SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2021] FAI 12

LIV-B75-20

DETERMINATION

BY

SHERIFF CHRISTOPHER DICKSON

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

into the death of

MARK BARRY

Edinburgh, 9 February 2021

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") that:

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

   That the late Mark Barry, born 3 June 1976, died at 1423 hours on 4 March 2017 at St John's Hospital, Livingston.

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 suspension by ligature.

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):**

   That the precaution which could reasonably have been taken that might realistically have resulted in the death being avoided was the placing of Mr Barry on the "Talk to Me" strategy on the morning of 3 March 2017.

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):**

   That 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):**

   That there were no other facts relevant to the circumstances of the death.

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):
That the following recommendation is made:

1. That Sodexo should ensure, so far as reasonably practicable, that all staff trained on the "Talk to Me" strategy are aware: (i) of the limited circumstances when a "concern form" should be completed (see finding in fact 20); (ii) that a single member of staff, trained on the "Talk to Me" strategy, can place a prisoner on the "Talk to Me" strategy by completing an "initiation form"; and (iii) that once a prisoner is placed on the "Talk to Me" strategy the procedures in finding in fact 19 must be followed, which must include at least one case conference taking place within 24 hours.

NOTE

Introduction

[1] This inquiry was held into the death of Mark Barry. At the time of his death Mr Barry was a convicted prisoner serving a sentence at HM Prison, Addiewell (hereinafter referred to as HMP Addiewell). HMP Addiewell is an adult male prison which is operated by Sodexo in terms of a contract with the Scottish Prison Service (hereinafter referred to as "SPS"). Mr Barry unfortunately hanged himself using white

material suspended from the top of the bathroom door in cell 21 of Forth Alpha Wing, HMP, Addiewell, between 1000 hours and 1235 hours on 4 March 2017. On being discovered he was transferred to St John's Hospital, Livingston, however, he was unable to recover and sadly passed away in that hospital, later in the afternoon of 4 March 2017. The death of Mr Barry was reported to the Procurator Fiscal (hereinafter referred to as "PF") on 6 March 2017. A preliminary hearing was held on 9 November 2020 and the inquiry took place over 3 days between 5 and 7 January 2021.

[2] The parties were represented as follows:

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

(2) Mr Kane, solicitor, represented Sodexo;

(3) Mr Holmes, solicitor, represented the Lothian Health Board; and

(4) Ms Thornton, solicitor, represented the SPS.

[3] The representatives had conscientiously agreed a significant amount of evidence in a joint minute of agreement which ran to a total of 77 paragraphs. That resulted in the need for oral evidence to be significantly reduced. The inquiry heard oral evidence from the following witnesses:

(1) Scott Lawrie, Prison Custody Officer (hereinafter "PCO"), HMP Addiewell;

(2) Jim Murphy, Prison Chaplain, HMP Addiewell;

(3) Heather McLeary, former internal auditor at HMP Addiewell;

(4) William Henry, former Senior PCO, HMP Addiewell; and

(5) Lesley McDowell, Acting Head of Strategy, SPS.

[4] PCO Lawrie gave evidence about his dealings with Mr Barry on Forth Alpha Wing during his morning shift on 3 March 2017. Reverend Murphy gave evidence about his previous dealing with Mr Barry and, in particular, a conversation he had with him in his cell on Forth Alpha Wing on 3 March 2017. Ms McLeary gave evidence about training provided at HMP Addiewell in relation to the SPS "Talk to Me" strategy, audits conducted in relation to that strategy and investigations she made following the death of Mr Barry. Senior PCO Henry gave evidence about previous dealings with Mr Barry and, in particular, his dealings with him on 3 March 2017. Ms McDowell had been responsible for implementing the "Talk to Me" strategy across the SPS prisons (HMP Addiewell is a privately run prison). Ms McDowell gave evidence about how the "Talk to Me" strategy should operate in practice and in relation to the fact that Sodexo had made a decision to adopt the "Talk to Me" strategy at HMP Addiewell. I found all five witnesses to be credible and mainly 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 Barry died in legal custody, and, therefore, the inquiry was a mandatory inquiry held in terms of section 2(1) and (4) 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 Barry 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] In this Note I will, first, set out the summary of the facts that I have found proved. Second, I will set out a brief outline 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 information before the inquiry, the conclusions I have reached. Finally, I will explain the recommendation that I consider to be appropriate.

[9] Findings in fact 14 to 20 are based on the evidence of Ms McDowell as read with the SPS written guidance on the "Talk to Me" strategy. Findings in fact 53 to 55 are based on the evidence of PCO Lawrie. Finding in fact 56 is based on a combination of the evidence of Ms McLeary, Senior PCO Henry and Ms McDowell. Finding in fact 59 is based on a combination of the evidence of PCO Lawrie, Senior PCO Henry and Reverend Murphy. Finding in fact 60 is based on a combination of the evidence of PCO Lawrie and Senior PCO Henry. Finding in fact 71 is based on the post mortem report prepared by Dr Ralph BouHaidar. The remaining findings in fact are based on

the substantial joint minute of agreement as read with the agreed documentary productions.

Summary

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

Background

1. That Mark Barry was born on 3 June 1976 and died, aged 40, on 4 March 2017 at St John's Hospital, Livingston.

2. That at the time of his death, Mr Barry was in lawful custody at HMP Addiewell.

3. That on 21 July 2015 Mr Barry appeared at Southend-on-Sea Magistrates Court and was remanded into custody at HMP Chelmsford, Essex, England.

4. That on 28 September 2015 Mr Barry was sentenced to a period of 2 years and 6 months imprisonment following his conviction at Southend-on-Sea Magistrates Court for burglary of a dwelling place.

5. That on 31 October 2016 Mr Barry was subject to a Mental Health Assessment by psychiatrist Dr Alexander Lapa and was diagnosed with alcohol and poly-substance dependence, drug seeking behaviour, anxiety, and anger issues.

