police custody nurse overnight between 28 and 29 December 2017;
4. Sergeant David Cameron, custody sergeant overnight between 28 and 29 December 2017;
5. Inspector Peter Hindley, who had management responsibility for the custody suite at Burnett Road Police Station, Inverness;
6. Dr Sian Margaret Jones, General Practitioner, who assessed Mr Banner at HM Prison Inverness on 30 December 2017;
7. Robert John Hendry, Prison Officer (hereinafter referred to as "PO"), who received Mr Banner into HM Prison Inverness on 29 December 2017 and conducted an assessment of him;
8. Suzy Calder, HHB, who was, amongst other things, Head of Service for Prison and Police Custody Healthcare, who reviewed the police and prison healthcare provision following Mr Banner's death;

9. Carey Kerr, Staff Nurse, who dealt with Mr Banner at HM Prison Inverness between 29 December and 31 December 2017; and
10. John Kelly, PO, who was acting First Line Supervision at HM Prison Inverness between 29 December and 31 December 2017 and dealt with Mr Banner during those dates.

[4] Margaret Balfour, Colin Fieldsend, Sheila Neil and Sergeant Cameron gave evidence about Mr Banner's care in police custody at Burnett Road Police Station, Inverness, between 28 and 29 December 2017. Inspector Hindley had management responsibility for the custody suite at Burnett Road Police Station and gave evidence about the custody suite procedures and the subsequent enquiries he made in respect of the care of Mr Banner whilst in police custody. Dr Jones gave evidence about her assessment of Mr Banner at HMP Inverness (all further references will be to this prison) on 30 December 2017. Robert Hendry worked at the prisoner reception at the prison and gave evidence about receiving Mr Banner into the prison on 29 December 2017, following his transfer from court, and conducting an initial assessment of him. Carey Kerr gave evidence about conducting a healthcare assessment of Mr Banner at the prisoner reception at the prison on 29 December 2017, immediately after he was assessed by PO Hendry, and the further dealings she had with him at the prison between 29 December 2017 and 31 December 2017. Suzy Calder gave evidence about conducting a review of the healthcare provision in police custody and at the prison following the death of Mr Banner and the making of a number of improvements to that provision. I

found all 10 witnesses to be credible and generally reliable and considered that they were all doing their best to assist the inquiry.

The Legal Framework

[5] This inquiry was held in terms of section 1 of the 2016 Act. Mr Banner died in legal custody, and, therefore, the inquiry was a mandatory inquiry held in terms of section 2 of the 2016 Act. The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (hereinafter "the 2017 Rules") and was an inquisitorial process. The Crown represented the public interest.

[6] The purpose of the inquiry was, in terms of section 1(3) of the 2016 Act, to establish the circumstances of the death of Mr Banner and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It was not the purpose of the inquiry to establish civil or criminal liability (see section 1(4) of the 2016 Act). The manner in which evidence is presented to an inquiry is not restricted. Information may be presented to an inquiry in any manner and the court is entitled to reach conclusions based on that information (see Rule 4.1 of the 2017 Rules).

[7] Section 26 of the 2016 Act sets out what must be determined by the inquiry. Section 26 of the 2016 Act is in the following terms:

> "**26 The sheriff's determination**
>
> (1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out—
>
> (a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and

(b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.

(2) The circumstances referred to in subsection (1)(a) are—

(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,

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

(3) For the purposes of subsection (2)(e) and (f), it does not matter whether it was foreseeable before the death or accident that the death or accident might occur—

(a) if the precautions were not taken, or

(b) as the case may be, as a result of the defects.

(4) The matters referred to in subsection (1)(b) are—

(a) the taking of reasonable precautions,

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

(c) the introduction of a system of working,

(d) the taking of any other steps,

which might realistically prevent other deaths in similar circumstances.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to—

(a) a participant in the inquiry,

(b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature."

[8] Whilst it is not necessary for me to make findings in fact in a fatal accident inquiry determination (see *Fatal Accident Inquiry into the Clutha Vaults Helicopter Crash* [2019] FAI 46 at para 139), I consider it was helpful to do so in this determination. In this

Note I will, first, set out the summary of the facts that I have found proved. I have structured the summary of facts into the following chapters: (1) Mr Banner's time in police custody between 28 and 29 December 2017; (2) Mr Banner's time on remand at HM Prison Inverness from 29 December 2017 to 1 January 2018 and subsequent events; and (3) improvements made to the healthcare information sharing between the police custody suite and the prison. Second, I will set out a summary of the submissions made by the Crown and the other parties. Third, I will consider the circumstances identified in section 26(2)(a) to (g) of the 2016 Act and explain, with reference to the evidence before the inquiry, the conclusions I have reached. Finally, I will explain the recommendations that I consider to be appropriate.

Summary

[9] I found the following facts admitted or proved:

Mr Banner's time in police custody between 28 and 29 December 2017

1. That Zach Aaron Banner was born on 11 March 1995 and ordinarily resided in Alness.
2. That Burnett Road Police Station, Inverness contains a custody suite with 42 cells. The on-duty custody sergeant is, whilst on duty, in charge of the custody suite and he or she is responsible for the care of the persons held in police custody. A number of police custody security officers (hereafter referred to as "PCSO") work in the custody suite. They are civilian employees of the police and assist the custody sergeant in running the

custody suite. The custody suite also normally has a police custody nurse on-duty twenty four hours a day. The police custody nurse is an employee of the HHB. The custody suite operates 24 hours a day with all staff working shifts. The custody suite has a medical room which can be used to examine, assess and provide treatment to persons in custody. The police operate a national custody computer system (hereinafter referred to as "the police custody computer") which the custody sergeant and the PCSOs have access to. A detained person's stay in police custody is recorded in an individual custody record on the police custody computer. Any medical intervention by the custody nurse, in respect of a detained person, can be recorded on an "Adastra" computer system operated by the NHS. The custody nurse or any other medical professional can also record a medical intervention, in respect of a detained person, in paper notes (hereinafter referred to as "medical notes"). These medical notes are kept within the custody suite. Police staff do not have access to these medical notes or the Adastra computer system for confidentiality reasons.

3. That if a detained person is exhibiting mental health difficulties there are number of options available to the custody sergeant. The custody sergeant can: (i) have them assessed by the police custody nurse; (ii) with their consent, have them referred to the HHB mental health team (the referral will normally be done by the police custody nurse), who will attend the police station and assess them; (iii) call out a Forensic Medical Examiner (who is

typical a GP) to assess the person; and (iv) ask the forensic mental health team to assess the person at court. These options can be used in combination with each other.

4. That when a detained person is being transferred from the custody suite to court one of the PCSOs on duty will complete a single page Personal Escort Record (hereinafter referred to as "PER"). The PER is the primary document used to transfer information between agencies. It is completed by the dispatching agency (the Police Service of Scotland), passed to the transporting agency (which was, at the relevant time, G4s and is now GEOAmey) and then on to the receiving agency (usually the SPS). The purpose of the PER is, amongst other things, for the dispatching agency to pass on any current information about risk factors to both the transporting and receiving agency. In December 2017 the transferring agency was G4s.

5. At the time of Mr Banner's death a blank PER form contained, amongst other things, the following: (i) space to provide details of what the detained person was charged with; (ii) space to insert the detained person's personal details; (iii) a tick box to indicate whether there were any risk factors; (iv) a tick box to state whether the supervision level of the detained person was low, medium or high; (v) a series of 26 tick box options setting out commonly encountered risks / useful information, including: (a) "medical condition", (b) "psychiatric condition", (c) "seen by doctor / nurse", (d) "drugs / alcohol issues", and (e) "suicide / self harm / bereavement"; (vi) space to provide

additional risk information; (vii) space to insert the detained person's property seal number; (viii) the outward escort "from" and "to" details (with this being typically from the custody suite to court); and (ix) the inward escort "from" and "to" details if required (with this being typically being from the court to prison).

6. A PER is normally completed in the early hours of the morning by the nightshift PCSO. Information can be added to the PER by the police custody staff at any point until the detained person is collected by the transporting agency. The transporting agency can also add information to the PER and it is the transporting agency that would insert the details of any inward escort (which would usually be from court to prison) after the outcome of the detained person's court appearance had been ascertained.

7. That about 16.05 hours on Thursday 28 December 2017 police officers attended at an address in Firhill, Alness to execute a search warrant. At that time they saw Mr Banner, who was not known to them, crouching down beside a quad bike with a petrol container on the ground beside him. When they engaged him in conversation Mr Banner would not make eye contact with them and provided a false name to the officers. When Mr Banner was asked to move towards the police officers, he picked up the petrol container and then placed it on the step of the back door of the address. Thereafter, when one of the officers took down his hood, challenged him about the details he had provided and took hold of his wrists, Mr Banner grabbed hold

of the petrol container, opened it and splashed petrol over himself and said officers. Mr Banner then struggled with the officers and in the course of doing so shouted "get the fuck off" and "I'll do it!". Mr Banner was sprayed with PAVA spray (an incapacitant spray similar to pepper spray). Once Mr Banner was restrained, his pockets were searched and a box of matches was found within his jacket pocket.

8. Mr Banner was then transported to Burnett Road Police Station, Inverness (all future references will be to this police station). When in the back yard of the police station Mr Banner alleged to a police officer that he was depressed following Christmas, that he did not mean to get petrol on the attending officers and that he had been attempting to douse himself with petrol in an effort to set himself on fire to kill himself.

9. Mr Banner was brought to the charge bar area of the custody suite at 17.22 hours on 28 December 2017. The police then assessed Mr Banner's vulnerability by asking him a series of vulnerability questions. These are question asked of each person brought into police custody in order to allow the police to assess the person's vulnerability. The police then make a vulnerability decision, which results in the person being assessed as either of "high" or "low" vulnerability. The questions Mr Banner was asked (including question 21, which the police ask of themselves) and Mr Banner's responses were recorded on the police custody computer as follows:

    Q1: Do you have any injuries?

A: Yes

Notes: Sprayed with PAVA. States he has no other injuries

Q2: Have you had any knocks to the head in the past 48 hours?

A: Yes

Notes: States that his head slammed off the kerb during his arrest.

Q3: Are you dependent on alcohol?

A: No

Q4: Have you used alcohol in the last 24 hours?

A: No

Q5: Are you dependent on drugs or other substances?

A: Yes

Notes: Heroin, methadone and valium.

Q6: Have you used drugs or any other substances or psychoactive substances (commonly known as legal highs) in the last 24 hours?

A: No

Q7: Are you a regular user of psychoactive substances (commonly known as legal highs)?

A: No

Q8: Are you suffering from or have you previously suffered from withdrawal symptoms?

A: No

Q9: Have you ever attempted self harm or suicide?

A: Yes

Notes: Stated he is suicidal and he is trying to get in to New Craigs [*which is a hospital in Inverness which offers treatment for mental health issues*] today. States that he tried to set fire to himself today.

Q10: Do you have any thoughts at present of self-harm or suicide?

A: Yes

Notes: States that he is suicidal.

Q11: Do you have any mental health problems or have you ever received treatment for mental health problems?

A: Yes

Notes: Depression and anxiety Inverness 28/12/2016 28/12/2017

Q12: Are you suffering from any ongoing medical condition, allergies or infectious diseases?

A: Yes

Notes: Asthma ventolin as required

Q13: Do you take any prescribed medication?

A: Yes

Notes: Pregablin and valium

Q14: Are you currently taking any other medication that you haven't mentioned already?

A: No

Q15: Do you have any dental or medical implants or surgical plates or pins?

A: Yes

Notes: Pin in right foot

Q16: Do you have any dietary requirements?

A: No

Q17: Do you have any difficulties reading or writing?

A: No

[*there was no question 18 or 19, the record jumped from Q17 to Q20*]

Q20: Have you ever served in HM Armed Forces?

A: No

Q21: Are there any compliance or other issues that might affect the care of this custody?

A: Yes

Notes: Smells strongly of petrol.

After considering Mr Banner's responses, acting Sergeant Neil Burgess, who was the on duty custody sergeant at that time, made a vulnerability decision which was recorded on the police custody computer as follows:

"Level: High

Reason: Suicidal. Clothing soacked [*sic*] with petrol. PAVA sprayed. Appears to be under the influence of some substance.

Decision Time: 28/12/2017 17.30"

10. Mr Banner was, following the vulnerability assessment, strip searched, given an anti- harm suit to wear, placed in a CCTV cell, which could be monitored from a room in the custody suite, and placed on constant observations.

11. About 19.00 hours on 28 December 2017 Sergeant Cameron received a handover from acting Sergeant Burgess and became the on duty night shift custody sergeant. As such, Sergeant Cameron had overall responsibility for the care of all persons being held in the custody suite, including Mr Banner. By the time of the handover Mr Banner was no longer on constant observations and was being observed every 30 minutes.

12. Whilst Mr Banner was in police custody PCSO John Kirkbride checked him regularly at thirty minute intervals as per his care plan which was on the police custody computer. PCSO was not sure what the risk was for Mr Banner and just knew he had to check him every thirty minutes.

13. At some point during his shift Sergeant Cameron completed an episode report form on the police custody computer in respect of Mr Banner. The episode report form was in the following terms:

> "**Incident Summary:**
>
> Custody had doused himself and two officers in petrol at the locus, pava was deployed and once control gained a search was carried out and he was in possession of matches. On arrival at custody his clothing was seized and he made comments similar to he only wanted to kill himself. He was placed in a cctv cell on 30 minute obs.

Action taken:

Pava deployed at locus, control gained, clothing seized, ahs [*anti-harm suit*] issued and cctv cell on 30 mi obs."

