SHERIFFDOM OF LOTHIAN AND BORDERS AT LIVINGSTON

[2021] FAI 51

LIV-B276-20

DETERMINATION

BY

SHERIFF JOHN A MACRITCHIE SSC

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

into the death of

JAMES GRAHAMES

Livingston, 20 August 2021

DETERMINATION

The Sheriff having considered the information presented at the Inquiry, determines in terms of section 26 of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act") that:

In terms of section 26(2)(a) of the Act, James Grahames, born 6 December 1961 (aged 56), was in long term legal custody within Her Majesty's Prison Addiewell, 9 Station Road, Addiewell, West Calder and on 27 July 2018, at or about 07:43 hours, died within Cell 3, in the Forth Alpha Wing of said prison.

In terms of section 26(2)(b) of the Act, the death was not the result of an accident which had occurred.

In terms of section 26(2)(c) of the Act, the cause of the death was suspension by a ligature (hanging), Mr Grahames having taken his own life.

In terms of section 26(2)(d) of the Act, the death was not the result of an accident.

In terms of section 26(2)(e) of the Act, no precautions could reasonably have been taken which, had they been taken, might realistically have resulted in the death being avoided.

In terms of 26(2)(f) of the Act, there were no defects in any system of working which contributed to the death.

In terms of section the 26(2)(g) of the Act, facts which are relevant to the circumstances of the death are that on 21 June 2018, approximately one month before he took his own life, Mr Grahames sought medical assistance in relation to his "mental health". Mr Grahames did so through a self-referral kiosk in HMP Addiewell. Such self-referral was however returned by Lothian Health Board personnel for Mr Grahames to provide further information detailing why he required to be seen and by whom. Mr Grahames did not thereafter provide such information. This isolated return of such self-referral was not clinically appropriate. A person self-referring might not be able to act with

administrative competence (for medical reasons, from a lack of education or otherwise), or simply lack the mental resolution to maintain such a self-referral. This should therefore have been proactively explored by the responsible Health Board and after such exploration actioned, if then considered clinically appropriate. In Her Majesty's Prison Addiewell and within the Scottish Prison Service generally, all such self-referrals are now so proactively explored by the responsible Health Board.

RECOMMENDATIONS

Since the death of Mr Grahames, systems are now in place whereby said "mental health" self-referrals are proactively explored, as aforesaid. I do not therefore consider it appropriate to make any recommendations 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, or (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances, in terms of section 26(1)(b) of the Act, as relative precautions, improvements, introductions and steps have already been taken, made and/or introduced.

NOTE

INTRODUCTION

The Inquiry was held into the death of James Grahames. At the time of his death, Mr Grahames was in legal custody within Her Majesty's Prison Addiewell, as aforesaid. Therefore, in terms of Section 2(1) and (4)(a) of the Act, an Inquiry required to be held

into the circumstances of his death.

The death was reported to the Crown Office and Procurator Fiscal Service on 30 July 2018.

The dates of preliminary hearings were 3 February, 26 March, 28 April and 5 May 2021; and of the Inquiry hearing, 27 July 2021.

The representatives of the participants of the Inquiry were Rebecca Swansey, Procurator Fiscal Depute for the Crown Office and Procurator Fiscal Service; Louise Houliston, Solicitor for Sodexo Justice Services; Ysabeau Middleton, Solicitor for the Scottish Prison Service; and Louise Jardine, Solicitor for Lothian Health Board.

A Joint Minute of Agreement and the productions and expert opinion referred to therein, constituted the entire evidence before the Inquiry.

THE LEGAL FRAMEWORK

An Inquiry was held under section 1 of the Act.

The Inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

The purpose of an Inquiry under section 1(3) of the Act is to (a) establish the

circumstances of the death, and (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

The matters which require to be covered in this determination under section 26 of the Act in relation to the death to which the Inquiry relates, are my findings as to:

(1) (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; and

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

This determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature.