6. That on 1 November 2016 Mr Barry was released from HMP Chelmsford on licence.

7. That Mr Barry was recalled on his licence on 3 November 2016 for failing to comply with his reporting conditions and was returned to custody on 11 November 2016 at HMP Inverness.

8. That on 11 November 2016 Mr Barry was subject to a Risk Assessment at the Admissions Reception of HMP Inverness and as a result of that assessment, Mr Barry was placed on "Act 2 Care", which was, at the time, the suicide risk management strategy of the SPS.

9. That as a result of being placed on "Act 2 Care", Mr Barry was subject to regular observations until 16 November 2016 when it was determined, at a Case Conference, that he no longer posed a risk to himself.

10. That on 8 December 2016 Mr Barry was released on licence from HMP Inverness.

11. That on 23 December 2016 Mr Barry was recalled on his licence for failing to comply with his reporting conditions and on 30 December 2016 he was returned to lawful custody at HMP Addiewell.

12. That Sodexo operates HMP Addiewell under contract to the SPS. HMP Addiewell is an adult male prison situated in West Lothian that houses all offender types with the exception of convicted young offenders.

HMP Addiewell opened in 2008. Staff are employed directly by Sodexo and go through a rigorous training regime of nine weeks prior to active engagement. They then receive a variety of ongoing training programmes and are subject to a recognition programme to encourage excellence in the workplace.

13. That following on from a review in 2014 entitled the Suicide Risk Management Review, led by the SPS with input from multiple agencies, the "Talk to Me" strategy was introduced throughout the SPS estate and within HMP Addiewell. The "Talk to Me" strategy replaced the "Act 2 Care" strategy.

14. That 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 custody 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. "

15. That all prison officers and other staff at an SPS 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 prison officer and then by a prison nurse. If either the prison officer or the prison nurse consider that a prisoner is "At Risk" of suicide they are managed under the "Talk to Me" strategy.

16. That 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 approach 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.

17. That 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 (eg 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.

18. That the "Talk to Me" strategy can be initiated at any time in respect of a prisoner by an individual prison officer or member of staff who is trained in the "Talk to Me" strategy. If a prison officer or other member of staff, trained in the "Talk to Me" strategy, has a concern that a prisoner is "At Risk" of suicide, they should complete an "initiation form". The completion of the "initiation form" results in the prisoner being placed on the "Talk to Me" strategy immediately.

19. That if a prisoner is placed on the "Talk to Me" strategy there should be an immediate case conference or one arranged within 24 hours. A pre-case conference healthcare assessment should also be arranged within 24 hours (the healthcare assessment should be carried out by a mental health nurse where possible). If the case conference is not held immediately an immediate care plan should be prepared by the officer in consultation with a first line manager. The care plan will include the maximum interval between contacts with the prisoner (some prison officers refer to said contacts as "observations"). The first case conference has a minimum attendance of the prisoner, prison officer, first line manager and a nurse and will assess whether or not the prisoner remains "At Risk" of suicide. If the prisoner remains "At Risk" of suicide a care plan should be either prepared (if an immediate case conference is possible) or reviewed (if an immediate case conference was not possible). If the prisoner is considered to be "At Risk" of suicide at the first case conference a further case conference should be scheduled within 7 days and the care plan should be implemented in the meantime. At the next case conference an assessment should be made whether the prisoner remains "At Risk" of suicide; if such an assessment is made then the care plan should be reviewed and a further case conference should 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.

20. That the "Talk to Me" strategy includes a "concern form". The primary use of a "concern form" should be when an external party, not trained in the "Talk to Me" strategy, such as a relative of the prisoner, contacts the prison to raise a concern about a prisoner. In that event the prison officer receiving the information should complete the "concern form" and then, in conjunction with a first line manager (or in cases of urgency with another officer), meet with the prisoner and consider which of the following three outcomes should be reached in respect of the prisoner: (i) no apparent risk; (ii) no apparent risk with referral; and (iii) risk identified. If a risk is identified the prisoner should be placed on the "Talk to Me" strategy by the completion of an "initiation form". A "concern form" can also be completed by a prison officer in circumstances where a prisoner has self-harmed. If the prisoner is not thought to be "At Risk" of suicide and not in need of being placed on the "Talk to Me" strategy, the "concern form" is used as a means of recording the fact that the prisoner has self-harmed. If the prisoner is thought to be "At Risk" of suicide an "initiation form" should be completed and the prisoner placed on the "Talk to Me" strategy. Save for a self-harm situation, a "concern form" should not be used by a prison officer or any other staff member, trained in the "Talk to Me" strategy, in circumstances where they consider a prisoner is "At Risk" of suicide; they should, instead,

simply use the "initiation form", which results in the prisoner being placed on the "Talk to Me" strategy immediately.

21. That Sodexo introduced formal training for the "Talk to Me" strategy in October 2016 prior to the introduction of the strategy in December 2016. All operational staff employed within HMP Addiewell must complete an 8 hour core training session designed to provide them with the knowledge to enable the application of the "Talk to Me" strategy and they must complete a refresher course every three years. Sodexo has the responsibility to ensure staff at HMP Addiewell are trained and competent in the "Talk to Me" strategy. A failure to complete the "Talk to Me" training results in employees being removed from active duty until compliance with the programme is attained.

Mr Barry's time at HMP Addiewell between 30 December 2016 and 4 March 2017

1st "Talk to Me" process

22. That on admission to HMP Addiewell on 30 December 2016, Mr Barry stated that he wanted to die and disclosed previous attempts of suicide by self-harming.

23. That as a result of those comments, a "concern form" was raised by PCO Steven Little in relation to Mr Barry and he was placed on the "Talk to Me" strategy.

24. That Mr Barry remained on the "Talk to Me" strategy on that occasion until 6 January 2017 by which point he was engaged with the mental health team at prison and stated that he no longer had thoughts of self-harm or suicide.