14. About 03.30 hours on 29 December 2017 Mr Banner was within his police cell when he complained of having heart palpitations. As a result both Sergeant Cameron and Sheila Neil, who was the night duty police custody nurse, went to see Mr Banner in his cell. Whilst on route to Mr Banner's cell, Sergeant Cameron explained the circumstances of his arrest to Ms Neil. Ms Neil discussed Mr Banner's concerns with him and took his observations, which were normal. Ms Neil offered to refer Mr Banner to the mental health team for an assessment in the morning and Mr Banner agreed with this proposed referral. Shortly after assessing Mr Banner, Ms Neil recorded her assessment on the Adastra computer system. Ms Neil was able to access the Adastra computer system from the custody suite. Ms Neil's entry on the Adastra computer system in the respect of her assessment of Mr Banner was as follows:

"**Diagnosis**

Asked to assess as Custody had stated at time of arrest that he intended to kill himself, he had thrown petrol over 2 police officer s [*sic*] at the scene and himself.

His behaviour had been unpredictable at the time of arrival. He had been placed in an anti harm suit and on CCTV.

he [*sic*] had settled however a disruptive Custody had been placed in the next cell which had unsettled Zach.

He requested review as he felt his heart was racing.

On entering the cell, he was sitting upright wrapped in a blanket. I explained my reason for reviewing him which he presented as understanding. He then told me he had taken 100 plus valium just before his arrested [*sic*] and had been smoking cannabis – denies this is usual practice but had taken them on impulse just before their arrival – he has now been in Custody since 17.30

Able to speak in full sentences, regular rate and tone.

Observations as above

Pulse taken manually rate rhythm and strengh [*sic*].

Custody reassured at this time.

Discussed his mood, he states he has been feeling very low for sometime – referral made to th [*sic*] MHLT who will kindly review him in the morning.

Treatment

Observations

Prescriptions

Follow-up(s)

No Follow Up – Seen by mental health team before court."

The above entry is an accurate summary of Ms Neil's assessment of Mr Banner.

15. Ms Neil subsequently made contact with the out of hours mental health team and explained the circumstances of Mr Banner's arrest and how he presented to her. Ms Neil then arranged for the mental health team to attend the custody suite and assess Mr Banner.

16. At some point during the early hours of 29 December 2017 PCSO Kirkbride completed the PER for Mr Banner. The completed PER provided, amongst other things, the following information: (i) that Mr Banner had been charged with "attempted murder x 2"; (ii) Mr Banner's personal details; (iii) the box to indicate Mr Banner was a risk was ticked; (iv) the box to indicate Mr Banner being of medium supervision level was ticked; (v) of the series of 26 tick box options setting out commonly encountered risks / useful information, only the box "PAVA spray" was ticked; (vi) the tick boxes: (a) "medical condition", (b) "psychiatric condition", (c) "seen by doctor / nurse", (d) "drugs / alcohol issues", and (e) "suicide / self harm / bereavement" were all left blank; (vii) in the space to provide additional risk information it was stated "PAVA sprayed – Doused himself and 2 police with petrol and brandished naked flame."; (viii) Mr Banner's property seal number; (ix) that the outward escort was from "Inv PS" [*Inverness Police Station*] to "Inv Ct" [*Inverness Sheriff Court*] on 29 December 2017.
17. Neither police officer involved in the arrest of the Mr Banner alleged that he had brandished a naked flame during the incident described at finding in fact 7 and, accordingly, the PER was inaccurate in that respect.
18. The PER was completed prior to the out of hours mental health team assessing Mr Banner. PCSO Kirkbride ceased duty around 06.00 hours on 29 December 2017.

19. Sometime after 06.20 hours on 29 December 2017 Mr Banner was assessed by both Margaret Balfour, mental health nurse, and Colin Fieldsend, mental health team leader, within the medical room of the custody suite. About 06.45 hours Sergeant Cameron handed over to acting Sergeant Burgess who was the day shift custody sergeant. The mental health assessment of Mr Banner concluded after Sergeant Cameron had handed over to acting Sergeant Burgess and ceased duty. At that time the outcome of a mental health assessment could be verbally handed over to the custody sergeant in the following ways: (i) by the mental health nurse verbally handing over to the police custody nurse who then relayed the key information to the custody sergeant / staff; (ii) the mental health nurse providing a verbal handover to both the police custody nurse and the custody sergeant at the same time; or (iii) the mental health nurse providing a verbal handover directly to the custody sergeant without the police custody nurse being present.

20. Ms Balfour provided a verbal handover to Ms Neil of the outcome of her assessment of Mr Banner in the presence of Mr Fieldsend (hereinafter referred to as "the Balfour verbal handover"). An unknown member of police custody staff was present for at least part of the Balfour verbal handover. Ms Balfour also prepared a handwritten note of the outcome of her assessment of Mr Banner. The Balfour verbal handover included the key points set out in the said handwritten note. Ms Balfour's handwritten note (hereinafter referred to as "the Balfour note") was in the following terms:

"Requested to be seen by mental health team. Speech slurred & slow throughout. Spoke of lots of social stressors leading him to feel that life not worth living.

Long standing drug problem. Seen by Osprey House in the past. Claims he managed to stop methadone about 1 week ago. Did so for sake of his girlfriend but relationship now ended. States his family don't speak to him & when he seen his mother yesterday she shouted at him. Acknowledged that his family don't speak because of his history of anti-social behaviour.

Last night states he felt suicidal & intended taking petrol out of his quad bike in order to set fire to himself.

Denies he intended to harm anyone else.

Spoke of wanting to try to come off drugs & make a better life for himself but can't see how this is possible.

Claims if he is remanded he will attempt to hang himself but has future plans to go to Birmingham & find work if he is released.

No evidence of any acute mental illness.

Advised to speak to mental health nurses if remanded which he agreed to do.

[*signed M Balfour*]

OOH Triage Nurse"

The above note is an accurate summary of Ms Balfour's assessment of Mr Banner.

21. Ms Neil read Ms Balfour's handwritten note and the said note was placed with Mr Banner's medical notes in the custody suite. It is not known whether Ms Neil separately (and in addition to the Balfour verbal handover) communicated the contents of the Balfour verbal handover or the Balfour

note to the police custody staff. Neither the police custody computer or the PER were updated following Ms Balfour's assessment of Mr Banner.

22. During the morning of 29 December 2017, prior to Mr Banner leaving police custody to attend court, PCSO Gaye MacDonald gave Mr Banner his breakfast and asked him two pre-release questions, one regarding any thoughts of self-harm or suicide and the other regarding harming anyone else. Mr Banner answered "no" to both questions. PCSO MacDonald had no issues with Mr Banner whilst she was on duty. PCSO MacDonald was unaware that Mr Banner had been assessed by Ms Balfour and therefore unaware of the comments Mr Banner had made to Ms Balfour.

23. At 8am on Friday 29 December 2017, Mr Banner was released from police custody into the care of G4s. At that time, G4s were provided with Mr Banner's PER.

24. At some point after G4s arrived at the police station on 29 December 2017 to collect Mr Banner and take him to court a member of G4s staff inserted, in the 26 tick box section of the PER, a "Y" in the tick box stating "Cell Sharing Risk – Specify Below" and added in the space to provide additional risk information on the PER "Risk noted – multiper cell".

25. On 29 December 2017 Mr Banner appeared on petition at Inverness Sheriff Court containing 14 charges including housebreaking (2 charges), theft (4 charges), breach of bail (1 charge) and assaulting the two officers in

relation to the incident narrated at finding in fact 7. Mr Banner was committed for further examination and remanded in custody.

26. Following Mr Banner's court appearance G4s staff recorded on the PER that the inward escort was from "Inv Sc" [*Inverness Sheriff Court*] to "hmp Inv" [*HM Prison Inverness*].

Mr Banner's time on remand from 29 December 2017 to 1 January 2018 and subsequent events;

27. The fact that Mr Banner had told Ms Balfour, whilst in police custody, that if he was remanded he would attempt to hang himself, was not passed on to the SPS via the PER or any other medium. The SPS do not have access to the police custody computer and, at that time, the healthcare staff at the prison did not use the Adastra computer system.
28. About 16.18 hours on 29 December 2017 Mr Banner arrived at the prison, having been conveyed there by G4s staff. Mr Banner was taken to the reception of the prison and the staff there were provided with Mr Banner's PER and a warrant from the court authorising the prison to hold Mr Banner within the prison. Mr Banner was assessed at the prison reception by PO Robert Hendry, under the SPS "Talk to Me" strategy.
29. The key aims of the SPS "Talk to Me" strategy are: (i) to assume a shared responsibility for the care of those "At Risk" of suicide; (ii) to work together to provide a person centred care pathway based on an individual's needs,

strengths and assets; and (iii) to promote a supportive environment where people in the custody of SPS can ask for help. The "Talk to Me" strategy makes clear, at page 5, that the assessment process is "a dynamic process, where levels of risk often change, sometimes very quickly" and identifies, at page 5, that:

> "There is a common misconception that all suicidal behaviour can be predicted and this can place undue pressure on those involved in the process. Effective assessment should be evidence-based, consistent and should balance protective and risk factors to achieve a high standard of care."

30. All prison officers and other staff at the prison interacting with prisoners are trained in the "Talk to me" strategy. Each prisoner arriving at the prison is assessed using the "Talk to Me" strategy. Each prisoner arriving at the prison is first assessed in the reception by a PO and then by a prison nurse. If either the PO or the prison nurse consider that a prisoner is "At Risk" of suicide they are managed under the "Talk to Me" strategy.

31. The "Talk to Me" strategy: (i) focuses on care and management where multi-disciplinary participation at case conferences is key to the process; (ii) identifies that the care of those "At Risk" of suicide should involve interactive supportive contact; (iii) recognises that observation in itself is not enough, and should include input from community sources, family and key support where appropriate; (iv) requires individual care plans to be prepared; (v) seeks to ensure that those "At Risk" of suicide are cared for in a normal environment where they feel safe, comfortable and relaxed; (vi) seeks

to offer those "At Risk" of suicide with therapeutic interventions utilising an interactive regime delivered in an appropriate and supportive environment; and (vii) seeks to promote an asset based approached within the whole prison community where care planning for those "At Risk" of suicide identifies the protective factors that support health and well-being and promote self-esteem and coping abilities of individuals.

32. All persons trained in the "Talk to Me" strategy are trained to look for the following common warning signs (also known as "cues and clues") that may indicate that an individual is "At Risk" of suicide:

Verbal Signs

(1) Says they are going to complete suicide;

(2) Expresses guilt, anger, depression, hopelessness;

(3) Constantly dwells on problems;

(4) Makes frequent minor complaints as a pretext to see staff;

(5) Talks about suicide or self-harm;

(6) States they find prison difficult to handle;

(7) Expresses low self-esteem;

(8) Talks about bullying or vulnerability;

(9) Requests a change in location;

(10) Minimal engagement in conversation;

Non-Verbal Signs

(11) Changes in mood – up or down;

(12) Lack of motivation (e.g. not planning for home leave, parole etc.);

(13) Self-neglect or not eating;

(14) Tidying up affairs /giving away possessions;

(15) Withdrawal from company of others, social isolation;

(16) Irrational behaviour;

(17) Sleep disturbance;

(18) Anger and aggression (especially in young people);

(19) Minor physical complaints;

(20) Self-harm behaviour;

(21) Increased phone calls to family member;

(22) Changes in behaviour/acting out of character.

33. If a prisoner is being managed under the "Talk to me" strategy there will either be an immediate case conference or one arranged within 24 hours. If the case conference is not held immediately an immediate care plan will be prepared. At the first case conference the care plan will be either prepared (if an immediate case conference is possible) or reviewed (if an immediate case conference was not possible) and an assessment made whether the prisoner is "At Risk" of suicide. If the prisoner is considered to be "At Risk" of suicide at the first case conference a further case conference will be scheduled within

7 days and the care plan will be implemented in the meantime. At the next case conference an assessment will be made whether the prisoner remains "At Risk" of suicide; if such an assessment is made then the care plan will be reviewed and a further case conference will be scheduled (with the care plan, as reviewed, being implemented in the meantime). This cycle will then continue until the prisoner is assessed as being of no apparent risk to himself. Once that assessment is made the case will be closed, the prisoner will no longer be managed under the "Talk to Me" strategy and a transitional action plan for the prisoner will be completed.

34. At 16.20 hours on 29 December 2017 PO Hendry commenced his reception risk assessment of Mr Banner under the "Talk to Me" strategy. The assessment was recorded in writing on a pre-printed form. Part 4 of the written assessment was completed as follows:

> "**Part 4: Assessment of Behaviour, Attitude and Risk**
>
> The officer will interview the individual to identify any concerns they may have. The officer should consider if this is the first time in custody; if the sentence/remand was expected and if they expect any issues with family contact. The officer should also determine during the interview if the individual feels suicidal at the moment.
>
> Summarise interview: *not surprised at being remanded is feeling the affects of drug withdrawal but does not feel suicidal or like self-harming.*
>
> Comment on individual's presentation throughout discussions considering eye contact, mood, anxiety or anger (list not exhaustive):
>
> *good eye contact. Coming off drugs so feeling rough but mood ok*"

35. At 16.50 hours on the same day PO Hendry assessed Mr Banner as being of "no apparent risk" and did not initiate the "Talk to Me" strategy. PO Hendry then passed Mr Banner to the prison nurse for the healthcare risk assessment to be completed. The mental health nurse would normally finish work at 17.00 hours.