The procurator fiscal represents the public interest, an Inquiry is an inquisitional process, and it is not the purpose of an Inquiry to establish civil or criminal liability.

Summary

Facts found

[1] On 6 December 1961, James Grahames was born.

[2] Since at or about 1977, when Mr Grahames was 16 years old, until his hereinafter referred to remand in Her Majesty's Prison, Addiewell ("HMP Addiewell") on 15 September 2017, Mr Grahames had a history of alcohol and substance abuse.

[3] Since at or about 1988 until his said remand, Mr Grahames had attempted to overdose using his prescribed medication, four or five times per annum. Mr Grahames did not however obtain medical assistance or tell medical professionals of such actings, other than as hereinafter referred to.

[4] Since 12 December 2008, Sodexo Justice Services ("Sodexo") has operated HMP Addiewell under contract to the Scottish Ministers, as representing the Scottish Prison Service ("SPS"). HMP Addiewell is therefore operated independently from the rest of the prison estate in Scotland. It has its own management chain, directly employed staff, and its own policies and procedures. These however include those SPS policies which Sodexo adopts either contractually or voluntarily.

[5] On 1 November 2011, the responsibility for the provision of healthcare for prisoners in HMP Addiewell was transferred from the SPS to the Lothian Health Board ("Health Board").

[6] On 3 May 2016, Mr Grahames was taken by ambulance to Monklands District General Hospital, having taken a planned overdose of 40 prescribed tablets of Fluoxetine (20mg). Mr Grahames was assessed by a Mental Health Advanced Nurse Practitioner, who assessed that "alcohol appear[ed] to be the main presenting issue". No evidence of any mental illness was noted. Mr Grahames self-discharged himself from the hospital.

[7] On 9 May 2016, Mr Grahames, while under the influence of alcohol, got into an argument about his abuse of alcohol. He locked himself in his home with a knife and inflicted a superficial cut to his chest. Mr Grahames was again taken by ambulance to said Monklands District General Hospital. Once sober, he was assessed by another Mental Health Advanced Nurse Practitioner. Mr Grahames denied any suicidal ideation and was remorseful and regretful for his actions. Again, no evidence of any mental illness was noted. Mr Grahames "was very clear that the main problem he was experiencing was alcohol dependence …".

[8] On 5 December 2016, the SPS adopted "Talk to Me", as its "Prevention of Suicide in Prison Strategy". Talk to Me was likewise adopted by Sodexo at HMP Addiewell. As part of Talk to Me, all prisoners are assessed upon entry or re-entry to HMP Addiewell. It is not however restricted to when a prisoner enters or re-enters an establishment. Any individual working with a prisoner may initiate a Talk to Me assessment, should they have concerns about a prisoner at any time. Staff are trained on "cues and clues" and precipitating factors that may indicate that a prisoner is at risk of self-harm or suicide. Talk to Me also sets out a process for review and support for the prisoner, where the

prisoner is assessed as being at risk of suicide or self-harm. Sodexo require that all of its employees are and remain trained and competent in Talk to Me.

[9] On 15 September 2017, Mr Grahames was remanded in lawful custody to HMP Addiewell. This was pending his being sentenced, he having been convicted after trial of lewd, indecent & libidinous practices and behaviour. Talk to Me processes were not activated on the reception of Mr Grahames, as there were no apparent self-harm warnings present at that time. Mr Grahames was however placed on the protection wing of the prison, due to the nature of his said conviction.

[10] On 16 September 2017, Mr Grahames met with a doctor for a medical check. Mr Grahames denied any thoughts of self-harm. There was no apparent risk of suicide.

[11] However, after his conviction Mr Grahames did feel suicidal now and again whilst he was in custody. Mr Grahames had acted on this on one occasion shortly after said conviction, by taking all the medication that he then had. These feelings and actings were however not then known, and there were no reasonable means by which they should have become known, to Sodexo or Health Board personnel, until later disclosed by Mr Grahames on 11 April 2018.