25. That on 6 January 2017 Mr Barry was deemed of "no apparent risk".

2nd "Talk to Me" process

26. That on 12 January 2017 Mr Barry reported that he could hear voices and was having suicidal thoughts.

27. That as a result of those reports, a "concern form" was raised by PCO Gary Stewart in relation to Mr Barry.

28. That following the '"concern form" being raised an "initiation form" was thereafter completed by PCO Patrick Vernal which included a care plan involving "no sharps, no IP meds, own clothes permitted…mental health team notified" and Mr Barry was placed on 30 minute observations.

29. That during the case conference on 13 January 2017, it was recorded that Mr Barry said "on several occasions he doesn't want to live anymore and he can't live with what he's done". As a result of this case conference, Mr Barry was placed on 15 minute observations and was only permitted to have an anti-ligature gown and blanket.

30. That during the case conference on 14 January 2017, Mr Barry was taken off anti-ligature measures, was given his "jail greys" and remained on 15 minute observations.

31. That during the case conference on 15 January 2017, Mr Barry was noted to have improved and was placed on increased 30 minute observations.

32. That during the case conference on 17 January 2017, Mr Barry denied having thoughts of self-harm or suicide, but was erratic and non-compliant during the meeting. The case conference required to be adjourned and reconvened later that day and it was decided that he would remain on 30 minute observations.

33. That during the case conference on 19 January 2017, Mr Barry was believed to now pose "no apparent risk" and had improved. All who attended the case conference on 19 January 2019 agreed for Mr Barry to be removed from the "Talk to Me" strategy.

Concern Form

34. That on 13 February 2017 a "concern form" was raised by PCO Lukasz Bujalski in respect of Mr Barry and was highlighted to Senior PCO N McMechan with medical staff also being notified;

35. That on 13 February 2017 Mr Barry was found to have inflicted superficial cuts to his right arm and it is noted by Senior PCO N McMechan on the "concern form" that:

> "Nurse L. Johnstone agreed with myself and PCO Bujalski that Mr Barry was not at risk of committing suicide, it appeared to be a way of attempting to get more tobacco, as constantly requested by Mr Barry. Mr Barry did claim to swallow plastic – no evidence to confirm this. "

That following the above assessment, Mr Barry was deemed to be of "no apparent risk" and was not placed on the "Talk to Me" strategy.

3rd "Talk to Me" process

36. That on 18 February 2017 an "initiation form" was raised by Senior PCO Alan Whiteford in respect of Mr Barry, stating on the form: "Mark has presented in various stages of mental health issues throughout the morning. Claiming [illegible] swallowing various articles". As a result, mental health were notified and Mr Barry was placed on "anti-ligature cell/clothing to prevent further harm" and 15 minute observations.

37. That during the case conference on 19 February 2017, it was agreed by all those in attendance that Mr Barry was allowed to have his normal clothes back and that he would be placed on 60 minute observations.

38. That during the case conference on 20 February 2017, Mr Barry was noted to be reluctant to go into mainstream population within the prison and had met with the hospital psychiatrist. All who were present at the case conference agreed that Mr Barry no longer required to remain on the "Talk to Me" strategy and he was deemed to be of "no apparent risk".

4th "Talk to Me" process

39. That on 25 February 2017 a "concern form" was raised by PCO Gary Meechan in relation to Mr Barry reporting that Mr Barry had stated that he was hearing voices and had self-harmed by cutting his right arm.

40. That on 25 February 2017 as a result of the concern raised, Mr Barry was placed on the "Talk to Me" strategy, taken to hospital, placed on anti-ligature measures and placed on 15 minute observations.

41. That during his case conference on 26 February 2017, Mr Barry was noted to present well and had admitted that his attempt to self-harm was not something that he thought he would do and that he had no further thoughts of self-harm.

42. That at the case conference on 26 February 2017, nurse Lorraine Mitchell highlighted that Mr Barry had been concealing his medication.

43. That on 27 February 2017 at approximately 1900 hours it was recorded in the care plan report that: "Mark has been very tearful…Mark has stated he wants to go as a protection prisoner as there are many people after him. "

44. That on the morning of 28 February 2017, Mr Barry arrived on Forth Alpha Wing following his request to move.

45. That it was recorded on 1 March 2017 in the care plan report that Mr Barry was "much better", "settled", and "out and about socialising with other prisoners".

46. That on 1 March 2017, it was confirmed to Mr Barry that his inter-prison telephone call would go ahead with his girlfriend who was in custody in England at the time. Mr Barry was noted in the care plan report to reply with the comment "Promise me if anything happens to me you will let my girlfriend know".

47. That during the case conference on 2 March 2017, Mr Barry was noted to have improved and progressed steadily and the periods of his observations had increased gradually.

48. That as a result of the noted improvement, Mr Barry was assessed as of "no apparent risk" and he was taken off the "Talk to Me" strategy.

49. That it was agreed that Mr Barry would be supported with weekly mental health meetings as well as one to one meetings with a view to addressing the precipitating factors and risks.

50. That all in attendance at the case conference on 2 March 2017, including Senior PCO Henry, agreed that the "Talk to Me" strategy would be closed and that there was constant support available through Wing Staff and Mr Barry's personal officer.

51. That Mr Barry was taken off the "Talk to Me" strategy at 1430 hours on 2 March 2017.

3 March 2017

52. That on Friday 3 March 2017, PCO Scott Lawrie was working an early shift, between 0700 hours and approximately 1230 hours, on Forth Alpha Wing of the prison. Forth Alpha Wing is protection wing for vulnerable prisoners. At that time Mr Barry was housed in cell 21 of Forth Alpha Wing. At some point during the morning of 3 March 2017, another prisoner on Forth Alpha Wing advised PCO Lawrie that Mr Barry was going to kill himself. PCO Lawrie went to see Mr Barry in his cell. Mr Barry had barricaded himself in his cell by placing his mattress over the door of his cell. PCO Lawrie spoke to Mr Barry through the hatch of the cell door. Mr Barry appeared paranoid and was saying that: (i) people were trying to kill him; and (ii) that people from down south were trying to get him. PCO Lawrie tried to reassure Mr Barry that he was not going to be harmed. After about 15 minutes discussion at the cell door hatch PCO Lawrie was able to enter Mr Barry's cell. Mr Barry was on his bed, curled up against the wall. Mr Barry appeared to be suspicious, was looking around his cell and said that he thought people were coming though the walls of his cell to get him. PCO Lawrie spent around 15 minutes in Mr Barry's cell trying to reassure him and calm him down. Mr Barry told PCO Lawrie that he was not going to harm himself. Once PCO Lawrie felt that Mr Barry had settled down he left the cell to get on with his other duties.