36. Mr Banner was then assessed by staff nurse Carey Kerr under the "Talk to Me" strategy. Staff nurse Kerr was not a mental health nurse. Staff nurse Kerr completed a written healthcare assessment which was in the following terms:

> "I confirm that I have read and understood the PER form and all information recorded from the Officer Assessment (*If not, discuss and clarify with relevant officer).* [*tick box ticked*]
>
> Assessment of Behaviour, Attitude and Risk
>
> As part of the assessment the nurse should consider if the individual has any current or previous mental health issues including treatment and psychological support. The health care professional should determine if the individual has previously attempted suicide or self-harm or if they currently have any thoughts of suicide or self-harm.
>
> Summarise responses: *Expected admission to HMP Inverness. Openly discussed previous overdose/hanging attempt in July/June + the incident yesterday where he poured petrol over himself + police officers + tried to set them alight. States did not intend to harm himself. States only did it to make the police go away.*
>
> Comment on individual's presentation throughout discussions considering eye contact, mood, anxiety or anger (list no exhaustive):
>
> *Under the influence of drugs on admission. Speech slurred at times. Unsteady on feet.*

> *Good eye contact. No signs of anxiety, low mood. Previous and recent self-harm/suicide attempts. Recommended period of observation. Also recommended drugs protocol.*"

37. At 17.30 hours on 29 December 2017 staff nurse Kerr concluded that Mr Banner was "At Risk" of suicide under the "Talk to Me" strategy and a first case conference was scheduled. As Mr Banner was also under the influence of drugs, he was assessed under the SPS's Management of an Offender at Risk of a Substance (hereinafter referred to as "MORS") policy. Under MORS, Mr Banner was initially placed on 15 minute visual and verbal observations and placed in an observation cell. At that point in time Mr Banner was being managed under both the "Talk to Me" strategy and the MORS policy.

38. Around 18.00 hours on 29 December 2017 staff nurse Kerr concluded a pre-case conference healthcare assessment. The pre-case conference healthcare assessment identified a number of risk factors. Staff nurse Kerr selected (by ticking a box) the following risk factors as being present: (i) history of self-harm or suicide attempts; (ii) history of diagnosis of mental health issues; (iii) history of drug or alcohol misuse; (iv) significant mood changes; (v) significant psychological reactions to stress; (vi) recent changes to prescribed medications; (vii) traumatic inter-personal problems; significant life events; (viii) expression of suicidal intent/ideas; and

(ix) expression of self harm. Staff nurse Kerr accurately recorded her record of interview as follows:

> "Seen in reception by nurse on admission. Visibly under the influence of a substance. PER stated 'Doused himself and 2 police with petrol and brandished naked flame'. States yesterday he took 50 x MSJ tablets in the morning then another 100 before arrival of police. Stated he was heavily under influence of the tablets when the police arrived. States at the time he thought if he covered himself in petrol and set himself alight then the police would go away and leave him alone. Stated he did not intend any suicide or self-harm from it although he did admit that he would have been 'not bothered' if he got burned at the time. Also discussed previous hanging attempt and over-dose attempts in June / July. States at this time he was 'in a low place'. States was also under the influence of drugs at this time. Currently withdrawing from self-imposed sudden stopping of methadone and recent heroin use. Will be referred to addictions team, mental health team and will be reviewed by G.P. in the morning. A period of observations recommended for safety due to very recent attempt at self harm and due to currently being in withdrawal and under influence of MSJ tablets. Health centre staff recommend drug protocol commenced also. Currently on observations – also to be reviewed"

Another name for MSJ tablets is "street valium". The reference to "very recent attempt at self harm" is a reference to the petrol dousing incident.

39. At about 18.45 hours on 29 December 2017 a first case conference was held under the "Talk to Me" strategy. The case conference was attended by Mr Banner, PO Johnson, staff nurse Kerr and Jim Kelly, Acting First Line Manger (a FLM is a prison officer with management responsibilities). The case conference was chaired by Mr Kelly. Mr Banner stated that he was not suicidal at that time. The case conference concluded that Mr Banner was "At Risk" of suicide. It was decided that he would remain in an observation cell overnight for hourly checks under the "Talk to Me" strategy and the MORS

policy. The conclusion of the first case conference was accurately recorded in the following terms:

> "Zach attended the initial case conference after discussion about a concern raised by the prison nurse which found him to be at risk. He stated that he was not suicidal at present but had attempted twice early in the year (April & June) to commit suicide. He said that those two attempts were because he was in a low mood. The staff present were concerned that his being under the influence of the 150 valium which he took before coming to Prison may be a facto[*r*] in his mood swinging when he comes off the effects. He was also currently being observed under the MORS protocol for 60 mins visual, in the observation cell. All agreed that he would be placed on Talk to Me for a period of 60 mins own clothing and items in use when he comes off MORS after seeing doctor in the morning."

40. Mr Banner did not like the experience of being in the observation cell and wanted to move out of it.

41. At 10.00 hours on 30 December 2017 Mr Banner was seen by Dr Sian Jones. Dr Jones had access to a nursing assessment form completed by staff nurse Kerr which noted that Mr Banner had previously attempted to overdose and hang himself in June or July 2017. Dr Jones also had information that Mr Banner had been placed on the "Talk to Me" strategy because when police had found him he had covered himself in petrol and threaten to set the petrol alight. Mr Banner was relaxed in the consultation with Dr Jones. He was making appropriate humour and maintained good eye contact. When Dr Jones asked Mr Banner whether he had any thoughts of harming himself he was resolute that he did not have any such thoughts. Dr Jones recorded

an accurate summary of her consultation with Mr Banner in his prison medical records in the following terms:

> "Consultation. New Admission. As detailed below [*referring to earlier entries in Mr Banner's prison medical records*], he had poured petrol over his trousers as he thought this would encourage the police to leave. He was already wanted and did not want to get caught. Says he had been emptying his quad bike to put petrol in his motorbike and for this reason had the petrol at hand. Says some spilled onto both police officers hence the escalation of the charge. Denies any thoughts of suicide or self harm and states he is in good place at the moment. Would like to speak to mental health about his mirtazapine and olanzapine. Has not been taking either outside. Stopped his methadone 35ml about 1 week before Christmas. Has been using various amounts of heroin and methadone since then. Took large dose of valium prior to arrest because he did not want the police to find it. States he does not usually use valium, just took this because the police were there. Certainly was relaxed and chatty, maintaining good eye contact."

42. At the end of the consultation Dr Jones concluded that Mr Banner no longer required to be under the MORS policy but did require to remain on the "Talk to Me" strategy. Mr Banner was removed from the MORS policy. Mr Banner remained on the "Talk to Me" strategy under 60 minute observations, but was moved to a normal cell. Dr Jones prescribed Mr Banner 90 milligrams of dihydrocodeine, in tablet form, to be taken twice daily, with one tablet being taken in the morning and one tablet taken about 17.00 hours. Staff nurse Kerr observed Mr Banner taking these tablets on both 30 and 31 December 2017.

43. After Mr Banner saw Dr Jones on 30 December 2017 he was ultimately allocated cell 2/3 in B hall with AB. AB had been asked if he was willing to share with Mr Banner and had agreed to do so as he had met him a few times before. Mr Banner took the top bunk when he moved into cell 2/3. AB felt

that he got on well with Mr Banner and described him as being in good spirits. However, he suggested that Mr Banner was worried that he was going to receive a lengthy prison sentence. AB also believed that Mr Banner was struggling with his medication.

44. Mr Banner's Care Plan under the "Talk to Me" strategy was updated with reports from prison officers detailing his progress between 30 December and 31 December 2017. The reports between 14.00 hours on 30 December 2017 and 13.15 hours on 31 December 2017 were in the following terms:

    (1) Between 14.00 and 17.35 on 30 December 2017 –"*Did not take recreation but used the phone. Feeling unwell spent afternoon in cell with cell mate seems in good form*"

    (2) Between 17.35 and 21.45 on 30 December 2017 – "*Zach a bit shaken tonight after witnessing his cell mate fitting. No issues or concerns*"

    (3) Between 21.45 on 30 December and 08.00 on 31 December 2017: "*Very quiet night had concerns about his cell mate having fits, after medical reassurance settled down for the night, no issues to report*."

    (4) Between 08.00 and 12.00 on 31 December 2017: "*Up this morning took a shower, not interested in church etc but went to exercise. Believes he was due medication at 11 but this was not the case. No issues I do not believe at this time that Mr Banner needs to be on TTM*"

(5) Between 12.00 and 13.45 on 31 December 2017: "*Zach was sleeping throughout the patrol shift. He moved position on a couple of occasions when checked. No other issues or concerns to report.*"

45. At 14.10 hours on Sunday 31 December 2017 the second case conference took place. The second case conference was attended by Mr Banner, PO Johnson, staff nurse Kerr and Jim Kelly, FLM. At that case conference Mr Banner stated that he had no intentions of self-harming and was not suicidal. It was agreed by all attending the second case conference, including Mr Banner, that Mr Banner was of "no apparent risk" of suicide and no longer required to be on the "Talk to Me" strategy. The conclusion of the case conference was accurately recorded in the following terms:

> "Zach attended the case conference today to see how he was progressing. Zach stated that he hadn't slept when he was in the obs cell on his first night mainly due to coming of the valium he had taken. He said that he was feeling a lot better today and wasn't in a low mood just feeling a little unwell, due to the cold bug. He stated that he had no intentions of self harming and wasn't feeling suicidal. He had a discussion with the nurse about seeing the mental health nurse and addictions nurse. He was informed that he would be listed to see them, but that the earliest would be the 3rd January due to the holiday period. We were all in agreement that Zach no longer needed to be on the TTM process. He was encouraged to talk if in low mood."

46. Whilst Mr Banner was within the prison he made a number of telephone calls, including calls to family members. In these telephone calls: (i) the family members expressed exasperation at Mr Banner recent behaviour whilst within the community; (ii) Mr Banner expressed remorse for his behaviour; (iii) Mr Banner requested that the family members assist him in

recovering property; and (iv) Mr Banner alluded to the family members changing the accounts they had already given to the police regarding his recent behaviour. Mr Banner's final call was made at 16.11 hours on 31 December 2017 to a family member. During that call Mr Banner, when discussing the likely length of the prison sentencing that he was facing, suggested that he might kill himself. At the end of that call Mr Banner agreed that he would not do anything stupid (with the context being that he was agreeing not to attempt suicide or self-harm).

47. Around 16.30 hours on 31 December 2017, staff nurse Kerr observed Mr Banner taking his prescribed medication. At that time Mr Banner's presentation was such that it did not give cause for any concern.

48. From about 18.00 hours on 31 December 2017, Mr Banner slept on his bunk within cell 2/3 in B Hall. From about 23.00 hours, AB and Mr Banner watched the New Year celebrations on television. About 00.05 hours on 1 January 2018, AB requested paracetamol and Mr Banner asked him to get two paracetamol for him as well. However, AB was only given two paracetamol tablets in total by PO Martin Morris. At that time Mr Banner was lying on the top bunk and the television was on. AB gave Mr Banner one of the paracetamol tablets and Mr Banner took it with some water. They said "happy new year" to each other and the last thing AB heard Mr Banner say was "the lighter is on top of the safe". AB then fell asleep on the bottom bunk.

49. AB then woke up and was aware of Mr Banner beside his bed. Mr Banner was not moving or making any noise. Mr Banner had something white tied around his neck. AB got up, ran to the door and started banging on door, screaming for the staff to come. AB then went to Mr Banner and found him unresponsive. He tried to lift him but he was not able to do so.

50. About 1.35am on 1 January 2018 PO Morris heard an emergency buzzer sounding, together with banging and shouting. PO Morris responded immediately and ran to cell 2/3 of B Hall. He looked through the peep hole and could see Mr Banner hanging from the top bunk with a piece of material around his neck. AB was shouting for PO Morris to enter the cell. PO Morris obtained permission from a manager to enter the cell. PO Morris and PO Norman Walker entered the cell and cut the material that was around Mr Banner's neck and which had been tied to the top rail of the bunk bed. The said material was lining from a torn duvet. Mr Banner was lowered to the floor and the material was cut away from his neck. Mr Banner was not breathing and PO Morris commenced CPR. A defibrillator machine was also used on him and an ambulance was called.

51. Ambulance staff arrived a short time later and took over CPR. Mr Banner was thereafter conveyed to Raigmore Hospital, Inverness and arrived at 02.13 hours on 1 January 2018. Mr Banner was taken to the Intensive Care Unit where he was found to be deeply unconscious. He was put on a ventilator and sedated.

52. Police officers carried out an examination of cell 2/3 in B Hall. Within the cell they found a letter that had been written by Mr Banner and was addressed to his mother. The letter was consistent with suicide.

53. At 10.00 hours on 3 January 2018 at Raigmore Hospital, Inverness Mr Banner was pronounced deceased. Following discussion with nearest relatives, consent was given for organ donation to take place.

54. On 5 January 2018, Dr Mark Ashton, Consultant Pathologist carried out a post mortem examination of Mr Banner. He noted a ligature mark on Mr Banner's neck, in keeping with the history of hanging and macroscopic evidence of hypoxic brain injury. Toxicology performed on hospital admission blood samples showed the presence of benzodiazepines, dihydrocodeine, paracetamol and methadone. The medical certificate of cause of death was completed as follows:

" I (a) Hypoxic brain injury

due to (or as a consequence of):

(b) Hanging."

55. In early January 2018 the SPS and NHS conducted a Death in Prison Learning, Audit and Review (known as "DIPLAR"). A DIPLAR is a joint SPS and NHS process for reviewing all deaths in prison and provides a system for recording any learning and identified actions. The aim of the DIPLAR is to learn from the incident. The persons conducting the DIPLAR were not

aware of the contents of the Balfour note. The conclusion of the DIPLAR was in the following terms:

> "This appears to be a largely spontaneous act, as his cell mate reported he was in good spirits only a short time before his death as they had both watched the New Year fireworks on the TV. Mr Banner appears to have been estranged from many of his family members and his stealing his Mother's car had placed additional stresses on the family relationships.
>
> It is without precedent for a successful suicide of this type to take place in a shared cell. Placing Mr Banner in a shared cell when he was removed from Talk to Me would be considered good practice and a protective factor for those who may be at risk of suicide.
>
> In all likelihood the charges he was faced with would have been reduced through the normal processes. He seemed to be thinking about ways to reduce the charges himself and ploys he would use, witnessed by the phone call asking family members to change their version of events.
>
> Mr Banner has been in prison before, and he did not appear concerned or raise any concerns about being in an adult prison compared to previous sentences in YOI Polmont. It is extremely tragic when someone so young takes their own life however Zach did not present as a risk of suicide at that time and there were no clues in his presentation that raised concerns with staff or Health Care Professionals."