[12] On 19 October 2017, Mr Grahames was sentenced to 4 years and 6 months imprisonment in respect of said charge, backdated to his said initial remand in custody on 15 September 2017.

[13] On 11 April 2018, Mr Grahames attended at a case conference meeting. At this meeting Mr Grahames reported that he did not feel suicidal at that time, but that he had however felt suicidal now and again whilst he had been in custody, as aforesaid.

Mr Grahames advised that he had acted on this on said one occasion only. Mr Grahames was made aware of the Talk to Me strategy and told that should he feel suicidal, he should speak to staff or a member of the Health Board Mental Health Team.

[14] Prior to 16 April 2018, Mr Grahames again attempted self-harm by taking prescribed medication, other than as he had been directed to do. Mr Grahames could not see a way forward and he felt isolated and lonely. These feelings and actings were however again not then known, and there were no reasonable means by which they should have become known, to Sodexo or Health Board personnel, until again shortly thereafter disclosed by Mr Grahames on 16 April 2018.

[15] On 16 April 2018, Mr Grahames was examined by a consultant psychologist. This was to assess whether Mr Grahames was an appropriate candidate for the 'Looking After Yourself ("LAY") programme. This programme is a low intensity programme that has been designed to promote recovery and good mental health and well-being for patients. During this consultation, Mr Grahames indicated that since at or about 1988, he had attempted to overdose using his prescribed medication four or five times per annum. Mr Grahames further advised that he tended not to tell professionals of such actings and that he had attempted suicide twice since arriving at HMP Addiewell, by using prescribed medication, as aforesaid. Mr Grahames advised that he did this because he could not see a way forward and that he felt isolated and lonely. He advised the consultant psychologist that he thought he should try hanging. This was then explored in detail. The consultant psychologist concluded that there was nothing to suggest an imminent risk of suicide. Mr Grahames was assessed as suitable for the

'LAY' group and accepted a place on this programme. The consultant psychologist then, with the agreement of Mr Grahames, disclosed to hall staff and members of the prison nursing team the information which had been provided to him by Mr Grahames.

[16] A prison custody officer ("PCO") then spoke with Mr Grahames and was satisfied that Mr Grahames could be managed effectively, with appropriate monitoring. The PCO then completed a "Talk to Me Responding to People in Distress: Concern Form" ("Concern Form") in respect of Mr Grahames. The PCO noted on this form:

> "I spoke with [Mr Grahames] today regarding suicidal thought. He explained to me he has suffered these thoughts for 30 years. He manages to deal with these himself. [Mr Grahames] does not have any suicidal thoughts at present, but will be happy to speak with staff if this changes."

Mr Grahames was therefore assessed as being of no apparent risk of suicide, at that time.

[17] Between 20 April and 2 July 2018, Mr Grahames attended all 12 sessions of the LAY programme, engaging meaningfully in discussions. All sessions involved experienced mental health nurses. The said consultant psychologist was involved in the delivery of nine of these sessions, including the first two and the last three of such.

[18] The consultant psychologist prepared a "Progress in Treatment Report" relative to Mr Grahames' participation in the LAY programme, which generally concluded that:

> "Mr Grahames … appeared to engage meaningfully with the process … [Mr Grahames] showed good levels of comprehension when he did. He was open to trying out various methods taught in group, and spoke positively of these. However it was not clear that he was applying these between sessions despite consistent encouragement to do so … He appeared to respond slightly better to a behaviour activation task. By the end of the group he seemed to have better insight, be more relaxed in the company of other group members and his mood appeared a little brighter; the general impression gained was that he had steadily made small but useful gains. There was nothing to indicate an imminent risk of attempting suicide."