53. That throughout the morning on 3 March 2017 PCO Lawrie was required to return to Mr Barry's cell on a number of occasions. On each occasion Mr Barry

presented as paranoid and was voicing the same concerns about people getting him. Throughout the morning Mr Barry also said that he had thoughts of harming himself. PCO Lawrie constantly sought to reassure Mr Barry that he was safe. After about the third or fourth visit to Mr Barry's cell that morning, PCO Lawrie formed the view that Mr Barry was at risk of harming himself. As a result PCO Lawrie decided that he should place Mr Barry on the "Talk to Me" strategy. At that time the Senior PCO for Forth Alpha Wing was William Henry but he was not on the Wing at the time.

54. That PCO Lawrie had had experience of using the "Act 2 Care" strategy but this was his first time using the "Talk to Me" strategy following having been trained in its use. PCO Lawrie commenced the completion of a "concern form" in relation to Mr Barry. PCO Lawrie commenced an observation sheet and placed Mr Barry on observations of either 15, 30 or 60 minutes. PCO Lawrie then carried out observations of Mr Barry at the level of intervals that he had set.

55. That the "concern form" used by PCO Lawrie came from training materials and, although identical to the "concern form" that was in operational use, ought not to have been used. In any event, in order to place Mr Barry on the "Talk to Me" strategy PCO Lawrie should have completed an "initiation form" and should not have completed a "concern form". The partial completion of "concern form" by PCO Lawrie in relation to Mr Barry did not result in Mr Barry being placed on the "Talk to Me" strategy. An "initiation form" was not completed in respect of Mr Barry on 3 March 2017.

56. That on Friday 3 March 2017, the mental health team at HMP Addiewell received a call requesting that Mr Barry be placed on the "Talk to Me" strategy due to voicing thoughts to hang himself.

57. That the officer who called the mental health team advised a nurse that Mr Barry would be placed on 30 minute observations and that they would discuss matters with their senior officer;

58. That around 1130 hours on 3 March 2017 PCO Lawrie handed the "concern form", in relation to Mr Barry, to Senior PCO Henry. Senior PCO Henry had previous experience of dealing with Mr Barry, including previously dealing with him on the "Talk to Me" strategy. At that time Mr Barry had not been placed on the "Talk to Me" strategy. Senior PCO Henry told PCO Lawrie that he was going to speak to Mr Barry. A short time later that day Senior PCO Henry and Reverend Murphy went to see Mr Barry in his cell. Mr Barry presented well to both Senior PCO Henry and Reverend Murphy, was laughing and joking and seemed to be buoyed up by his forthcoming inter-prison telephone call with his girlfriend. Mr Barry promised both Senior PCO Henry and Reverend Murphy that he would not harm himself and shook both their hands to confirm the promise that he gave them. Mr Barry also made arrangements to meet with Reverend Murphy on Monday 6 March 2017 and asked Reverend Murphy on a number of occasions to reassure him that that meeting would take place. Reverend Murphy provided that reassurance. After their conversation with Mr Barry, the genuinely held belief of both Senior

PCO Henry and Reverend Murphy was that Mr Barry was of no apparent risk of suicide and that he did not need to be managed on the "Talk to Me" strategy. Shortly before PCO Lawrie's shift ended on 3 March 2017, Senior PCO Henry advised PCO Lawrie that Mr Barry did not need to be managed on the "Talk to Me" strategy.

59. That following Mr Barry's conversation in his cell with Senior PCO Henry and Reverend Murphy, Mr Barry was not managed on the "Talk to Me" strategy.

4 March 2017

60. That on 4 March 2017 PCO Gary Collinge carried out accommodation fabric checks which required all equipment within the cells to be tested.

61. That at around 1000 hours on 4 March 2017 PCO Collinge carried out accommodation fabric checks within Mr Barry's cell (cell 21) on Forth Alpha Wing.

62. That during these checks PCO Collinge described Mr Barry as being fine and sitting on his bed watching the television.

63. That between 1230 hours and 1235 hours on 4 March 2017 PCO William Hamilton and PCO Collinge, were performing a "lockdown" procedure on Forth Alpha Wing in order that staff could take their breaks.

64. That PCO Hamilton was responsible for locking down Mr Barry's cell (cell 21) on Forth Alpha Wing.

65. That on entering cell 21 on Forth Alpha Wing PCO Hamilton looked behind the cell door and saw Mr Barry slumped in front of the bathroom door. Mr Barry was in a seated position with his legs out and slumped to the right with white material around his neck and suspended from the top of the bathroom door.

66. That Mr Barry was found to be unresponsive and a "Code Blue" was immediately called in order to alert other staff that a prisoner was not breathing.

67. That prison staff immediately made their way to cell 21 on Forth Alpha Wing and commenced CPR on Mr Barry whilst an ambulance was called.

68. That Mr Barry was conveyed to the Accident and Emergency department at St John's Hospital, Livingston, by emergency ambulance.

