SHERIFFDOM OF LOTHIAN AND BORDERS AT LIVINGSTON

[2022] FAI 3

LIV-B215-20

DETERMINATION

BY

SUMMARY SHERIFF JOHN A MACRITCHIE SSC

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

into the death of

STUART GIBB

Livingston, 23 November 2021

Determination

[1] 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:

When and Where the Death Occurred

[1.1] In terms of section 26(2)(a) of the Act, Stuart Gibb, born 10 September 1987 (aged 29), died within Cell 12, Douglas Alpha Wing, Her Majesty's Prison Addiewell, 9 Station Road, Addiewell, West Calder, on or about 17 July 2017 at 11:19 hours.

When and Where Any Accident Occurred

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

The Cause of the Death

[1.3] In terms of section 26(2)(c) of the Act, the cause of the death was hanging, Mr Gibb having taken his own life.

The Cause of Any Accident

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

Reasonable Precautions

[1.5] 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.

Defects in Any System of Work

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

Other Relevant Facts

[1.7.1] In terms of section 26(2)(g) of the Act, there are no other facts that are relevant to the circumstances of Mr Gibb's death.

Recommendations

[2] In terms of section 26(1)(b) of the Act, I do not 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.

NOTE

Introduction

[3] The inquiry was held under the Act into the death of Mr Gibb. At the time of his death, Mr Gibb was in legal custody within HMP Addiewell. Therefore, in terms of section 2(1) and (4)(a) of the Act, an inquiry is required to be held into the circumstances of Mr Gibb's death.

[4] Mr Gibb's death was reported to the Crown Office and Procurator Fiscal Service on 17 July 2017.

[5] The dates of preliminary hearings were 23 November 2020, 27 January, 25 February, 20 April, 19 May and 30 June 2021; and of the inquiry hearings, 27 July, and after further investigations were completed, 16 November 2021.

[6] The representatives of the participants at the inquiry were Ms Swansey, Procurator Fiscal Depute for the Crown Office and Procurator Fiscal Service; Mr Holmes, Solicitor for Lothian Health Board; Ms Houliston, Solicitor for Sodexo Justice Services; Ms Thornton, Solicitor for the Scottish Ministers for the Scottish Prison Service and Mr McGovern, Solicitor for Mr Gibb's family.

[7] In the first part of the inquiry, on 27 July 2021, evidence was provided by a Joint Minute of Agreement which detailed agreed evidence from witness statements from:

[7.1.] AB, Security Manager, HMP Addiewell;

[7.2] CB, Prison Custody Officer ("PCO"), HMP Addiewell;

[7.3] LT, PCO, HMP Addiewell;

[7.4] ML, PCO, HMP Addiewell;

[7.5] PV, PCO, HMP Addiewell (2);

[7.6] SW, Senior PCO, HMP Addiewell (2);

[7.7] TG, Senior PCO, HMP Addiewell;

[7.8] WJ, Senior PCO, HMP Addiewell;

[7.9] Dr ZH, Locum GP, HMP Addiewell;

[7.10] KG, mother of Mr Gibb; and

[7.11] SM, Families Outside Staff.

Together with agreed productions, namely:

[7.12] Final Post Mortem Examination Report dated 8 September 2017, (Crown Production no.1);

[7.13] Death in Prison Learning, Audit & Review (DIPLAR) dated 25 May 2018, (Crown Production no.2);

[7.14] Death in Custody Prison Pack containing interview sheets and screening forms (Crown Production no.3)

[7.15] Mr Gibb's prison medical records (Crown Production no.4);

[7.16] Talk to Me Guidance (Part 2), (SPS Production no.1);

[7.17] Governors & Managers: Action (GMA) 032A/20 - Revised Process for Recording a Communication of Concern - Electronic Concern Form, (SPS Production no.2);

[7.18] Electronic Concern Form, (SPS Production no.3);

[7.19] Talk to Me Conversion PowerPoint training presentation, April 2016, (SPS Production no.5);

[7.20] Talk to Me Awareness Training Session Plan, April 2016, (SPS Production no.6);

[7.21] Talk to Me Awareness PowerPoint training presentation, December 2016, (SPS Production no.7);

[7.22] Talk to Me Core Training PowerPoint, November 2020, (SPS Production no.8);

[7.23] Case Studies used in Talk to Me Core Training, (SPS Production no.9);

[7.24] Families Outside form dated 26 March 2017, (Gibb Family Production no.1);

[7.25] Families Outside attendance note dated 26 March 2017, (Gibb Family Production no.2);

[7.26] Entries dated 17 March and 20 October 2015 from Police Scotland Vulnerable Persons Database; and

Agreed affidavits from:

[7.27] LM, Head of Health Strategy, Scottish Prison Service (SPS Production no.4);

[7.28] FM, Director of HMP Addiewell; and

An Agreed opinion of:

[7.29] Dr DA, Consultant Forensic Psychiatrist, (Crown Production no.5).