[19] On 1 May 2018, Mr Grahames attended the Mental Health Triage Clinic and was seen by two mental health nurses. A mental health assessment was carried out at that time and it was noted that:

> "[Mr Grahames] admits to feeling suicidal all the time and would use tablets to complete same, [Mr Grahames] appeared quite [blasé] about this as though it was a normal way of thinking for him…will discuss with pharmacy to have medication put as in-possession (supervised)."

[20] On 12 May 2018, a PCO was told by another prisoner that Mr Grahames was collecting paracetamol to end his life. The PCO recorded events in a relative Concern Form:

> "I spoke to [Mr Grahames] in his cell & he told me this is not true. I asked to search his cell, he agreed & I found no paracetamol. [Mr Grahames] told me he has made numerous attempts at suicide in the past but is feeling very positive at the moment. He said he has been attending psychology sessions [LAY programme] & seeing [a person] from open secret who ha[d] been very helpful."

Mr Grahames was assessed as being of no apparent risk of suicide.

[21] On or about 31 May 2018, Mr Grahames used the HMP Addiewell self-referral kiosk to request assistance from the Addictions Team, in relation to his said history of alcohol abuse.

[22] On 31 May 2018, Mr Grahames met with the Addictions Service Team Leader. Mr Grahames advised that he hoped for parole the following year. He advised that he had previous to his imprisonment, drank alcohol until he was unconscious. He advised that he had had previous community detoxification, but that he had not been able to maintain abstinence from alcohol. The Team Leader decided that Mr Grahames may be suitable for clinical support in respect of such alcohol use closer to his liberation. One to

one support was to be offered in the meantime, to explore issues related to alcohol triggers.

[23] On 21 June 2018, Mr Grahames again used the HMP Addiewell self-referral kiosk, this time to request assistance in relation to his "mental health". Mr Grahames had not however completed any details as to why he required to be seen and by whom. His referral was therefore returned by Health Board personnel. Mr Grahames was asked to provide more information regarding his need for such a referral, including which team he wished to seen by. This response was at this time considered appropriate, so as to (a) prevent prisoners from self-referring to different teams in respect of the same issue, in an attempt to secure the medication which they wanted and (b) ensure that prisoners accessed the correct person for their issue. Mr Grahames did not however provide this information and the self-referral was as a consequence not further progressed.

[24] For the referral to be returned with no follow up from a member of the Health Board Mental Health Team, was not clinically appropriate, (as is opined by Dr Alcock, Consultant Psychologist, in his agreed report of 9 April 2021). A person self-referring might not be able to act with administrative competence (for medical reasons, from a lack of education or otherwise), or simply lack the mental resolution to maintain such a self-referral.

[25] On or about 2 July 2018, upon conclusion of the LAY programme, as aforesaid, all participants (including Mr Grahames) were advised that the course organiser's would carry out follow up sessions with them in August 2018. All participants were

reminded that they could always self-refer to the Health Board Mental Health Team. Only one entry had been made in Mr Grahames' medical records during the course of the LAY programme, despite the said numerous sessions at which he had attended.

[26] Of even date, Mr Grahames was also seen by triage nurse regarding bilateral upper arm pain that had been ongoing for a few weeks. Mr Grahames reported that the pain was getting worse. A "GP Attention Form" was submitted for ibuprofen gel to be prescribed to Mr Grahames and it duly was.

[27] On 26 July 2018, during evening recreation, Mr Grahames asked a PCO to lock him up early, which she did. This was not an unusual occurrence for Mr Grahames. The PCO checked on Mr Grahames a short time later, at which time he was asleep in his bed. At approximately 20:45 another PCO was carrying out a numbers check and then the lock-up procedure. On both occasions this PCO opened Mr Grahames' cell door and said "goodnight", to which Mr Grahames responded "goodnight". There was no indication that Mr Grahames was unhappy or angry at that time.