69. That at 1423 hours on 4 March 2017, Dr Andrew Stevenson pronounced Mr Barry's life extinct.

Post mortem examination

70. That on 7 March 2017 Dr Ralph BouHaidar, Consultant Forensic Pathologist, conducted a post mortem examination of Mr Barry at the Edinburgh City Mortuary and subsequently prepared a report. The conclusion of Dr BouHaidar, following said examination, was as follows:

> "Post mortem examination showed that this 40-year-old man died from suspension by ligature. There were two ligature marks around the neck associated with fracture of the left hyoid bone and some haemorrhage surrounding this with further haemorrhage surrounding the left upper

> horn of the thyroid cartilage. This was associated with petechial haemorrhages on the face and conjunctivae.
> Elsewhere on the body there were marks suggestive of medical intervention and a number of scars on the forearms with features suggesting self-infliction.
> Subsequent toxicology was negative for alcohol and drugs. "

71. The medical certificate of cause of death was completed as follows:

"1a Suspension by ligature"

Submissions

[11] All parties helpfully prepared written submissions. In the written submissions all parties sought formal findings in respect of section 26(2)(a) and (c) of the 2016 Act. Lothian Health Board also sought findings in respect of section 26(2)(b) and (d) of the 2016 Act on the basis that the hanging event was an accident. However, whilst I agreed with Lothian Health Board's analysis of the factual position, I have determined that it was not an accident and have therefore not made any findings under those sections. The formal findings sought were based on the agreed evidence before the inquiry and my findings in relation to section 26(2)(a) and (c) of the 2016 Act mirror those sought by each of the parties. In the written submission both the Crown and Sodexo submitted that a finding should not be made in terms of section 26(2)(e) of the 2016 Act on the basis of Mr Barry's conversation with Senior PCO Henry and Reverend Murphy (see finding in fact 59). However, during oral submission both the Crown and Sodexo accepted, for the reasons set out at para [29] below, that a precaution which could reasonably have been taken that might realistically have resulted in the death being avoided was the

placing of Mr Barry on the "Talk to Me" strategy on the morning of 3 March 2017. Sodexo also accepted that there appeared to be confusion as regards when a "concern form" ought to be used. None of the parties invited the inquiry to make a recommendation.

Discussion and conclusions

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

[12] In this inquiry there was no dispute as regards when and where the death occurred. Mr Barry died at 1423 hours on 4 March 2017 at St John's Hospital, Livingston.

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

[13] There was no dispute that the incident that resulted in Mr Barry taking his own life occurred between 1000 and 1235 hours on 4 March 2017 within cell 21 of Forth Alpha Wing at HMP Addiewell. 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)

[14] There was no dispute as regards the cause or causes of death. The conclusion of Dr Ralph BouHaidar, Consultant Forensic Pathologist has been set out at finding in

fact 71 above. Dr BouHaidar carried out a post mortem examination of Mr Barry on 7 March 2017. He noted two ligature marks around the neck of Mr Barry, an associated fracture of the left hyoid bone and haemorrhaging. The medical certificate of cause of death was completed as follows: "1a Suspension by ligature"

[15] 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)

[16] There was no dispute that the incident that resulted in Mr Barry taking his own life arose as a result of: (i) Mr Barry using white fabric or material to make a ligature and suspending the white fabric or material from the bathroom door in cell 21 of the Forth Alpha Wing at HMP Addiewell; and (ii) Mr Barry placing the ligature around his neck and using it to hang himself from the said bathroom door.

[17] In the circumstances, Mr Barry's 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)

[18] 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 edition at paragraph 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."

[19] 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 paragraph 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 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.

[20] In the present case the majority of the evidence was either agreed or undisputed and the vast majority of the findings in facts are based on that agreed evidence (see para [9] above). The only issues which emerged from the oral evidence heard by the inquiry were: (i) whether PCO Lawrie completed a "concern form", "observation sheet" and an "initiation form"; and (ii) whether the "Talk to Me" strategy was being operated in accordance with the SPS guidance.

[21] As regards the first issue, PCO Lawrie detailed how Mr Barry was presenting on the morning of 3 March 2017 (see findings in fact 53 and 54) and explained that by the third or fourth time of seeing Mr Barry that morning he formed the view that he was going to harm himself and decided to put him on the "Talk to Me" strategy.
PCO Lawrie explained that he started completing the "Talk to Me" strategy documentation by putting a brief explanation of why he was putting Mr Barry on the "Talk to Me" strategy and the interval between observations that he had decided was appropriate. PCO Lawrie stated that he commenced an observation sheet. When PCO Lawrie was referred in evidence to a blank "concern form" and a blank "initiation form" he stated that he completed both but, understandably given the passage of time since 3 March 2017, could not remember what he wrote. When pressed PCO Lawrie stated that he completed the first part of the "concern form" but could not recall completing parts 4 (record of decision), 5 (record of referrals and other actions) and 6 (confirmation that the recommended referrals have been made and any actions

completed). Ultimately, PCO Lawrie said that he knew he filled in the book (meaning the "Talk to Me" strategy documentation) but he did not know how far. PCO Lawrie could not recall whether he telephoned the mental health team in relation to Mr Barry (see findings in fact 57 and 58) but accepted it was a possibility. PCO Lawrie was clear that he saw Senior PCO Henry about 1130 hours on 3 March 2017 and said that he told him that he was worried that Mr Barry was going to harm himself and that he had placed him on the "Talk to Me" strategy. PCO Lawrie explained that before the end of his shift he handed Senior PCO Henry the "full 'Talk to Me' book" and the observation sheet. PCO Lawrie explained that Senior PCO Henry went to speak to Mr Barry and, after doing so, told PCO Lawrie that Mr Barry did not need to be on the "Talk to Me" strategy. PCO Lawrie initially explained that he was not concerned with Senior PCO Henry's decision because: (i) he was an experienced officer; (ii) he had dealt with Mr Barry before; and (iii) he trusted him to make the correct call. However, later in his evidence, PCO Lawrie stated he did not agree with the decision taken by Senior PCO Henry. PCO Lawrie explained that he returned to work on Monday 6 March 2017 and on that day he saw "the book" (meaning the "Talk to Me" strategy documentation he had completed in respect of Mr Barry) in the office of the Senior PCO.