56. Throughout his time in prison between 29 December and 31 December 2017 Mr Banner exhibited very few of the common warning signs set out in finding in fact 32. He did request to move from the observation to cell to a shared cell and this request was granted. His sleep was disturbed in the observation cell due to him withdrawing from drugs and also, later, when his cell mate had a fit. However, after his cell mate had had a fit Mr Banner was reassured by medical staff and settled down. Mr Banner did have some telephone calls with his family members but the contents of these calls were

not known to the prison staff and it is not known what affect that they had on his mood.

57. Throughout his time in prison between 29 December and 31 December 2017 Mr Banner repeatedly stated that he did not feel suicidal and interacted well and appropriately with the SPS staff.

58. The information that: (i) Mr Banner had stated to police officers in the police yard that he had doused himself in petrol in an effort to set himself on fire to kill himself; (ii) Mr Banner stated that he was suicidal on arrival at the police station; and (iii) Mr Banner had stated to Ms Balfour that he would attempt to hang himself if he was remanded; ought to have been summarised on the PER and, thereby, passed on to the prison staff. That information would have been used by the prison staff to assess Mr Banner under the "Talk to Me" strategy and would have resulted in him being questioned about that information. Mr Banner's answers to those questions would have informed the overall risk assessment undertaken under the "Talk to Me" strategy. However, the fact that the said information was not passed on to the prison staff did not result in a different assessment being reached when he was initially assessed by the prison staff under the "Talk to Me" strategy on 29 December 2017. Had the prison staff been aware of the said information it is highly likely that Mr Banner would have been considered to be "At Risk" of suicide and managed under the "Talk to Me" strategy. However, in any event, the prison staff had sufficient information before them, when

conducting the initial assessment of Mr Banner, to assess him as being "At Risk" of suicide and placed him on the "Talk to Me" strategy.

59. Having being placed on the "Talk to Me" strategy Mr Banner was appropriately managed under that strategy. The placing of Mr Banner in a shared cell, whilst being managed under the "Talk to Me" strategy, was an appropriate protective step to take in the prevention of suicide. When the decision was taken at the second case conference, on 31 December 2017, to remove Mr Banner from the "Talk to Me" strategy he was not presenting as being "At Risk" of committing suicide. After the second case conference nothing changed in Mr Banner's presentation and at no time between then and him being found by his cell mate did he exhibit any outward behaviour that was suggestive of him being "At Risk" of committing suicide.
60. Mr Banner's decision to take his own life was an act which could not have been predicted by prison staff.

Improvements made to the healthcare information sharing between the police custody suite and HM Prison Inverness.

61. In July 2019 Suzy Calder reviewed the process of referral, assessment and the sharing of information, in relation to the mental health of detained persons, between the police custody suite and the prison. As part of that process it was identified that a variety of IT systems are in place across the different disciplines. These are, in summary, as follows:

(1) "SCI Store" – Only NHS staff have access to SCI Store. This includes the police custody healthcare staff, the mental health team in the community and the prison healthcare staff. It holds information on, amongst other things, referrals and results.

(2) "Adastra" – Only the police custody healthcare staff and the prison healthcare staff have access. It is a patient record system. Neither the mental health team in the community or police staff have access to it.

(3) "VISION" – Only the prison healthcare staff have access. It contains the healthcare records for prisoners.

62. Following the review referred to in finding in fact 61 a new system was implemented in relation to person referred for mental health assessments whilst in police custody (hereinafter referred to "the HHB pilot"). The key features of the HHB pilot are as follows:

(1) Detained person in police custody is assessed by the police custody nurse or FME;

(2) Healthcare professional (either the police custody nurse or FME) assessing the detained person completes a referral form and emails it to the mental health team; Healthcare professional completing the referral form also telephones the mental health team to alert them to referral sent by email;

(3) The mental health team acknowledge the referral form by either email or telephone and arrange to attend the custody suite to conduct a mental health assessment;

(4) The mental health assessment of the detained person is then carried out by the mental health team at the custody suite;

(5) The outcome of the mental health assessment is verbally communicated to the police custody nurse by the mental health team who also write the outcome of the assessment in the space provided in the referral form;

(6) The outcome of the mental health assessment is then: (i) inputted onto the detained person's Adastra record by the police custody nurse; and (ii) inputted onto the detained person's mental health records at New Craig's Hospital (where the mental health team are based) by the mental health team; (iii) uploaded onto SCI store by the mental health team within 48 hours of the assessment;

(7) The police custody nurse then shares the relevant details of the outcome of the mental assessment with the police custody staff who record it on the medical assessment page of the police custody computer. This will include any information which suggests that the detained person is a risk to himself or others (hereinafter referred in this finding in fact as "the key information");

(8) The key information will be recorded on the PER by police custody staff. The PER will be checked by the custody sergeant and the police custody nurse (who check all PERs when there has been any healthcare involvement with the detained person) prior to the detained person being handed over to the transporting agency;

(9) A new form (hereinafter referred to as "the medical PER") will be completed by the police custody nurse and attached to the PER if the detained person has been seen by a healthcare professional whilst in police custody; the medical PER makes clear that the person in police custody has been assessed by a healthcare professional whilst in police custody and requests that the prison nurse contacts the police custody nurse on receipt of the medical PER;

(10) Where the likelihood is that the person in police custody will be admitted to HM Prison Inverness the police custody nurse will telephone the prison nurse to give a verbal handover and then scan to them, via a dedicated email address (which is accessible to all prison nurses), the completed mental health referral form); and

(11) On admission to prison the prison nurse will: (i) record that they have seen the PER and; (ii) sign the medical PER to confirm that they have received it; (iii) check Adastra (which will include the mental health referral form containing the outcome of the mental health assessment).

Submissions

[10] All parties helpfully prepared detailed written submissions. All parties sought formal findings in respect of section 26(2)(a) and (c) of the 2016 Act. The findings sought were based on the uncontroversial evidence before the inquiry and my findings mirror those sought by each of the parties. A summary of the submission made by the parties in respect of sections 26(2)(e) to (g) of the 2016 Act and in relation to whether any recommendations should be made, in terms of section 26(1)(b) of the 2016 Act, are set out below.

Submission for the Crown

[11] As regards section 26(2)(e) of the 2016 Act, the Crown submitted that the information that: (i) Mr Banner had stated to police officers in the police yard that he had doused himself in petrol in an effort to set himself on fire to kill himself;
(ii) Mr Banner stated that he was suicidal on arrival at the police station; and
(iii) Mr Banner had stated to Ms Balfour that he would attempt to hang himself if he was remanded (hereinafter collectively referred to as "the relevant information"); ought to have been made known to the prison staff. However, the Crown contended that it could not be said that if the relevant information had have been provided to the prison staff that Mr Banner's death might have been avoided. This was because: (i) the PER did include the words "PAVA sprayed – Doused himself and 2 police with petrol and brandished naked flame" (hereinafter referred to as "the PER additional risk information"); (ii) the prison staff had, in any event, treated this information as a

possible attempt at suicide and self-harm, which resulted in Mr Banner being asked about it anyway; (iii) that the prison staff were aware that Mr Banner had made previous suicide attempts earlier in the year as a result of Mr Banner volunteering that information as part of staff nurse Kerr's assessment in the prison; and (iv) Mr Banner was, in any event, assessed as being "At Risk" of suicide and placed on the "Talk to Me" strategy. Further, that throughout the "Talk to Me" process Mr Banner consistently maintained that he was not suicidal and presented as sociable and engaging with others.

[12] The Crown submitted that the inquiry did not hear any definitive explanation as to why Mr Banner decided to take his own life and contended that any attempt to do so would amount to speculation. It could not be said whether Mr Banner entered prison with thoughts of suicide which persisted throughout his time there or whether his action in the early hours of 1 January 2018 were impulsive. The most that could be said is that, if he did have thoughts of suicide when he came into prison, he consistently hid those thoughts from the prison staff and maintained a positive persona.

[13] The Crown contended that even if the prison staff had been provided with the relevant information it was not possible to say whether Mr Banner would have remained on the "Talk to Me" strategy after the second case conference. Further, even if Mr Banner had remained on the "Talk to Me" strategy, until after seeing a mental health nurse on 3 January 2018, that would not have necessarily resulted in the outcome being any different because Mr Banner was subject to 60 minute observations, which still left opportunity between observations. In order to make any finding to the effect that remaining on the "Talk to Me" strategy might have changed the outcome, the

observation periods would have needed to have been greatly increased (in the sense of there being much shorter periods between observations). Given Mr Banner's generally positive demeanour and interactions with staff, the Crown contended that it would be difficult to make any finding under section 26(2)(e) of the 2016 Act with confidence.

[14] As regards section 26(2)(f) of the 2016 Act, the Crown submitted that the inquiry identified deficiencies in the system of working as regards the provision of the relevant information to the SPS. However, the Crown submitted, for the reason outlined in their submissions in respect of section 26(2)(e) of the 2016 Act, that it could not be said that these defects contributed to Mr Banner's death.

[15] As regards section 26(2)(g) of the 2016 Act the Crown suggested a finding ought to be made that the PER did not fully reflect the relevant information available, which resulted in the prison staff involved in the "Talk to Me" process not being able to consider and ask questions about the relevant information when attempting to assess the correct level of risk. The Crown noted that the PER additional risk information was inaccurate, in respect of the suggested brandishing, but contended that would have had the inadvertent effect of heightening the seriousness of the incident and the potential assessment of risk. However, the Crown submitted that the PER should have included a full picture of all the relevant information. In addition, it would prudent for the custody sergeant to check the all PERs to ensure they were accurate with all relevant information and for this to be done as close as possible to the handover with the transferring agency.

[16] The Crown submitted that there was not sufficient evidence to clearly establish whether police custody staff were present at the Balfour verbal handover. What the

evidence did show was that there was a lack of a clear system of working to ensure that the key information from the outcome of a mental health assessment was cascaded to those responsible for the detained person in police custody and in prison. However, Ms Calder had described the HHB pilot, subsequently introduced by the HHB, which provided a step by step written process for ensuring that the key information was appropriately shared. The Crown noted that the HHB pilot continues to be reviewed but submitted that the new process addressed the uncertainty that existed at the time when Mr Banner was in custody.

[17] As regards section 26(1)(b) of the 2016 Act the Crown, whilst acknowledging that the inquiry focused on information sharing in the Inverness area and did not hear evidence about the processes in place in other parts of the country, submitted that there may be merit in making a recommendation that Police Scotland and NHS Scotland consider the issues raised in this inquiry in relation to the sharing of information and the improvements that have been identified and made, with a view to identifying any learning opportunities from their own processes and procedures that exist in other areas of the country.

Submissions for the family of Mr Banner

[18] As regards section 26(2)(e), (f) and (g) of the 2016 Act, Counsel for the family submitted that there had been a deficiency in recording information accurately in the PER and a failure to communicate the contents of the Balfour note. Cumulatively these issues resulted in the prison staff not having the information that they ought to have had

and resulted in the deceased receiving a deficient standard of care. Counsel for the family contended that the likelihood was that the Balfour verbal handover had been provided to both the custody nurse and custody staff. It was fanciful for it to be suggested that a fourth person at the Balfour verbal handover could have been someone other than police custody staff. In any event the critical point was that the key information from the Balfour note had not been included in the PER and not passed onto the prison staff. This had been a serious breakdown in communication and a clear failure to communicate all the relevant information to the prison staff. It was also a matter of concern that the PCSO completing the PER in this case was not sure what the risk for Mr Banner was. The key information from the Balfour note ought to have been communicated to the police custody staff and all the relevant information ought to have been accurately included in the PER. The fact that it was not, resulted in the prison staff not having vital information that would have informed how they conducted their assessment of Mr Banner. There was not any criticism of the prison staff or the "Talk to Me" strategy, but it was self-evident that no-one could know what Mr Banner would have said if confronted with this vital information by the prison staff (namely, that he had said to the police that he intended to kill himself during the petrol dousing incident and his stated intention to attempt to hang himself if he was to be remanded). If the prison staff had had that vital information, taken together with the information about the two previous suicide attempts, it could have put in sharper focus the vital information that was not passed on and changed the course of the conversations Mr Banner had with prison staff. As a result, the possibility existed that had the vital

information been known to prison staff, Mr Banner would not have been taken off the "Talk to Me" strategy when he was. Had Mr Banner remained on the "Talk to Me" strategy he may have remained in an observation cell and may not have been availed of the opportunity to kill himself. In the circumstances there was a real and lively possibility that had the communication from the police custody suite to the prison been effective and comprehensive a different chain of events may have come into play and Mr Banner's death would thereby have been avoided. In all the circumstances findings under section 26(2)(e) and (f) of the 2016 Act could be made.

[19] The new HHB pilot was a welcome improvement to the system of communicating information about the mental health of a detained person. However, it was not clear from the evidence whether the prison nurses were all aware that the new medical PER required the prison nurse to contact the police custody nurse on receipt of the medical PER. Counsel for the family submitted that the court should make a recommendation: (a) that the new medical PER should be completed and attached to the PER where there has been any healthcare involvement with a detained person in police custody; and (b) that where a medical PER was attached to the PER, the prison nurse should be required to both contact the police custody nurse and check the Adastra computer system.

[20] As regards the PER, it should be a requirement for the police custody nurse to check the PER to ensure that all the relevant information is included in the PER.

Submissions for the Chief Constable of the Police Service of Scotland

[21] The solicitor for the Chief Constable submitted that there should not be any findings under section 26(2)(e) to (g) of the 2016 Act and that no recommendations should be made.

[22] The solicitor for the Chief Constable explained that when Mr Banner was admitted to police custody on 28 December 2017 he was assessed as being of high risk of self-harm or suicide by police custody staff. Appropriate measures were put in place and followed by the custody staff throughout Mr Banner's time in custody. The solicitor for the Chief Constable submitted that the police custody staff were not informed either verbally or in writing that Mr Banner had made comments during his mental health assessment that he intended to hang himself if remanded. Had they been informed of this the police custody computer and the PER would have been updated with this information.