[28] On 27 July 2018, at 07:14 hours two PCOs were conducting a numbers check in the Forth Alpha Wing of the prison. Upon entering cell number 3 they observed Mr Grahames slouched to the left against the toilet stall door, with a ligature made out of a bedsheet around his neck. A PCO gave a 'Code Blue' alert over their radio.

[29] One PCO then used an anti-ligature knife to cut the ligature and Mr Grahames was then lowered to the ground. Healthcare staff attended Mr Grahames' cell as a result of the said 'Code Blue' alert. They were unable to provide any emergency treatment due

to Mr Grahames being patently deceased, as rigor mortis had already set in. At 07:43 Mr Grahames' life was formally pronounced extinct by an attending paramedic.

[30] On or about 1 August 2018, Mr Grahames' body was taken to Edinburgh City Mortuary, Cowgate, Edinburgh. On 1 August 2018, Mr Grahame's body was examined by Consultant Pathologist Dr Ian H Wilkinson. The medical cause of death was certified as "suspension by a ligature (hanging)".

[31] On 28th September 2018, a Death in Prison Learning, Audit & Review ("DIPLAR") multi-agency meeting took place to review the care and treatment provided to Mr Grahames within HMP Addiewell. It was concluded that "… there does not appear to have been any prior indication that Mr Grahames was to take his own life. Nor was there any indication on admission and at his core screen".

[32] From the DIPLAR meeting, several general learning points were however identified. These related to relatively broad issues of assigning responsibility for the fuller recording of a patient's involvement with the LAY programme, putting in place reviews of such groups to learn and improve from the same and ensuring effective sharing of information about a prisoner.

[33] Of specific note (standing my said finding in terms of 26(2)(g) of the Act) was a recognition that there required to be a revised prison kiosk system for patients self-referring to Mental Health Services. The Healthcare Manager was tasked to discuss this issue with Health Board Mental Health Team and to ensure that there was clear communication between patients and prison staff on such referrals and that all such referrals be accepted and not returned as here, for ultimately administrative reasons.

[34] At national level, the SPS Suicide Prevention Manager has responsibility for ensuring compliance with and providing guidance in relation to the "Talk to Me" and DIPLAR policies. The SPS Suicide Prevention Manager considers the DIPLAR learning from the previous three months and provides a quarterly update to the Suicide Prevention Co-Ordinators, who are the Unit Managers within each prison, and the National Suicide Prevention Management Group ("the NSPMG"). The NSPMG's membership includes the SPS Head of Health Strategy, the SPS Suicide Prevention Manager, Governors of prisons, the NHS Prison Health Board Lead, SPS Estates, SPS Audit & Assurance, the SPS Chaplaincy Advisor, SPS Psychology, the Executive Director of Samaritans Scotland, Families Outside, the NHS Organisational Lead in Public Mental Health, Breathing Space, and local Suicide Prevention Coordinators. The NSPMG's remit includes ensuring the implementation of "Talk to Me" and revising national policy based on learning points taken from deaths in custody. Additionally, any learning points taken from DIPLARs are made available to all Suicide Prevention Co-Ordinators on the SPS's intranet, Sharepoint. They are also sent to the local Suicide Prevention Co-Ordinators at HMP Addiewell and HMP Kilmarnock.

[35] The Suicide Prevention Co-Ordinator in HMP Addiewell holds and chairs monthly meetings with all local staff trained to provide training in "Talk to Me", the local chaplains, NHS Mental Health Teams and "Listeners"(who are prisoners trained by the Samaritans charity to provide peer support). The purpose of these meetings is to communicate and discuss learning points from DIPLARs at a local level. A summary of these systems issues was also shared with NHS Scotland's Healthcare Managers Group,

who are entrusted with sharing good practice between all prisons across all Health Boards in Scotland.

[36] At latest by January 2019, all of the said learning points had been assessed and rectified at HMP Addiewell (and throughout the SPS) and in particular all said mental health self-referrals are now proactively explored and after such exploration actioned, if then considered clinically appropriate.