[22] Senior PCO Henry noted that he had previously dealt with Mr Barry in circumstances where he had behaved irrationally, emotionally, was talking incoherently and making statements that people were going to get him. Senior PCO Henry had also previously dealt with Mr Barry when he had self-harmed by inflicting superficial cuts to his arm. On 3 March 2017 Senior PCO Henry explained that PCO Lawrie came to him

with a "concern form" in relation to Mr Barry. Senior PCO Henry explained that a "concern form" was not for internal use but ought to be used when someone outside the prison reported a concern about a prisoner. If such a concern was reported by an external party that would then result in a PCO visiting the prisoner to see whether further action was needed (which would include consideration of whether to place the prisoner on the "Talk to Me" strategy). Senior PCO Henry explained that if a PCO had a concern about a prisoner that they could place the prisoner on the "Talk to Me" strategy. Senior PCO Henry explained that PCO Lawrie told him that Mr Barry had said that he was going to kill himself. After speaking with PCO Lawrie, Senior PCO Henry went to speak to Mr Barry. On route he asked Reverend Murphy to come with him. When Senior PCO Henry and Reverend Murphy arrived at Mr Barry's cell, Mr Barry was sitting within his cell chatting to another prisoner. Senior PCO Henry explained that he asked Mr Barry about him saying that he was going to kill himself. Senior PCO Henry explained that Mr Barry said that he was only joking and that he was not going to act upon saying he was going to kill himself. Mr Barry then went on to talk about a phone call that he was due to have in the next few days with his partner who was in custody in another prison. Senior PCO Henry noted that Mr Barry was laughing and joking with him; that Mr Barry gave him his word that he would not try to kill himself and shook the hands of both Senior PCO Henry and Reverend Murphy to confirm that he was not going to do anything to himself. Senior PCO Henry advised that in those circumstances he did not think that Mr Barry required to be placed on the "Talk to Me" strategy.

[23] Reverend Murphy confirmed and supported Senior PCO Henry's account of what had occurred in Mr Barry's cell and, in particular, confirmed: (i) that Mr Barry seemed a lot better than he had been when Reverend Murphy had previously met with him; (ii) that Mr Barry said that he had no thoughts of harming himself; (iii) that Mr Barry promised Reverend Murphy and Senior PCO Henry that he would not harm himself and shook both their hands to confirm that promise; (iv) that Mr Barry was taking about a phone call which had been set up with his girlfriend who was in prison and seemed to be buoyed up by this; and (v) that Mr Barry made Reverend Murphy promise, on two or three occasion, that Reverend Murphy would come and visit him on the following Monday (which would have been Monday 6 March 2017). Reverend Murphy explained that on leaving Mr Barry's cell he did not have any concern that Mr Barry would harm himself. Had he had the slightest concern he would have voiced that concern to Senior PCO Henry and insisted that Mr Barry be placed on the "Talk to Me" strategy, however, he had no such concern.

[24] Heather McLeary explained at the time of Mr Barry's death she was employed at HMP Addiewell as an internal auditor. That role included acting as a trainer in respect of the "Talk to Me" strategy and acting as a co-ordinator in respect of deaths in custody. The co-ordinator role involved gathering in all the data about a particular death. Ms McLeary explained that she was tasked with ingathering data in relation to the death of Mr Barry. She advised: that she had spoken to PCO Lawrie; that he had made her aware that he had completed a "concern form" in respect of Mr Barry; and that the "concern form" was located in Senior PCO Henry's office. Ms McLeary explained that

she initially could not find this "concern form" but eventually found it Senior PCO Henry's office. In that office she found half a dozen "Talk to Me" booklets that had been used for training purposes. These booklets contained forms used in the "Talk to Me" strategy. Ms McLeary advised that she looked through the booklets and, in one of them, found the "concern form" that PCO Lawrie had completed in respect of Mr Barry. Ms McLeary thought that the form said something like that Mr Barry was of low mood. Nothing further was completed on the form and no other forms had been completed in the booklet. Ms McLeary explained that the training booklets should not have been used and that there were loose leaf "concern forms" located throughout the prison that PCO Lawrie could have used. Ms McLeary did not locate any "initiation form" completed by PCO Lawrie in respect of Mr Barry. Ms McLeary explained that the partially completed "concern form" in relation to Mr Barry, which she had found in Senior PCO Henry's office, subsequently went missing and was not subsequently found.

[25] I considered that PCO Lawrie, Senior PCO Henry, Reverend Murphy and Ms McLeary were all doing their best to assist the inquiry but were hampered by the passage time between the events and the date they were giving evidence. PCO Lawrie said he remembered filling "in the book" (meaning the "Talk to Me" strategy documentation) but he did not know how far he completed it. He could not recall completing parts 4, 5 and 6 of the "concern form". When he was asked about the "initiation form" he thought that he did complete it but explained what he would have completed without having any recollection of what was actual completed (if anything). PCO Lawrie also confirmed that he saw "the book" (meaning the "Talk to Me" strategy

documentation that he completed in respect of Mr Barry) in the office of the Senior PCO on Monday 6 March 2017. Senior PCO Henry was clear that he only received a "concern form" from PCO Lawrie. I considered his evidence was supported by the fact that Ms McLeary found the training booklet in Senior PCO Henry's office (which appears to be the same office that PCO Lawrie said he saw "the book") with only "the concern form" partially completed, that no other forms had been completed in that booklet and that PCO Lawrie had only told her about completing a "concern form". After considering all the evidence, I concluded, on balance, that PCO Lawrie: (i) only commenced completing a "concern form" in respect of Mr Barry; (ii) did not fully complete the said "concern form"; and (iii) did not complete an "initiation form". It was not clear how far the "concern form" had been completed. PCO Lawrie was clear that he completed an observation sheet and that was to some extent supported by the telephone call made to the mental health team (see finding in fact 58) where an officer stated that Mr Barry would be placed on 30 minute observations. Unfortunately, no observation sheet was ever located by Ms McLeary. In all the circumstances I considered that it was likely that it was PCO Lawrie that made the telephone call to the mental health team, that he did commence an observation sheet in respect of Mr Barry, but that the observation sheet had somehow been lost.