[23] The solicitor for the Chief Constable submitted that, in any event, the PER additional risk information resulted in G4s, the prison staff, and Dr Jones assuming that Mr Banner had attempted to kill or harm himself. Due to this, and Mr Banner's two prior attempts at suicide, he was treated as "At Risk" of suicide and placed on the "Talk to Me" strategy on admission to prison on 29 December 2017. Thereafter the "Talk to Me" strategy allowed for the risk of suicide to be continually assessed. Given the way in which Mr Banner presented to all prison staff he was not deemed to be at risk of suicide on 31 December 2017 and was removed from the "Talk to Me" strategy.

[24] The solicitor for the Chief Constable contended that had the police custody staff been informed of key information from the Balfour note and updated the PER to reflect that key information (including ticking the tick box "suicide / self harm / bereavement"), it would not have altered the risk assessment that was made of Mr Banner at prison. Mr Banner would still have been regarded as "At Risk" of suicide and placed on the "Talk to Me" strategy. Further, this key information was unlikely to have altered the decision made at the second case conference to remove Mr Banner from the "Talk to Me" strategy, given Mr Banner's responses to direct questions about suicide ideation and the way he consistently presented, both verbally and non-verbally, to prison staff whilst in prison.

Submissions for Ms Neil

[25] The solicitor for Ms Neil submitted that there should not be any findings under section 26(2)(e) to (g) of the 2016 Act and that no recommendations should be made.

[26] The solicitor for Ms Neil accepted that all the relevant information was not included in the PER, which resulted in the relevant information not being passed to the prison staff when it ought to have been. However, Ms Neil did not bear any responsibility for the relevant information not being conveyed to the prison staff. There were three ways in which information as regards the outcome of a mental health assessment at the police station could be passed on from the mental health nurse conducting assessment: (i) verbal handover to the custody nurse; (ii) verbal handover to the custody nurse and the custody sergeant; and (iii) verbal handover direct to the

custody sergeant. What had occurred in this case was that the mental health nurse, namely Ms Balfour, had provided a verbal handover to both Ms Neil (the police custody nurse) and a member of the police custody staff. In such circumstances Ms Neil did not, at that time, require to do any more. There was also, at that time: (i) no requirement for Ms Neil to place the Balfour note on the Adastra computer system; and (ii) the prison nurses did not use the Adastra computer system.

[27] The solicitor for Ms Neil contended that, in any event, the provision of the relevant information to the prison staff would not have altered the manner in which Mr Banner was assessed at prison. The robustness of the "Talk to Me" strategy implemented at the prison, and the professionalism of the prison staff implementing it, ensured that the assessment of Mr Banner was appropriate and comprehensive. The "Talk to Me" strategy fully considered Mr Banner's risk of suicide and self-harm (which included consideration of his previous suicide attempts) and he was appropriately managed on both that strategy and the MORS policy.

[28] The solicitor for Ms Neil noted that the HHB pilot was a welcome improvement to system of sharing mental health information about a detained person between the police custody suite and the prison.

Submissions for Ms Balfour

[29] The solicitor for Ms Balfour submitted that there should not be any findings under section 26(2)(e) to (g) of the 2016 Act and that no recommendations should be made.

[30] The solicitor for Ms Balfour contended that Ms Balfour had completed all professional duties incumbent on her. She had conducted a mental health assessment of Mr Banner at the police station and verbally handed over the outcome of that assessment to the police custody nurse. The verbal hand over would have included the key information from the assessment including Mr Banner's suicidal ideation. A member of the police custody staff may have been present during the verbal handover but all that was required of Ms Balfour was to complete a verbal handover to the police custody nurse and there was no dispute that that is exactly what she had done. Ms Balfour then completed a detailed note of her mental health assessment, handed it to the police custody nurse and asked her to make a copy so that Ms Balfour could retain it for her own recording purposes. The police custody nurse confirmed that the verbal handover took place and that she received the Balfour note. The police custody nurse then filed the Balfour note in Mr Banner's police medical records. Ms Balfour, Mr Fieldsend and the police custody nurse all confirmed that the plan going forward was for Mr Banner to speak to the mental health nurses at the prison if he was remanded. That plan was set out in the Balfour note. Ms Balfour had no input into the PER and had followed all the correct procedures that were in place at that time.

[31] The solicitor for the Ms Balfour submitted that the failure to pass on of the information contained in the Balfour note to the prison staff could amount to a reasonable precaution or defect in the system of working. However, there was no evidence to find that the passing on of that information might realistically resulted in the death being avoided or that the failure to pass on that information contributed to the

death. This was because Mr Banner had, in any event, been appropriately managed under the "Talk to Me" strategy in the prison and there was not sufficient evidence to allow a finding to made that the information from the Balfour note would have made a difference to how Mr Banner was managed at the prison. Mr Banner's presentation in prison was positive and he repeatedly denied having any suicidal ideation. In the circumstances the solicitor for Ms Balfour submitted that the evidence pointed towards Mr Banner's suicide being an impulsive act.

[32] The solicitor for Ms Balfour welcomed the new HHB pilot as regards the sharing of information about the mental health of a detained person and submitted that the checking of the PER by the police custody nurse and the custody sergeant, together with the introduction of the medical PER, were important improvements to the system.

Submissions for the SPS

[33] The solicitor for the SPS submitted that there should not be any findings under section 26(2)(e) to (g) of the 2016 Act and that no recommendations should be made.

[34] The solicitor for the SPS submitted that there were three broad issues, first, the breakdown in communication at the police station, second, the management of Mr Banner at the prison, and third whether the communication of the relevant information to the prison would have made any difference as regards how Mr Banner was managed in the prison.

[35] As regards the breakdown of communication at the police station, there clearly had been a breakdown in communication at the police station which resulted in the

relevant information not being passed to the prison. The relevant information ought to have been included in the PER, but it was not. The breakdown in communication was a matter for the police and HHB and it was not a matter which the SPS could meaningfully assist the inquiry with.

[36] As regards the management of Mr Banner at the prison, the SPS had robust policies in place to manage prisoners under the influence of drugs (the MORS policy) and "At Risk" of suicide or self-harm (the "Talk to Me" strategy). Mr Banner had been managed, initially under both MORS policy and the "Talk to Me" strategy. He was subsequently removed from the MORS policy but remained on the "Talk to Me" strategy. At the second case conference all the professionals involved took account of all the information before them and unanimously assessed Mr Banner as being of no apparent risk of suicide. Had any one of these professionals had a concern, Mr Banner would have remained on the "Talk to Me" strategy. Further, the evidence before the inquiry was that rather than showing the common warning signs that might be indicative of suicide, Mr Banner's conduct and actions were suggesting the opposite. Even after Mr Banner was removed from the "Talk to Me" strategy he came into contact with a number of members of prison staff who were all trained to identify the said common warning signs, but none were identified. The placing of Mr Banner in a shared cell was recognised as being good practice and acted as further protective measure against suicide. The solicitor for the SPS submitted that, in all the circumstances, Mr Banner was managed appropriately throughout his time in prison.

[37] As regards whether the communication of the relevant information to the prison would have made any difference as regards how Mr Banner was managed in the prison, the solicitor for the SPS submitted that it would not have made any difference and that Mr Banner would have still been removed from the "Talk to Me" process on 31 December 2017. The relevant information, which was not passed to the prison, would have been one element of the overall information considered during the various assessments of the Mr Banner in the prison. The relevant information may have been a factor that pointed to Mr Banner being "At Risk" of suicide but, in any event, that assessment was still made. At the time of the second case conference, given how Mr Banner was presenting, it was likely that he would have been removed from the "Talk to Me" strategy even if the relevant information had been known. Even if Mr Banner had remained on the "Talk to Me" strategy after 31 December 2017 the likelihood would have been that he would have remained on 60 minute observations resulting in him still having the opportunity to take his own life in between observations. Accordingly, 60 minute observation would not have been a measure which might realistically have prevented Mr Banner's death. Further, given the way Mr Banner had been presenting, it would not have been reasonable (and therefore not a precaution that could have been reasonably taken) to have returned Mr Banner to an observation cell or reduced the time between observations.

Submissions for the Scottish Prison Officers' Association

[38] The solicitor for the Scottish Prison Officers' Association (hereinafter referred to as "SPOA") submitted that there should not be any findings under section 26(2)(e) to (g) of the 2016 Act and that no recommendations should be made.

[39] The solicitor for SPOA submitted that the decisions made at the case conferences held under the "Talk to Me" strategy were correct based on the information the prison staff had and what they had observed as regards Mr Banner's presentation. The "Talk to Me" strategy made clear that the response had to be proportionate to the risk posed. To have someone unnecessarily on observations would overwhelm the system and compromise the ability to look out for those who genuinely needed them as well as having a detrimental effect on a prisoner (who could face the prospect of being woken by lights on in the night or being spoken to every hour during the night). It was not known if the decision at the second case conference would have been the same if the relevant information was known to the prison staff, although it was contended that it might have been the same given that the themes thrown up by the Balfour note were discussed at the case conferences. Even if a different decisions had have been reached at the second case conference it was likely that it would have meant Mr Banner remaining on the "Talk to Me" strategy on 60 minutes observations. If that was the case Mr Banner would still have had the opportunity to have taken his own life in between observations. The "Talk to Me" strategy made clear that not every suicide was preventable and that it is a misconception that all suicides are predictable (see finding in fact 29). In the present case Mr Banner was consistently denying thoughts of self-harm or suicide to multiple

persons at the prison and was not acting in a way that suggested that that was his intention. Indeed he may not have been feeling that way until the evening of 31 December 2017 or the early hours of 1 January 2018.

Submissions for the HHB

[40] Counsel for the HHB submitted that there should not be any findings under section 26(2)(e) to (g) of the 2016 Act and that no recommendations should be made.

[41] Counsel for the HHB noted that the completion of the PER was not a matter that was the responsibility of the Board's employees. There were clear deficiencies in the PER but even in the state it was there could be no misapprehension by G4s or the prison staff of: (i) the very serious nature of the circumstances of Mr Banner's arrest; and (ii) that he had tried to kill himself in the petrol dousing incident (indeed that was PO Hendry's assumption when he assessed Mr Banner at the prison reception). It was accepted that Mr Banner's threat to attempt to hang himself if remanded was not passed on to the prison staff via the PER. However, it was contended that Mr Banner's said threat should not be elevated to some sort of "position statement". It was one of many utterances made by Mr Banner and should be seen in context. Mr Banner had been arrested in difficult circumstances, having doused himself and two officers with petrol. He was initially charged with attempted murder of the two officers and was heavily under the influence of drugs having admitted to taking 150 valium tablets. The mental health assessment was conducted in the early hours of morning, before the prospect of a court appearance and remand. It was no more than a "snap shot" assessment and even

by the time Mr Banner was leaving police custody he answered one of the two standard police release questions to the effect that he was not suicidal. The Balfour note also had positive aspects to it, including plans to go to Birmingham to seek work and an indication of a desire to come off drugs. Ms Balfour found no evidence of an acute mental illness and had given Mr Banner advice to speak to the mental health nurses in prison if he was remanded and he agreed to do so.

[42] The inclusion of the relevant information in the PER was not a precaution that might realistically have avoided Mr Banner's death because of the following factors. First, it was extraordinary that Mr Banner himself did not raise the issue of him feeling suicidal if it continued to be live issue for him whilst in prison, when he had no difficulty in volunteering two suicide attempts in the past year. The obvious explanation for Mr Banner not raising that issue was that he had either forgotten what he said when under the influence of drugs in police custody or did not consider it to be of lasting importance. Second, Mr Banner's presentation in prison was one which gave no cause for concern to any of the prison staff who were all trained in the "Talk to Me" strategy. He had effectively none of the common warning signs indicative of being "At Risk" of suicide and it was unlikely that his presentation would have changed if the relevant information had been known. Third, Mr Banner consistently stated in prison that he had no thoughts of suicide and it was unrealistic to suggest that he would have totally reversed his position if he had been referred to the relevant information. Finally, no one suggested that even if he had remained on the "Talk to Me" strategy, until 3 January 2018, that he would have remained in an observation cell. That would have

been against his wishes and detrimental to him. Accordingly, Mr Banner would have still have had the opportunity, under 60 minute observations, to take his own life.

[43] Counsel for the HHB submitted that there were no defects in the Board's system of work which contributed to death. The system for the mental health nurses attending the police station was that a request would be made for them to attend the police station to conduct an assessment. They would then: attend between 06.00 hours and 7.30 hours; assess the detained person; verbally discuss their assessment with, usually, the police custody nurse and sometimes the custody staff (generally the custody sergeant); and prepare a note. Ms Balfour had followed that procedure in relation to Mr Banner.

[44] Counsel for the HHB submitted that the system of verbally communicating any relevant medical information from the nursing staff to the police custody staff was, on the face of it, a clear and extremely simple procedure. It was a procedure which readily lent itself to be done verbally (especially given the time restraints involved) and was a system understood by all concerned. He contended that the threat of Mr Banner to attempt hang himself if remanded was verbally communicated to the police custody staff in accordance with the accepted system. Ms Balfour had a clear recollection of discussing matters with the police custody nurse and a member of the police custody staff. Mr Fieldsend recalled four people at the discussion (with the other three being Ms Balfour, Mr Fieldsend and the police custody nurse, Ms Neil). Ms Neil had little recollection of matters but the accounts of Ms Balfour and Mr Fieldsend would explain why Ms Neil did not need to update the custody sergeant separately (because a member of the police custody staff was present at the discussion). No contrary evidence had

been given by any witness and the inquiry should be very cautious in accepting hearsay evidence of Inspector Hindley to the effect that acting Sergeant Burgess was not told the outcome of the mental health assessment. The suggestion that the fourth person at the discussion might simply have been a police officer not working as part of the police custody staff was fanciful. On the other hand, it would seem extraordinary if nothing at all was communicated to the police custody staff about the mental health assessment given the highly unusual and troubling circumstances at the time of Mr Banner's arrest and in circumstances where the custody sergeant must have been waiting for the outcome of the assessment. In all the circumstances it was submitted that there was no defect the Board's system of working and that the key information from the mental health assessment was communicated to the police custody staff. However, even if there was some error in communication (at the hands of the nurses or the custody staff), then that was an individual error as opposed to a system error. Further, even if there was a defect in the system of working, it did not, for reason set out it in para 41 to 42 above and para 45 below, contribute to the death.