[37] Subject to the failure to proactively explore said self-referral, Mr Grahames was generally appropriately cared for within HMP Addiewell prior to his death.

Submissions

[38] The initial written submissions of all of the participants at the Inquiry were that my findings in terms of section 26(2)(a) to (g) of the Act should be but formal and that I should not make any recommendations in terms of section 26(1)(b) of the Act. However, I had requested the Crown to obtain a report from a Consultant Psychologist (said Dr Alcock). I thereafter invited further submissions during the Inquiry, as to whether the said systems issues, (in particular the circumstances of the said return of Mr Grahame's self-referral for mental health treatment on 21 June 2018), should form the basis of findings in terms of section 26(2)(e), (f) and/or particularly (g) of the Act.

[39] Ms Swansey, for the Crown, submitted that there appeared to be no basis for findings under section 26(2)(e) or (f) of the Act. However, the return of Mr Grahames' self-referral seeking mental health care, as he had not given any details as to why he needed to be so seen, could be recorded in a finding under section 26(2)(g)of the Act.

There was no requirement for any relative recommendation under section 26(1)(b), as the issue had been rectified. The public would thereby be informed, that while this had been an issue, it has since been fully addressed in HMP Addiewell and in the SPS estate, as all such self-referrals are now accepted and appropriately actioned.

[40] Ms Jardine, for the Health Board, submitted that there appeared to be no basis for a finding under section 26(2)(e) or (f) of the Act. It was further initially submitted that the said systems issues were unrelated to Mr Grahames' death and had in any event been shared with the Healthcare Management Group. This group share good working practice between all prisons across all health boards in Scotland. This is the same group that any formal note from the court would be shared with. As such, there was no need for any formal note of an unrelated error to be recorded by the court in terms of section 26(2)(g) of the Act, as these findings have already been disseminated to the health boards. It was however thereafter accepted that Health Board would "struggle" to submit that these issues should not be made public in any determination, but as the Crown had submitted, if so, it should be made clear that these have since been fully addressed.

[41] Ms Houliston, for Sodexo, submitted that there appeared to be no basis for a finding under section 26(2)(e) or (f) of the Act. Further, as the said systems issues had all been actioned, there was no requirement for any findings under section 26(2)(g) of the Act.

[42] Ms Middleton, for the SPS, submitted that there appeared to be no basis for a finding under section 26(2)(e) or (f) of the Act. It would be possible to record the fact

that learning had been taken from Mr Grahames' death and that action had been taken as a result, without formally making a finding under section 26(2)(g) of the Act. It was however a matter for the court as to whether the said systems issues were facts which are relevant to the circumstances of the death. As these issues did not have any "bearing" on Mr Grahames' death, there was no requirement to make such a finding under section 26(2)(g). DIPLAR deals with a wide variety of issues, which often explore things which may not have a "direct bearing" on the individual's death and are not necessarily always going to be relevant to the circumstances of the death, for the purposes of section 26(2)(g) of the Act.

Discussions and conclusions

[43] Having carefully considered the foregoing evidence presented at the Inquiry and relative submissions, I have no difficulty in making said formal findings, in terms of 26(2)(a) to (d) of the Act, all as aforesaid.

[44] Notwithstanding all of the participants initial submissions, that there should only be formal findings, I have required to consider *ex proprio motu*, whether any of the said systems issues require findings in terms of section 26(2)(e), (f) and/or particularly (g) of the Act. Indeed, the said preliminary hearings were essentially focused on the Crown acquiring, at my request, an independent expert report from said Dr Alcock, to assist me in my considerations of such. Despite the absence of other information to support Mr Grahames' said disclosure that he had made two attempts at self-harm shortly after his conviction and thus while in custody, in view of the circumstances of

this disclosure and Mr Grahames' previous self-harm, it is reasonable to conclude that these probably happened.