[26] The second issue is whether the "Talk to Me" strategy was being operated in accordance with the SPS guidance. Lesley McDowell was employed by the SPS and had overall responsibility for the implementation of the "Talk to Me" strategy, which went live in December 2016. Ms McDowell explained how the "Talk to Me" strategy should

work (see findings in fact 14 to 19) and explained the purpose and limited use of "concern forms" (see finding in fact 20). Ms McDowell's evidence, taken together with the SPS "Talk to Me" strategy guidance, made clear:

(1) That the "Talk to Me" strategy can be initiated at any time in respect of a prisoner by an individual prison officer or member of staff who is trained in the "Talk to Me" strategy.

(2) That if a prison officer or other member of staff has a concern that a prisoner is "At Risk" of suicide, they should complete an "initiation form".

(3) That the completion of the "initiation form" results in the prisoner being placed on the "Talk to Me" strategy immediately.

(4) That once a prisoner is placed on the "Talk to Me" strategy the procedure set out in finding in fact 19 should be followed;

(5) That the primary use of a "concern form" should be when an external party, not trained in the "Talk to Me" strategy, such as a relative of the prisoner, contacts the prison to raise a concern about a prisoner. In that event the prison officer receiving the information should complete the "concern form" and then, in conjunction with a first line manager (or in cases of urgency with another officer), meet with the prisoner and consider which of the following three outcomes should be reached in respect of the prisoner: (i) no apparent risk; (ii) no apparent risk with referral; and (iii) risk identified. If a risk is identified the prisoner should be placed on the "Talk to Me" strategy by the completion of an "initiation form".

(6) That a "concern form" can also be completed by a prison officer in circumstances where a prisoner has self-harmed. If the prisoner is not thought to be "At Risk" of suicide and not in need of being placed on the "Talk to Me" strategy, the "concern form" is used as a means of recording the fact that the prisoner has self-harmed. If the prisoner is thought to be "At Risk" of suicide an "initiation form" should be completed and the prisoner placed on the "Talk to Me" strategy.

(7) That save for point (6) above, a "concern form" should not be used by a prison officer or any other staff member trained in the "Talk to Me" strategy, in circumstances where they consider a prisoner is "At Risk" of suicide; they should, instead, simply use the "initiation form", which results in the prisoner being placed on the "Talk to Me" strategy immediately.

[27] PCO Lawrie explained that he had been trained on the "Talk to Me" strategy but made clear that he had not, at the time, used it in a live situation. PCO Lawrie was clear that he wanted to place Mr Barry on the "Talk to Me" strategy. As can be seen from para [26] above, PCO Lawrie should not have completed a "concern form". Rather, he should have completed an "initiation form", which would have resulted in Mr Barry being placed on the "Talk to Me" strategy immediately. The partial completion of a "concern form" in relation to Mr Barry did not result in Mr Barry being placed on the "Talk to Me" strategy. Given that a "concern form" had been commenced and handed to Senior PCO Henry, it was not clear why Senior PCO Henry did not record his decision in that form that he considered Mr Barry to be of no apparent risk of suicide.

[28] Ms McLeary trained staff at HMP Addiewell on the "Talk to Me" strategy but she was not asked about what training had been given in relation to the proper use of a "concern form". She did correctly identify that once a "concern form" was completed, two officers (which should normally be an officer and a first line manager) should meet with the prisoner to ascertain whether they were at risk of suicide. However, at one point in her evidence, she appeared to suggest that it required two officers to decide to place a prisoner on the "Talk to Me" strategy. If that was what Ms McLeary was suggesting then that was not correct. Ms McDowell made clear in her evidence that any single officer or single member of staff, trained in the "Talk to Me" strategy, could place a prisoner on the "Talk to Me" strategy. Once that had been done (by way of completing the "initiation form"), Ms McDowell explained that the procedure in finding in fact 19 must be followed and that a senior officer could not unilaterally decide to take a prisoner off the "Talk to Me" strategy even if they consider that the prisoner was of "no apparent risk" of suicide. To be fair to Ms McLeary, it is possible she was referring to the completion of the immediate care plan after a prisoner had been placed on the "Talk to Me" strategy, which does require the officer completing the immediate care plan to prepare it in discussion with a first line manager.

[29] In evidence Senior PCO Henry demonstrated that he understood the proper use of the "concern form" (see para [22] above, as read with finding in fact 20) and correctly understood that when he went to speak to Mr Barry in his cell that he had not in fact been placed on "Talk to Me" strategy (because an "initiation form" had not been completed). The SPS "Talk to Me" strategy, Guidance Part 1, makes clear, at page 3, that

the assessment of prisoners "is a dynamic process, where levels of risk often change, sometimes very quickly" and I considered that Mr Barry's levels of risk had changed quickly on the morning of 3 March 2017. I accepted the evidence of both Senior PCO Henry and Reverend Murphy as regards what Mr Barry was saying and how he was presenting when they both spoke to him in his cell. I accepted that, at that time, both Senior PCO Henry and Reverend Murphy's genuine belief was that Mr Barry was of no apparent risk of suicide and therefore, at that time, did not need to be placed on the "Talk to Me" strategy. I also accepted the evidence of PCO Lawrie in relation to how Mr Barry was presenting earlier that morning and accepted that Mr Barry's presentation caused PCO Lawrie, for cogent reasons, to consider that Mr Barry was "At Risk" of suicide. PCO Lawrie clearly considered that Mr Barry should be placed on the "Talk to Me" strategy. I considered that PCO Lawrie was trying to do his best for Mr Barry and genuinely believed that he had placed Mr Barry on the "Talk to Me" strategy (even though that was not case as an "initiation form" had not been completed). It was, paradoxically, extremely unfortunate that Mr Barry's presentation had significantly changed for the better when he had spoken to Senior PCO Henry and Reverend Murphy and resulted in him not being placed on the "Talk to Me" strategy. However, had the correct procedure been followed an "initiation form" (not a "concern form") would have been completed by PCO Lawrie and Mr Barry would have been placed on the "Talk to Me" strategy on the morning of 3 March 2017 prior to Senior PCO Henry and Reverend Murphy going to speak to him. Had that occurred, Senior PCO Henry would not, if the correct procedure had been followed, have been able to