[45] Counsel for the HHB submitted that Mr Banner was managed appropriately under both the MORS policy and the "Talk to Me" strategy and that a finding could be made that the provision of the relevant information to the prison would have made no difference as regards how he was managed. Particular support for such a finding could be found from the evidence of staff nurse Kerr when she accepted that even if the prison had the relevant information, Mr Banner would have still been removed from the "Talk to Me" strategy when he was unless he either changed his position to express suicidal

thoughts or changed his presentation. Neither of those changes occurred and even though Mr Banner had been managed appropriately under the "Talk to Me" strategy, had consistently denied suicidal thoughts in prison, had the protection of a shared cell and had been making plans for attending appointments on 3 January 2018, still took his own life. In the circumstances, it was submitted that the suicide of Mr Banner was an unexpected and impulsive act.

[46] Counsel for the HHB submitted that the new HHB pilot will result in the prison nurse being fully appraised of all relevant information regarding the outcome of a mental health assessments undertaken at the police station. The improvements made by the HHB pilot were subject to review and it was submitted that it would inappropriate to go beyond these improvements which had been agreed by the agencies involved. In addition, as the inquiry had not considered the practice of other police stations, other health boards and other prison it would be inappropriate to make any wider recommendations.

Discussion and Conclusions

Section 26(2)(a) of the 2016 Act (when and where the death occurred)

[47] In this inquiry there was no dispute as regards when and where the death occurred. Mr Banner died at 10.00 hours on 3 January 2018 at Raigmore Hospital, Inverness.

Section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred)

[48] There was no dispute that the incident that resulted in Mr Banner taking his own life occurred between 00.05 and 01.35 hours on 1 January 2017 within cell 2/3 of B Hall at the prison. In the circumstances, his death did not result from an accident and it is therefore not necessary to make a formal finding under section 26(2)(b) of the 2016 Act.

Section 26(2)(c) of the 2016 Act (the cause or causes of death)

[49] There was no dispute as regards the cause or causes of death. The conclusion of Dr Mark Ashton, Consultant Pathologist has been set out at finding in fact 54 above. Dr Ashton carried out a post mortem examination of Mr Banner on 5 January 2018. He noted a ligature mark on Mr Banner's neck, which was in keeping with the history of hanging and macroscopic evidence of hypoxic brain injury. Toxicology performed on hospital admission blood samples showed the presence of benzodiazepines, dihydrocodeine, paracetamol and methadone. The medical certificate of cause of death was completed as follows:

> "I (a) Hypoxic brain injury
>
> due to (or as a consequence of):
>
> (b) Hanging."

In the circumstances I determined that the cause of death was as recorded in the medical certificate.

Section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in death)

[50] There was no dispute that the incident that resulted in Mr Banner taking his own life arose as a result of: (i) Mr Banner tying one end of a torn duvet around his neck and the other end of the torn duvet to the rail of the top bunk in cell 2/3 of B Hall at the prison; and (ii) Mr Banner using the torn duvet to hang himself from the top bunk in cell 2/3 of B Hall.

[51] In the circumstances, his death did not result from an accident and it is therefore not necessary to make a formal finding under section 26(2)(d) of the 2016 Act.

Section 26(2)(e) of the 2016 Act (any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided)

[52] Section 6(1)(c) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 (hereinafter referred to as "the 1976 Act)" was the predecessor to section 26(2)(e) of the 2016 Act and required the court to consider "the reasonable precautions, if any, whereby the death and any accident resulting in death might have been avoided". In Carmichael, *Sudden Deaths and Fatal Accident Inquiries*, 3rd at para 5-75 the author set out what I considered to be the correct approach to section 6(1)(c) of the 1976 Act:

> "… If the cause of an accident is known, then it may well be possible, even with what is now said to be the 'wisdom of hindsight' to point to something which, if done, might have avoided or even prevented the death or accident resulting in death. …The precise wording of section 6(1)(c) must be kept in mind. What is required is not a finding as to reasonable precautions whereby the death or

> accident resulting in death 'would' have been avoided, but whereby the death or accident resulting in death 'might' have been avoided … Certainty that the accident or death would have been avoided by the reasonable precaution is not what is required. What is envisaged is not a 'probability' but a real or lively possibility that the death might have been avoided by the reasonable precaution."

[53] The explanatory notes to the 2016 Act clearly envisaged a similar approach being taken to section 26(2)(e) of the 2016 Act. The explanatory notes state at para 72:

> "72. Subsection (2)(e) requires the determination to set out any precautions which were not taken before the death which is the subject of the FAI, but that could reasonably have been taken and might realistically have prevented the death. The precautions that the sheriff identifies at this point relate to the death which is the subject of the FAI and might not be the same as those recommended to prevent other deaths in the future under subsection (4)(a). In subsection (2)(e)(i), 'reasonably' relates to the reasonableness of taking the precautions rather than the foreseeability of the death or accident. A precaution might realistically have prevented a death if there is a real or likely possibility, rather than a remote chance, that it might have so done. "

In my view that the task of this inquiry is to consider, with the wisdom of hindsight, whether there were any precautions which could reasonably have been taken which might realistically have resulted in death, or any accident resulting in death, being avoided. I consider that a precaution might realistically have resulted in the death, or any accident resulting in death, being avoided, if there was a real or lively possibility that it might have done so.

[54] In the present case the majority of the evidence was either agreed or undisputed and almost all the findings in facts are based on that agreed or undisputed evidence. In the circumstances I will approach matters by first considering the evidence that was in dispute and thereafter consider whether a finding should be made in terms of section 26(2)(e) of the 2016 Act.

The Disputed Issues

[55] There were really only three issues of controversy. The first was the procedure for the outcome of a detained person's mental health assessment to be communicated to the custody sergeant; the second was the question of who was present at the Balfour verbal handover and what was communicated; and the third was the extent to which the Adastra computer system was used as at December 2017.

[56] As regard the first issue, Sergeant Cameron was of the view that the outcome of any mental health assessment would normally be verbally handed over to him by the police custody nurse. He did not consider it to be normal for the verbal handover to be communicated to the custody sergeant directly from the mental health nurse and he could not recall any occasion where that had happened. He also did not consider it normal for the verbal handover by the mental health nurse to be given to both police custody nurse and the custody sergeant at the same time. Ms Balfour (the mental health nurse) explained that she would normally provide the verbal handover to the police custody nurse but that the verbal handover could be given to police custody nurse or the police custody staff or both. Mr Fieldsend advised that the verbal handover by the mental health nurse could be provided to the police custody nurse or the police custody staff but, in the vast majority of cases, the verbal handover would be given to the police custody nurse. He also noted that there were occasions when there would not be a police custody nurse on duty and, in those circumstances, the verbal handover would be given to the police custody staff. Ms Neil (the police custody nurse) explained that the outcome of a mental health assessment could be verbally handed over to the custody

sergeant in the following ways: (i) by the mental health nurse verbally handing over to the police custody nurse who then relayed that to the custody sergeant / staff; (ii) the mental health nurse providing a verbal handover to both the police custody nurse and the custody sergeant at the same time; or (iii) the mental health nurse providing a verbal handover directly to the custody sergeant (with that sometimes happening because the police custody nurse was dealing with another detained person). Inspector Hindley supported the explanations given by Ms Balfour, Mr Fieldsend and Ms Neil and explained that it was possible for the mental health nurse to provide a verbal handover direct to the custody sergeant or to both the custody sergeant and the police custody nurse and that he had received direct verbal handovers from the mental health nurse when he had been a custody sergeant.

[57] Ms Balfour and Mr Fieldsend both explained in their evidence that they attended the police station around twice a week to conduct mental health assessments and Mr Fieldsend estimated that his team conducted between 50 and 100 mental health assessments at the police station per year. Ms Neil, as the police custody nurse, would, when on duty, always have been the person to initiate such assessments and would generally be involved in the verbal handover of the outcome of the mental health assessment by the mental health nurse. I considered that Ms Balfour, Mr Fieldsend and Ms Neil were best placed to confirm what the verbal handover procedure was at the time. Their evidence was supported by Inspector Hindley and I accepted that the verbal handover by the mental health nurse could, as at December 2017, be provided to the custody sergeant in the ways outlined by Ms Neil (see para 56 above). I considered that

the reason for the differing view of Sergeant Cameron may have simply been because his experience came from what happened when he was on duty and that his experience / practice may well have been for the verbal handover of the outcome of the mental assessment to have always been provided to him by the police custody nurse.

[58] As regards the second issue, Ms Balfour explained that she would always provide a verbal handover that summarised the outcome of the mental health assessment she conducted. In the case of Mr Banner she recalled providing the verbal handover to both the police custody nurse and a member of the police custody staff (although she could not recall who either the police custody nurse or the member of the police custody staff were). Both Ms Balfour and Mr Fieldsend advised that, although they could not now remember what was said at the verbal handover, it would have included that Mr Banner had threatened to attempt to hang himself if he was remanded and that he had future plans if released. Mr Fieldsend thought the verbal handover was provided to the police custody nurse and perhaps a member of the police custody staff. His recollection was that there was four persons present during the verbal handover. Ms Neil recalled receiving a verbal handover from Ms Balfour but not all the detail. She recalled discussing with Ms Balfour that Mr Banner had thoughts of suicide, that he was drowsy and that he would follow up with the mental health nurses in the prison. Ms Neil considered that it would have been likely that Ms Balfour provided both herself and the custody sergeant with a verbal handover. If the custody sergeant was present at the said verbal handover, Ms Neil did not consider that she needed to repeat it to the custody sergeant separately. However, Ms Neil could not say with any certainty

whether the fact that Mr Banner had said he would attempt to hang himself if remanded, was communicated to the custody sergeant. Ms Neil confirmed that she received and read the Balfour note. Ms Neil thought she would have received the verbal handover from Ms Balfour first and then read the Balfour note. Ms Neil advised that, at that time, she would not routinely contact the prison nurses and that she had no input into the PER. The expectation, as far as she was concerned, was that all the risk information would be included on the PER by the police custody staff.

[59] There was no dispute that Sergeant Cameron and PCSO Kirkbride had ceased duty prior to the mental health assessment of Mr Banner concluding and that acting Sergeant Burgess had taken over from Sergeant Cameron. Unfortunately, acting Sergeant Burgess did not give evidence to the inquiry due to illness. The court did, however, hear from Inspector Hindley. Inspector Hindley explained that there was CCTV in the area where the Balfour verbal handover would have taken place but unfortunately it had not been retained. Inspector Hindley advised that he had spoken to acting Sergeant Burgess and he (acting Sergeant Burgess) had said that he had not spoken to the mental health nurses on the morning of 29 December 2017 and had not seen the Balfour note. Inspector Hindley agreed with a suggestion that the fourth person at the Balfour verbal handover could be the custody sergeant or a member of the police custody staff or a police officer passing through the custody suite. The evidence of Ms Balfour, Mr Fieldsend and Ms Neil was hampered by the passage of time but I considered that they were all credible witnesses doing their best to recollect what had occurred approximately two years ago. In all the circumstances I considered that, on the

balance of probabilities, that there were, at least at times, four person present during the Balfour handover. I considered that it was highly unlikely that Ms Balfour and Mr Fieldsend, who were both highly experienced, would have been discussing the outcome of a detained person's mental health assessment with an unconnected police officer passing through the custody suite. In all the circumstances I considered that what the evidence showed, on a balance of probabilities, was: (i) that Ms Balfour provided a verbal handover to the police custody nurse of the outcome of her assessment of Mr Banner in the presence of Mr Fieldsend; (ii) that the key information, which was contained in the Balfour note, would have been included in the Balfour verbal handover (including the fact that Mr Banner had stated that he would attempt to hang himself if remanded); and (iii) that an unknown member of police custody staff was present for at least part of the Balfour verbal handover. Whether that unknown member of the police custody staff understood that they were receiving a verbal handover that they needed to act upon was not clear.

[60] As regards the third issue, Ms Neil explained that the Adastra computer system was, as at December 2017, relatively new and that she used it to record examinations of detained person in police custody. Staff nurse Kerr explained, at that time, that the prison nurses did not use the Adastra computer system although they may have had log in details for it. Staff nurse Kerr explained that prison nurses now use the Adastra computer system and it can be checked when a person is being assessed in the prison reception. Ms Calder understanding was that, at that time, both the police custody nurses and the prison nurses had access to Adastra computer system, however, she did

not know what information the police custody nurse required to record on Adastra. Ultimately, there may well have been nothing between the evidence of Ms Calder and staff nurse Kerr with the position being that, at that time, the prison nurses had the ability to access the Adastra system but with the practice being that they did not use it. I accepted the evidence of staff nurse Kerr that the prison nurses did not use the Adastra computer system at that time. There was no evidence to suggest that there was any requirement on Ms Neil, at that time, to input the outcome of the mental health assessment onto the Adastra computer system.