[45] These acts were however not immediately known, and there were no reasonable means by which they should have become so known about, by relative Sodexo or the Health Board personnel. Most significant is that these personnel were fully aware of such, shortly after Mr Grahames' said disclosures. I have therefore concluded that, even if there had been more entries in Mr Grahames' medical records during the LAY programme and a greater sharing of information, it was in any event clear in the foregoing circumstances that the essential historical information, (which such fuller records and shared information would have but added to), anent the repeated attempts of Mr Grahames to self-harm over the years and recently, was well known by all of the Sodexo and Health Board personnel that were working with him.

[46] Accordingly, the resolution of such systems information issues, as has now been done, would not have meaningfully enhanced the state of knowledge of such personnel any further, in the particular facts and circumstances of Mr Grahames' death. While the actions taken to resolve such information issues could reasonably have been taken prior to Mr Grahames death, they were not therefore precautions in terms of section 26(2)(e) which had they been taken, "might realistically" have resulted in the Mr Grahames' death being avoided. Equally, while these could be described as defects in the system of working, they in no way appear, in terms of section 26(2)(f), to have contributed to the death of Mr Grahames, for similar reasoning.

[47] The systems issue which *prima facie* caused me the greatest concern, was the circumstances of the said return, without follow up, of Mr Grahame's self-referral for mental health treatment on 21 June 2018, (a little over a month before he took his own life), on the grounds that he had not given any details as to why he needed to be so seen. Dr Alcock expressed the opinion that it seemed unusual that any self-referral for access to mental health services would be declined on the basis of the self-referee not providing sufficient information for the referral. For the referral to be returned with no follow up from the Health Board, was not in his opinion clinically appropriate.

[48] Dr Alcock did <u>not</u> however think that this contributed to Mr Grahames' death, as Mr Grahames had on the 31 May 2018, contact with a drug addictions specialist and would have had the opportunity to have raised any concerns about his mental health at that time. Equally, subsequent to his self-referral, on the 2 July 2018 Mr Grahames had contact with a triage nurse in relation to a physical health issue and again he could have raised concerns at that point about any mental health issues he was having.

[49] I have come to a similar conclusion in this respect and on a similar basis. I, however, also consider it to be particularly significant that between 20 April and 2 July 2018, Mr Grahames was, in any event, attending all twelve sessions of the LAY programme, engaging meaningfully in discussions with experienced mental health nurses and a consultant psychologist, during which time he could have raised any such concerns and during which he was being continuously assessed by mental health personnel.

[50] The Sodexo and Health Board personnel working with Mr Grahames, when required, took appropriate steps in arranging for supervision of his medication and performing cell searches, so as to endeavour to negate the potential for Mr Grahames self-harming with prescribed medication. Accordingly, I have concluded after careful consideration, that while providing a further consultation with a mental health professional, at or about 21 June 2018 following said self-referral, could reasonably have been done (and indeed would have been desirable if it had, after exploration, been deemed clinically appropriate), this was not a precaution in terms of section 26(1)(e) which "might realistically" have resulted in Mr Grahames' death being avoided. There was already significant mental health treatment being provided to Mr Grahames at or about the time of the said returned self-referral and indeed thereafter. I consider that it would be but gross speculation to conclude that any further consultation "might realistically", have resulted in Mr Grahame's death being avoided. Such self-referral having been returned, does not accordingly justify any finding by me in terms of section 26(2)(e) of the Act. For similar reasoning, I consider that such a defect in the then self-referral system, in no way contributed to Mr Grahames' death, in terms of section 26(2)(f) of the Act.

[51] In the absence of any active indicators of such mental illness or otherwise, which would have warranted more extreme precautions of suicide prevention, the death of Mr Grahames was I have concluded, in these particular circumstances, realistically unavoidable.