decide that Mr Barry should not be on the "Talk to Me" strategy and Mr Barry would have then benefited from the procedures set out in finding in fact 19, which would have included a pre-case conference healthcare assessment within 24 hours, an immediate care plan (if an immediate case conference was not possible) and at least one case conference within 24 hours (which would have had the minimum attendance of an officer, first line manager, a nurse and Mr Barry). Any immediate care plan would have included the maximum intervals between contacts with Mr Barry (Ms McDowell made clear that a contact is not just about observing the prisoner to make sure they are safe but also to interact with them in a meaningful way). Had these measures been put in place on the morning of 3 March 2017 and had Mr Barry been on the "Talk to Me" strategy on 4 March 2017, there could still clearly be no guarantee that Mr Barry would not have deliberately taken his own life between 1000 hours and 1235 hours on 4 March 2017, but he would have had less opportunity to do so and would have had additional supports in place. Indeed, it may even have been possible for the procedures in finding in fact 19 to have been followed quickly and that Mr Barry, given the way he presented to Senior PCO Henry and Reverend Murphy, could possibly have been removed from the "Talk to Me" strategy prior to taking his own life. However, on all of the previous recent occasions that Mr Barry had been placed on the "Talk to Me" strategy (on which see para [31] below), he had remained on it for a number of days. In all the circumstances, I have determined that the placing of Mr Barry on the "Talk to Me" strategy on the morning of 3 March 2017 was a precaution which could reasonably have

been taken, and, had it been taken, might realistically have resulted in Mr Barry's death being avoided on 4 March 2017.

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)

[30] 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 into the death of Mildred Allan (an extract of which is set out in Carmichael at paragraph 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 s. 6(1)(d)) as to defects, if any, in any system of working which contributed to the 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."

[31] In the present case I have explained how the "Talk to Me" strategy should have operated and in what respect the proper procedure was not followed. There was, however, no suggestion that there was any defect in the "Talk to Me" strategy itself, provided that that system of working was properly followed. The evidence in respect of the 1st to 4th "Talk to Me" processes, that Mr Barry had recently been on, was agreed ((for the 1st process see findings in fact 22 to 25; for the 2nd process see findings in fact 26 to 33; for the 3rd process see findings in fact 37 to 39; for the 4th process see findings in fact 40 to 52) and was not explored in oral evidence. The agreed evidence showed that a

"concern form" had been completed in the 1st, 2nd and 4th "Talk to Me" processes. Whilst the use of "the concern form" in 4th "Talk to Me" process was in accordance with the SPS "Talk to Me" strategy guidance (due to Mr Barry having self-harmed), the use of the "concern form" in the 1st and 2nd "Talk to Me" processes appeared, on the basis of the agreed evidence, to be unnecessary. However, the agreed evidence in respect of the 3rd "Talk to Me" process showed that Senior PCO Whiteford had not used a "concern form" and had correctly completed an "initiation form", which resulted in Mr Barry being placed on the "Talk to Me" strategy. In addition Senior PCO Henry was aware of the circumstances when a "concern form" ought properly to be used and both he and Ms McLeary were clear that it was not necessary to complete a "concern form" prior to placing a prisoner on the "Talk to Me" strategy. Further, the "concern form" of 13 February 2017 appeared to have been used appropriately. I considered whether there may have been a defect in the way that the "Talk to Me" strategy had been implemented at HMP Addiewell (by way of officers unnecessarily completing a "concern form" when they considered a prisoner to be "At Risk" of suicide) but I came to view that I had not heard sufficient evidence to make a finding in that regard. I have, however, made a recommendation to attempt to ensure that any misunderstanding in relation to the correct use of a "concern form" is removed.

[32] In the circumstances, I do not consider that were any defects in the systems of working which contributed to Mr Barry's death.

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

[33] There were no other facts which were relevant to the circumstances of Mr Barry's death.

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)

[34] As I have set out in para [31] above, in addition to the unnecessary use of the "concern form" on 3 March 2017, the agreed evidence showed that the use of the "concern form", in the 1st and 2nd "Talk to Me" processes, appeared to be unnecessary. I considered that the unnecessary completion of a "concern form", in circumstances where an officer considers a prisoner to be "At Risk" of suicide, could result in: (i) a delay (between the commencement of the completion of the "concern form" and the time taken for the officer and their first line manager to speak to and assess the prisoner in accordance with the "concern form" procedure) in placing a prisoner "At Risk" of suicide on the "Talk to Me" strategy (and therefore a delay in implementing an immediate care plan for prisoner "At Risk" of suicide); and (ii) the prisoner, in the period before being spoken to and assessed by the officer and first line manager in accordance with the "concern form" procedure, changing presentation, and not being

assessed as "At Risk" of suicide and therefore not placed on the "Talk to Me" strategy (which is akin to what occurred in the present case).

[35] Further, PCO Lawrie appeared to accept that a Senior PCO could remove a prisoner from the "Talk to Me" strategy without the procedures set out in finding in fact 19 being followed (the procedures set out in finding in fact 19 should always be followed) and Ms McLeary appeared to suggest that it required two persons, trained in the "Talk to Me" strategy, to place a prisoner on the "Talk to Me" strategy (any individual member of staff, trained in the "Talk to Me" strategy, can place a prisoner on the strategy by completing an "initiation form"). In the circumstances I consider the steps set out in the following recommendations might realistically prevent other deaths in similar circumstances:

1. That Sodexo should ensure, so far as reasonably practicable, that all staff trained on the "Talk to Me" strategy are aware: (i) of the limited circumstances when a "concern form" should be completed (see finding in fact 20); (ii) that a single member of staff, trained on the "Talk to Me" strategy, can place a prisoner on the "Talk to Me" strategy by completing an "initiation form"; and (iii) that once a prisoner is placed on the "Talk to Me" strategy the procedures in finding in fact 19 must be followed, which must include at least one case conference taking place within 24 hours.

Postscript

[36] At the outset of the inquiry I extended my condolences to Mr Barry's family. I was joined in those condolences by the other parties. I wish to formally repeat my condolences to Mr Barry's family in this determination.