Whether to make a finding under section 26(2)(e) of the 2016 Act

[61] All parties accepted that the PER (the actual completed PER is appendix A of this determination) did not fully reflect all the relevant information obtained from and about Mr Banner during his time in police custody. Mr Banner had: (i) stated to police officers in the police yard that he had doused himself in petrol in an effort to set himself on fire to kill himself (he also made similar comments to Ms Balfour - see the Balfour note at finding in fact 20; and the police clearly thought that this information was important given that Sergeant Cameron completed an episode report form - see finding in fact 13); (ii) stated that he was suicidal on arrival at the police station; and (iii) stated to Ms Balfour that he would attempt to hang himself if he was remanded. The PER ought to have included a summary of this information but only contained the PER additional risk information. The PER had the following further deficiencies: (i) that the risk supervision level was marked as "medium" when Mr Banner had been assessed at high

risk by the police (it was also unclear why "medium risk" was an option given that the police only assess a detained person as being of either high or low risk); (ii) the tick box "medical condition" was not ticked despite that fact that Mr Banner had stated on arrival at the police station that he suffered from asthma (see finding in fact 9, Q12); (iii) the tick box "psychiatric condition" was not ticked despite the fact that Mr Banner had stated on arrival at the police station that he suffered from depression and anxiety (see finding in fact 9, Q11); (iv) the tick box "seen by doctor / nurse" was not ticked despite Mr Banner being seen by both the police custody nurse and the mental health nurse; (v) the tick box "drugs / alcohol issues" was not ticked despite the fact that Mr Banner had stated on arrival at the police station that he was dependant on heroin, methadone and valium (see finding in fact 9, Q5), that he had stated to the police custody nurse that he had taken "100 plus valium" just before being arrested (see finding in fact 14) and that he had told Ms Balfour that he had a long standing drugs problem (see finding in fact 20); (vi) the tick box "suicide / self harm / bereavement" was not ticked despite what Mr Banner had stated the police officers in the yard, to the custody sergeant on arrival and to Ms Balfour; and (vii) the PER additional risk information stated that Mr Banner "brandished naked flame" when he did not do so (although I agree with the Crown that that error did have the effect of heightening the seriousness of petrol dousing incident and perhaps contributed to the prison staff considering that the petrol dousing incident was an attempt at self-harm / suicide – see finding in fact 38 and para 62 at point 3).

[62] The deficiencies in the completion of the PER resulted in the prison staff not receiving the relevant information. However, the PER did contain the additional risk information, which staff nurse Kerr considered to be an attempt at self-harm and both PO Hendry and Mr Kelly, FLM considered to be an attempt at suicide. Clearly it would have been preferable for the prison staff to have received the relevant information and it is clear from the evidence that had they done so it would have informed their assessment of Mr Banner (in the sense that Mr Banner would have been questioned about the relevant information and his responses would be taken into account in their overall assessment of him). However, the question for the inquiry, at this stage, is whether the correct completion of the PER (which would have resulted in the relevant information being passed to the prison staff) was a precaution which could reasonably have been taken that might realistically have resulted in Mr Banner's death being avoided? In order to answer that question it is necessary to consider the following factors:

1. That when Mr Banner stated to Ms Balfour that he would attempt to hang himself if remanded, it was very early in the morning of 29 December 2017 when he was under the influence of street valium and in circumstances where there was a very real prospect that he would be remanded in custody when he appeared in court later that day;
2. That when Mr Banner left police custody he was asked the two standard release questions. One of those questions enquired whether Mr Banner had any thoughts of self-harm or suicide and he answered "no";

3. That when Mr Banner was assessed in the prison reception by staff nurse Kerr: (i) she was aware that Mr Banner had, earlier in the year, attempted suicide on two occasions by overdose and hanging; (ii) she identified that Mr Banner was under the influence of drugs; (iii) she had before her the PER additional risk information, which she considered detailed an attempt at self-harm (as noted above, PO Hendry and Mr Kelly, FLM, read the additional risk information as an attempt at suicide); (iv) she specifically asked Mr Banner about the petrol dousing incident and he stated he did not intend suicide or self-harm and just wanted the police to go away (he also stated that he would not have been bothered if he got burned during the petrol dousing incident);
4. That if any person is considered "At Risk" of suicide at the prison they will be managed under the "Talk to Me" strategy;
5. That staff nurse Kerr considered, on the information before her, that Mr Banner was, in any event, "At Risk" of suicide resulting in him being managed under the "Talk to Me" strategy and a first case conference being scheduled. She also considered, given both his presentation and his disclosed use of street valium, that he should be managed under the MORS policy (she also arranged referrals to both the addictions team and the mental health team (which was in line with Mr Banner's agreement with Ms Balfour to speak to the mental health nurses at the prison) and arranged for the doctor to see him the next morning);

6. That at the first case conference on 29 December 2017 Mr Banner discussed the two previous suicide attempts he had made earlier in the year and stated that he was not suicidal at that time;
7. That at his consultation with Dr Jones on 30 December 2017 Mr Banner: (i) stated that he poured petrol over himself in order to encourage the police to leave; (ii) denied any thoughts of suicide or self-harm and stated that he was a in a good place; and (iii) sought to make arrangements to speak to the mental health team (which was again in line with Mr Banner's agreement with Ms Balfour to speak with the mental health nurses at the prison);
8. That between his consultation with Dr Jones on 30 December 2017 and the second case conference at 14.10 hours on 31 December 2017, Mr Banner was monitored by prison officers in terms of the "Talk to Me" strategy and had no issues and gave no cause for concerns (other than being a bit shaken when his cell mate had a fit);
9. That at the second case conference on 31 December 2017 Mr Banner stated he had no intentions of self-harm or suicide and had discussions with staff nurse Kerr about seeing the mental health nurse and addictions nurse on 3 January 2018;
10. That at the second case conference all the prison staff present, including staff nurse Kerr and Mr Kelly, FLM, who had consistently dealt with Mr Banner throughout his time in custody, considered that he was no

longer "At Risk" of suicide and should be removed from the "Talk to Me" strategy;

11. That throughout his time at the prison Mr Banner presented well, displayed very few of the common warning signs which may indicate an individual was "At Risk" of suicide and consistently denied any thoughts of suicide or self-harm.

[63] Having considered the above factors and the totality of the evidence in relation to Mr Banner's time at the prison it is, in my opinion, inconceivable that, had the relevant information been available to staff nurse Kerr, it would have resulted in her reaching a different conclusion to her assessment than she in fact reached. In other words, had the relevant information been available to the prison staff, Mr Banner (whatever his responses to being questioned about the relevant information) would, in any event, have been assessed to be "At Risk" of suicide and would have been managed under both the "Talk to Me" strategy and the MORS policy. The prison staff that Mr Banner was interacting with were all experienced professionals (staff nurse Kerr qualified in 2009 and had been working as a prison nurse since about 2013; Dr Jones qualified as a GP in 2002 and had commenced working at the prison in 2010; and Mr Kelly had been a prison officer since about 1989) who were trained in the "Talk to Me" strategy. Mr Banner, throughout his time at the prison, presented well, appeared to be open with the staff (including discussing previous suicide attempts), displayed very few of the common warning signs which may indicate an individual was "At Risk" of suicide, and consistently denied any thoughts of suicide or self-harm. He was also

making arrangements to see both the mental health nurse and addictions nurse on 3 January 2018. Clearly, it is not possible to say what Mr Banner's responses would have been had he been challenged with the relevant information (i.e. if he was challenged: (i) that when he said to the prison staff that the petrol dousing incident was an attempt to get the police to go away, that he had in fact told officers that the petrol dousing incident was an effort to set himself on fire to kill himself; and (ii) that when he told prison staff that he was not suicidal, that he had in fact said in police custody that he was suicidal and would attempt to hang himself if remanded) but, on all the information before the inquiry, including both his general presentation and his openness regarding previous suicide attempts, it seems: (i) likely that he would have advised the prison staff at the case conferences and Dr Jones at the consultation if he continued to have suicidal thoughts at that time; (ii) unlikely that he would have reversed his consistently stated position that he did not have thoughts of suicide or self-harm at that time.

[64] In all the circumstances it appears that the provision of the relevant information to the prison staff would have made little, if any, difference to how Mr Banner was managed in the prison. Mr Banner would still have still been assessed at the prison reception, he would still have been managed under the "Talk to Me" strategy and would still have had a consultation with Dr Jones. By the time of the second case conference Mr Banner had been observed by prison staff over a three day period (during which time the effects of the drugs he had taken had worn off) and all the professionals (and Mr Banner himself) were in agreement that he was not presenting as being "At Risk" of suicide. In my opinion, the decision at the second case conference, to remove Mr Banner

from the "Talk to Me" strategy, was entirely reasonable on basis of the information that the prison staff had at that time. I consider, given Mr Banner's consistent presentation at prison between 29 and 31 December 2017, that the decision at the second case conference was unlikely to have been any different had the relevant information had have been known. Even if Mr Banner had remained on the "Talk to Me" strategy after the second conference, I do not consider there was anything in his presentation which would have resulted in the 60 minute observation period being reduced or him being moved out of the shared cell (which was a protective factor) back to the observation cell (which Mr Banner did not like and had not slept well in – see finding in fact 40 and 45). Therefore, even if Mr Banner had remained on the "Talk to Me" strategy it would have been highly likely that he would, on the evening of 31 December 2017 and the early hours of 1 January 2018, been on 60 minute observations and therefore had the opportunity to take his own life during the period between observations. Mr Banner did have a number telephone calls with family members during his stay at prison (see finding in fact 46). It is not known what affect these telephone calls had on Mr Banner's mood but the content of the calls were not known to prison staff and Mr Banner's outward presentation did not give any indication that he was of low mood. After the second case conference nothing changed in Mr Banner's presentation and at no time between then and him being found by his cell mate did he exhibit any outward behaviour that was suggestive of him being "At Risk" of committing suicide. In the circumstances I consider that Mr Banner's decision to take his own life was an act which could not have predicted by prison staff.

[65] In the all circumstances, whilst I do consider that the correct completion of the PER (with the relevant information) was a precaution that could reasonably have been taken, I do not consider that it was a precaution that might realistically have resulted in Mr Banner's death being avoided.

Section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or the accident resulting in death)

[66] Section 6(1)(d) of the 1976 Act was the predecessor to section 26((2)(f) of the 2016 Act and required the court to consider "the defects, if any, in any system of working which contributed to the death or any accident resulting in death". Sheriff Kearney in his determination in the death of Mildred Allan (an extract of which is set out in Carmichael at para 8-99) set out what I consider to be the correct approach to section 6(1)(d) of 1976 Act and also now section 26(2)(f) of the 2016 Act:

> "In deciding whether to make any determination (under s6(1)(d)) as to defects, if any, in any system of working which contributed to death or any accident resulting in the death the court must, as a precondition to making such a recommendation, be satisfied that the defect in question did in fact cause or contribute to the death."

[67] In the present case there was clearly a breakdown in communication which resulted in the key information from the mental health assessment not finding its way to the PER. However, I agree with Counsel for the HHB that there was a system in place for that key information to be passed to the custody sergeant (see finding in fact 19 and para 56 to 57 above) but it appears that, for reasons which are not clear, that that system was not fully followed on 29 December 2017. There were also other deficiencies with the

completion of the PER (which I have highlighted at para 61 above), with the overall result being that the PER did not fully reflect all the relevant information obtained from and about Mr Banner during his time in police custody (which resulted in the relevant information not being passed onto the prison staff). At the time that the PER was completed there was no system in place for the custody sergeant and / or police custody nurse to check the PER before the detained person was transferred to the transporting agency. That situation has now been remedied but had it been in place at the time it may have prevented the PER from being deficient.

[68] However, for the reasons I have explained, at paras 61 to 65, the fact that the relevant information was not communicated to the prison staff, via the PER, had little or no effect on the way Mr Banner was managed in the prison. In the circumstances, I do not consider that it has been proved that any defect in the systems in place at the police station contributed to Mr Banner's death.

Section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death)

[69] The Crown suggested a finding ought to be made that the PER did not fully reflect all the relevant information available, which resulted in the prison staff involved in the "Talk to Me" process not being able to consider and ask questions about the relevant information when attempting to assess the correct level of risk. I have set out my observations as regards the completion of the PER at para 61. For the reasons given

in that para I am in agreement with the Crown's submission and I have determined that the relevant information ought to have been included in the PER.

[70] The Crown also made further submissions under this head as regards the sharing of the key information from outcome of a mental health assessment and the new HHB pilot. I have addressed those points at para 56 to 59 and 67 above and para 73 to 74 below.

Recommendations

Section 26(1)(b) of the 2016 Act (recommendations (if any) as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances)

[71] Whilst I have concluded that a finding should not be made in terms of section 26(2)(e) or (f) of the 2016 Act that does preclude the making of recommendations regarding the matters set out in section 26(4) of the 2016 Act if they might realistically prevent other deaths in similar circumstances. Indeed the whole purpose of an inquiry is to establish the circumstances of the death and consider what steps (if any) might be taken to prevent other deaths in similar circumstances. In the present case the PER did not fully reflect all the relevant information obtained from and about Mr Banner during his time in police custody (which resulted in the relevant information not being passed onto the prison staff). However, Mr Banner was immediately placed on the "Talk to Me" strategy at the prison and managed appropriately under that strategy despite the

relevant information not being passed to the prison staff. However, in other cases the failure to pass on relevant information may result in the prison staff taking a different course of action than they otherwise would have done had all relevant information been known to them. That could include reaching a decision that a person was not "At Risk" of suicide (and therefore not being managing them under the "Talk to Me" strategy) when all the relevant information would have led to a decision that they did pose such risk. Clearly, if such a scenario arose it could have the potential to have fatal consequences.