[52] I have, however, also considered whether the said systems issues in relation to the documenting and sharing of medical information and in particular the said return of Mr Grahame's self-referral, should form the basis of findings in terms of section 26(2)(g) of the Act, as facts which are relevant to the circumstances of the death. It was submitted variously, as aforesaid, that these were (a) not facts which are relevant to the circumstances of the death and/or (b) that as these systems issues had in any event been remedied and the lessons learned had been distributed to all relevant parties and that accordingly there was therefore no requirement to make any findings in terms of section 26(2)(g) of the Act.

[53] In the *Inquiry into the death of Elizabeth Lowrie* 2011 WL 5105556, Sheriff Andrew Cubie stated:

> "The purpose of a fatal accident Inquiry is to enlighten and inform those persons who have an interest in the circumstances of the death. It is to ensure that members of the deceased person's family are in possession, so far as possible, of the full facts surrounding the death".
>
> "The broader function of such an Inquiry can be additionally to ensure that the circumstances are fully examined and disclosed in the public domain".

[54] In the *Inquiry into the death of James McAlpine*, 1985, Sheriff Brian Kearney, in relation to section 6(1)(e) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (which was in similar terms to what is now section 26(2)(g) of the Act), stated that:

> "The provisions of s 6(1)(e) are very widely stated and, in my view, entitle and indeed oblige the court to comment on and, where appropriate, make recommendations in relation to any matter which has been legitimately examined in the course of the Inquiry as to a circumstance surrounding the

> death, if it appears to be in the public interest to make such comment or recommendation."

This was quoted with approval by Sheriff Principal Lockhart in the *Inquiry concerning deaths at Rosepark Care Home* 2011 WL 1151452.

[55] Agreeing with such opinions and reflecting on all of the evidence led in the course of the Inquiry, I have concluded that I am entitled and indeed obliged to make findings in terms of section 26(2)(g), "in relation to any matter which has been legitimately examined in the course of the Inquiry as to a circumstance surrounding the death, if it appears to be in the public interest to make such comment or (my emphasis) recommendation."

[56] Accordingly, I do not agree with the submissions that, as the said systems issues have all been actioned and/or rectified, that there is accordingly no requirement for any findings under section 26(2)(g) of the Act. By that same logic, it could be said there would accordingly be no requirement for any findings in terms of section 26(2)(e) and (f) of the Act, where precautions or defects had been actioned and/or rectified. That would patently not be correct. A determination, as aforesaid, must "enlighten and inform those persons who have an interest in the circumstances of the death", "ensure that members of the deceased person's family are in possession, so far as possible, of the full facts surrounding the death" and "ensure that the circumstances are fully examined and disclosed in the public domain."

[57] I do however agree with the submission that not all DIPLAR findings anent systems issues, are necessarily relevant to the circumstances of the death, such that

it would always be in the public interest to make a relative finding in terms of section 26(2)(g) of the Act. Indeed in the instant Inquiry the systems issues addressed by DIPLAR in relation to the documenting and sharing of medical information, appeared to be more about seeking commendably best practice in generally documenting and sharing information. These did not appear to be of any particular significance to the circumstances of the death of Mr Grahames, so as to warrant any public interest finding in terms of section 26(2)(g) of the Act.

[58] There is however a clear public interest in highlighting in the public domain, in terms of section 26(2)(g) of the Act, that the Health Board should not have returned the mental health self-referral by Mr Grahames on 21 June 2018, approximately one month before his death, simply on the basis that Mr Grahames has not provided sufficient information therein, all for the reasons set out in this determination, as aforesaid.

[59] It is however also important to highlight in the same public domain, as I was also invited to do in said submissions and as I have also done in this determination, as aforesaid, that the circumstances of such return of the self-referral have since been fully examined and that all mental health self-referrals are now proactively explored, again as aforesaid, and that this is no longer an issue.

Any other information, observation or comment

[60] I conclude by repeating my sincere condolences, which I also gave at the Inquiry, as likewise were given by all participants, to the family and friends of Mr Grahames, for their loss.