[72] In the present case the PER was looked at in significant detail during the inquiry. The PER is the primary document used to transfer risk information between agencies and it is crucial that it is completed accurately. It should be simple to complete and framed in such a way that prompts the persons responsible for completing and checking the form to include all the relevant risk information. The inquiry was advised that the PER currently in use is broadly the same as the PER in use on 28 December 2017 (although the transporting agency has changed). The system that was in place on 28 December 2017 involved the PCSO completing the PER in the early hours of the morning with there being no requirement on the custody sergeant to check the PER prior to the detained person being transferred to the transferring agency. That has now changed and the custody sergeant checks all PERs prior to the detained person being transferred to the transferring agency. That is an important improvement to the system. However, I consider that the actual layout and content of the PER in use on 28 December 2017 could be improved to further reduce the prospect of relevant risk information being

omitted from the PER. I consider that if such improvements were made that it might realistically prevent other deaths in similar circumstances. In my view the following points would be worthy of consideration in relation to both the PER in use on 28 December 2017 and, more importantly, any updated PER currently in use:

1. There would seem to be no reason for the supervision level to have a choice of "medium" when the police only assess risk as "high" or "low". It would seem sensible for the supervision level in the PER to be in line with the police assessment of risk.
2. Whilst the 26 tick options all have relevance, consideration should be given to giving the risks of suicide or self-harm (and also harm to others) greater prominence on the PER. In particular, consideration should be given to including specific questions, to be answered by the person completing the PER, designed to identify: (i) whether the detained person has displayed any behaviour which could indicate a current risk of suicide or self-harm (with a space to complete basic details if they have); and (ii) whether the detained person has displayed any behaviour which could indicate that he was at a current risk of harm to others (with a space to complete basic details if they have). Such questions would have the effect of requiring the person completing the form to address his or her mind to those issues on every occasion.
3. Whilst additional information could be attached to the PER as at 28 December 2017, the PER itself does not contain any box to indicate whether or not additional information has been attached (with the risk that if the additional

information became detached it would not be known about). Consideration should therefore be given to including in the PER space to briefly indicate whether any documentation has been attached and the brief details of such documentation. In particular, the PER ought to make clear whether or not a medical PER has been attached.

4. The two pre-release questions seem to be entirely sensible and answers to both would seem to be relevant to both the transporting agency and the receiving agency (which is generally the prison). Consideration should therefore be given to including the pre-release questions and answers on the PER (which would also result in the PER being considered immediately before the detained person is transferred to the transferring agency – see point 6 below).
5. The PER is currently one page and one can see the desirability of keeping it as clear and simple as possible but if any changes make it necessary for it to run over two pages it may be prudent to have all the risk information on page 1 and the outward and inward escort details on page 2.
6. This inquiry has shown that the risk information about a detained person can change during their stay in police custody (here mental health assessment took place shortly before Mr Banner was due to be transferred to court and after the PER had already been completed) and it is important that the PER is checked shortly before the detained person is transferred to the transferring agency to ensure it contains all up to date relevant information. In the circumstances it may be prudent for the PER to contain space for both the custody sergeant and

the police custody nurse to indicate they have checked the PER and the time that they did so.

[73] The HHB pilot was welcomed by all parties. I consider that the HHB pilot has significantly improved the way that the outcome of a mental health assessment of a person in police custody is shared with prison staff. It also has the potential to include the sharing of other medical information about a person in police custody. The basic details of the HHB pilot are set out at finding in fact 62 and the inquiry was advised that it is currently in the process of being reviewed. One of the features of the new pilot was the new medical PER (the form is currently headed "PERSONAL ESCORT RECORD – HANDOVER" and can be found at Appendix B of this determination). The medical PER currently requests the police custody nurse to make an assessment of risk but Ms Calder advised that that aspect of the form is due to be removed. The medical PER is attached to the PER and is supposed to prompt the prison nurse, on receipt of the medical PER, to: (i) to check the Adastra computer system; and (ii) contact the police custody nurse. The medical PER currently states in red type:

"Assessed by Custody practitioner Burnett Road Police Station Inverness

Please contact [*telephone number*]"

However, staff nurse Kerr was not clear that the medical PER required the prison nurse to telephone the police custody nurse and therefore the current review process ought to consider changing the above wording to specify the healthcare professional that assessed the detained person in police custody and to make it clear what the prison nurse is required to do (i.e. whether they are to: (i) check the Adastra computer system

only; or (ii) check the Adastra computer system and call the police custody nurse). In addition, the HHB pilot currently requires the police custody nurse to verbally handover the outcome of the mental health assessment to the "police custody staff". However, it may preferable for the said verbal handover to given directly to custody sergeant and again the current review process ought to consider this point. Finally, if a PER has a medical PER attached there is currently no space on the PER for it to be made clear that a medical PER is attached (with the risk that the medical PER would not be known about if it became detached). Again that is matter that the current review ought to consider. Counsel for the family of Mr Banner submitted: (i) that the court should make a recommendation: (a) that the new medical PER should be completed and attached to the PER where there has been any healthcare involvement with a detained person in police custody; and (b) that where a medical PER was attached to the PER, the prison nurse should be required to both contact the police custody nurse and check the Adastra computer system; and (ii) that there should be a requirement for police custody nurse to check the PER to ensure that the all the relevant information is included in the PER. I agree that these are sensible suggestions but it was my understanding that new HHB pilot now required all these points to be completed (with the police custody nurse checking any PERs where the detained person has healthcare involvement whilst in police custody). In the circumstances I do not consider it necessary to make recommendations in relation to these points.

[74] The inquiry did not hear any evidence about the process of sharing the outcome of mental health assessments, or other medical information, between police custody

nurses and prison nurses in areas other than the Highlands. It is therefore not know how other Health Boards approach matters and whether the HHB pilot could feasibly operate in the central belt where the demands on both the police custody nurses and prison nurses may be different. However, the HHB pilot certainly seems to put in place a robust system which, firstly, ensures, so far as reasonably practicable, that important health information about a person in police custody is shared with the prison nurse and, secondly, maintains confidentiality. I also consider that it would, if possible, be desirable for the same system of sharing medical information about a detained persons to be used across Scotland. I therefore consider that it should at least be explored whether a system, based on the HHB pilot, ought to be rolled out across Scotland.

[75] In the circumstances (and taking account of the current Covid-19 pandemic), I make the following recommendations:

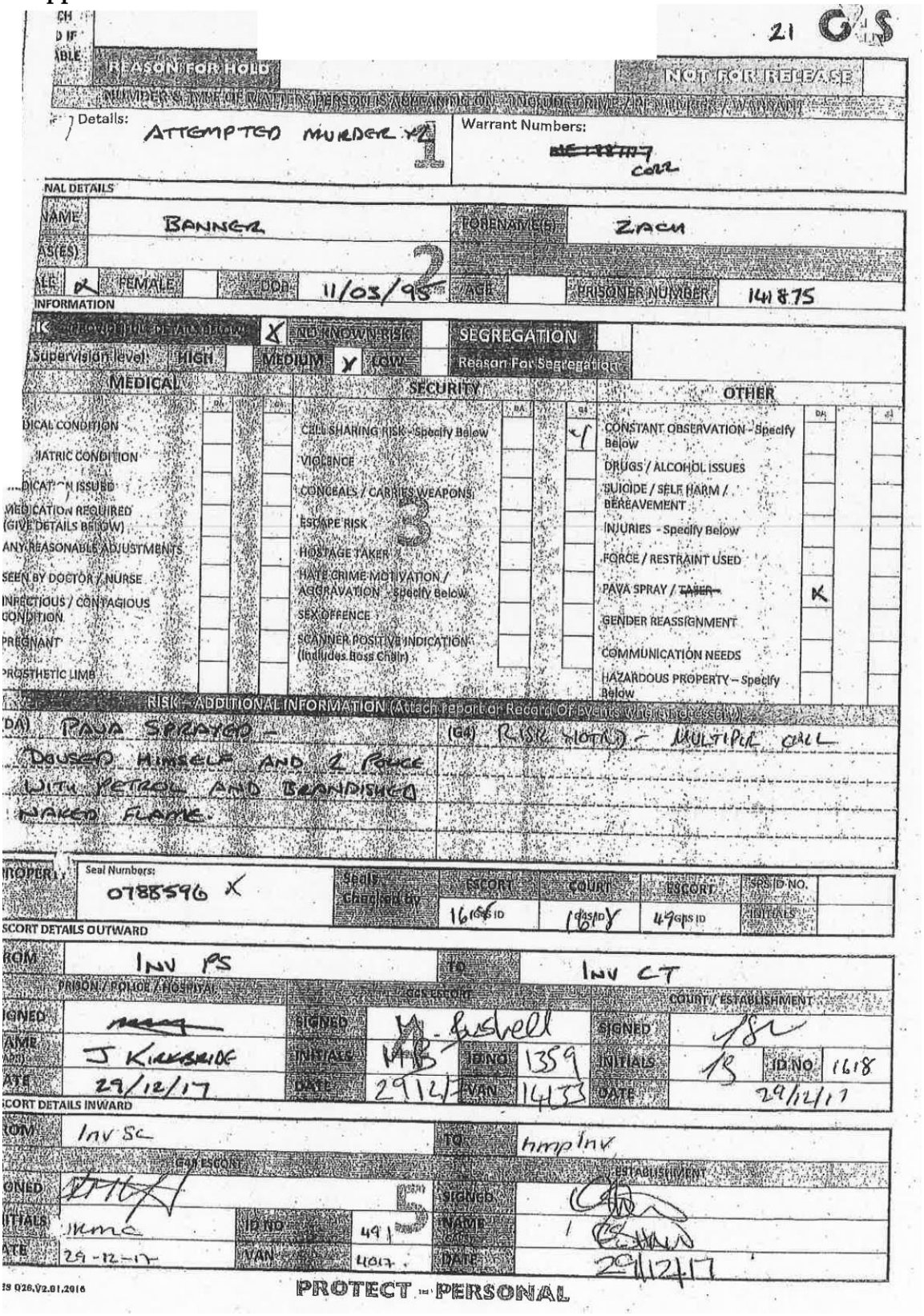
1. That once normality has resumed following the Covid-19 pandemic, the Police Service of Scotland, in consultation with the current transporting agency, local Health Boards and the Scottish Prison Service, should review the contents and layout of the current PER in light of this determination and consider whether any improvements could be made to ensure, as far as reasonably practicable, that all relevant information, including, in particular, information in relation to: (i) the risk of suicide or self-harm; and (ii) the risk of harm to others, is included on the PER.
2. That once normality has resumed following the Covid-19 pandemic, the Police Service of Scotland should consult with local Health Boards and the Scottish

Prison Service as regards the system or systems of sharing medical information between police custody suites and local prisons with a view to considering whether a system, based on the HHB pilot, ought be rolled out in other parts of the country.

Postscript

[76] At the outset of the inquiry I extended my condolences to Mr Banner's family. I was joined in those condolences by the other parties. Mr Banner's family were present throughout the inquiry and I wish to formally repeat my condolences to Mr Banner's family in this determination.

Appendix A



21 GS

REASON FOR HOLD — NOT FOR RELEASE

NUMBER & TYPE OF WARRANTS, PERSONS ABSCONDING ON - INCLUDING DRIVER NUMBER / WARRANT

Details: ATTEMPTED MURDER x2 1

Warrant Numbers: [redacted] CO22

PERSONAL DETAILS

NAME: BANNER — FORENAME(S): ZACH

ALIAS(ES):

SEX: M — FEMALE — DOB: 11/03/95 — AGE: 22 — PRISONER NUMBER: 141875

RISK INFORMATION

RISK — PROVIDE FULL DETAILS BELOW — X — NO KNOWN RISK — SEGREGATION

Supervision level: HIGH — MEDIUM — X — LOW — Reason For Segregation:

MEDICAL	DA	GA	SECURITY	DA	GA	OTHER	DA	GA
DICAL CONDITION			CELL SHARING RISK - Specify Below			CONSTANT OBSERVATION - Specify Below		
IATRIC CONDITION			VIOLENCE			DRUGS / ALCOHOL ISSUES		
DICATION ISSUED			CONCEALS / CARRIES WEAPONS			SUICIDE / SELF HARM / BEREAVEMENT		
MEDICATION REQUIRED (GIVE DETAILS BELOW)			ESCAPE RISK 3			INJURIES - Specify Below		
ANY REASONABLE ADJUSTMENTS			HOSTAGE TAKER			FORCE / RESTRAINT USED		
SEEN BY DOCTOR / NURSE			HATE CRIME MOTIVATION / AGGRAVATION - Specify Below			PAVA SPRAY / ~~TASER~~	K	
INFECTIOUS / CONTAGIOUS CONDITION			SEX OFFENCE			GENDER REASSIGNMENT		
PREGNANT			SCANNER POSITIVE INDICATION (Includes Boss Chair)			COMMUNICATION NEEDS		
PROSTHETIC LIMB						HAZARDOUS PROPERTY – Specify Below		

RISK - ADDITIONAL INFORMATION (Attach report or Record Of Events where necessary)

(DA) PAVA SPRAYED - DOUSED HIMSELF AND 2 POLICE WITH PETROL AND BRANDISHED NAKED FLAME.

(G4) RISK NOTED - MULTIPLE CALL

PROPERTY — Seal Numbers: 0788596 X — Sealed / Checked by — ESCORT — COURT — ESCORT — SPS ID NO. — INITIALS

ESCORT DETAILS OUTWARD

	PRISON / POLICE / HOSPITAL		GEO ESCORT			COURT / ESTABLISHMENT		
FROM	INV PS	TO				INV CT		
SIGNED		SIGNED	M. Bushell			SIGNED	JSC	
NAME	J KIRKBRIDE	INITIALS	MB	ID NO	1359	INITIALS	JS	ID NO 1618
DATE	29/12/17	DATE	29/12/17	VAN	1433	DATE	29/12/17	

ESCORT DETAILS INWARD

	GEO ESCORT				ESTABLISHMENT
FROM	Inv Sc	TO			hmp Inv
SIGNED		SIGNED			
INITIALS	Imma	ID NO	491	NAME	
DATE	29-12-17	VAN	4017	DATE	29/12/17

PSI 026.V2.01.2016 — PROTECT - PERSONAL

Appendix B

Name		DOBICHI
Aaaeued by Custody prac.ti tioner **Burnell** Road Police Station Inverness **Please contact 01483228 4H** (Please Circle)		
High Riek	Medium Risk	jLow Risk
Ha11dov&t to GEOAmey		
Healthcare Custody (Signed)		GEOAmey (Signed)
Date		Time
Receiving Prison	{Name of Establishment)	
Prition Nui'$e (Signed}		
Date		t im·e