[8] In the second part of the inquiry, on 16 November 2021, further evidence was provided by a Supplementary Joint Minute of Agreement, which detailed the agreed evidence in witness statements from:

[8.1] Dr WS, Lead GP for HMP Edinburgh and HMP Addiewell (Lothian Health Board Production no.1); and

[8.2.] IY, Head of Service Delivery at Practitioner Services Division of NHS National Services Scotland (Lothian Health Board Production no.2); and

Together with further agreed productions, namely:

[8.3] Trial Electronic Concern Form (SPS Production no.10);

[8.4] Trial Electronic Concern Form Guidance (SPS Production no.11); and

Agreed affidavits from:

[8.5] BH, Acting IT Manager at HMP Addiewell;

[8.6] SL, Rehabilitation Unit Manager at HMP Addiewell;

[8.7] DM, Health Policy Manager, Scottish Prison Service (SPS Production no.12); and

[8.8] DS, Acting Deputy Head of Digital Services for the Scottish Prison Service (SPS Production no.13).

The legal framework

[9] This inquiry was held under section 1 of the Act.

[10] This inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[11] The purpose of this inquiry under section 1(3) of the Act was 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.

[12] The matters which required to be covered in this determination under section 26 of the Act, in this inquiry into Mr Gibb's death, are 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, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

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

[14] The procurator fiscal depute 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

Historical background

[15] On 10 September 1987, Stuart Gibb was born.

[16] Since opening in 2008, HMP Addiewell has been operated by Sodexo Justice Services ("Sodexo"), having been contracted to do so by the Scottish Prison Service ("SPS"). Sodexo employs HMP Addiewell staff.

Healthcare resources at HMP Addiewell

[17] On 1 November 2011, responsibility for the medical care of prisoners in HMP Addiewell was transferred from the SPS to the Lothian Health Board. Between

HMP Addiewell and HMP Edinburgh, the Lothian Health Board Healthcare Team ("Healthcare Team") consist of two medical general practitioners ("GPs") and six advanced nurse practitioners. There are ten half-day sessions per week from Monday to Friday, which the Healthcare Team must cover. While prisoners generally get a longer appointment than other patients in the community, there is still not much time. Admission appointments may take 10 to 15 minutes, and other appointments may take slightly longer depending on the prisoner's needs. The Healthcare Team does not have access to hospital notes, as is also the case with GPs in the community. Health Boards hold such hospital records. Likewise, the Healthcare Team do not generally have access to a prisoner's community GP medical notes, although these can be requested if considered necessary.

[18] However, a form is sent by the Healthcare Team to a prisoner's community GP when they are admitted to prison. This requests details of medications, allergies and any significant medical history. This form is generally received back within 24 hours from such community GP. The Healthcare Team also has access to a central emergency care summary for any prisoner, being a central record of current medications and allergies.

[19] Suppose it were technically possible to access all of a prisoner's community medical notes before or during a consultation. In that case, the Healthcare Team would not realistically, in practice, have time to do so. Time is too limited, and community medical notes are often voluminous with much irrelevant material in them. The best available evidence of a prisoner's current condition is the patient sitting in front of the

Healthcare Team member. Suppose a prisoner denies suicidal ideation and appears to be well. In that case, that will not result in a trawl through volumes of community medical records, if available, to see whether there are any notes to the contrary. Even a note to the contrary within the last year or two years would not, in any event, activate the hereinafter referred to "Talk to Me" suicide prevention procedures. "Talk to Me" is a system that is designed to protect those *immediately* vulnerable. If it were deployed in the case of every patient who had a previous episode of low mood or suicidal thoughts, then it would quickly become overwhelmed, and those in immediate need would be missed.

Previous attempted self-harm

[20] On 17 March 2015, police were contacted and attended at Mr Gibb's home. Mr Gibb told police that he had taken approximately 100 paracetamol tablets. Mr Gibb was taken to hospital.

[21] On 20 October 2015, police were advised that Mr Gibb had stopped taking his medication. Mr Gibb was feeling suicidal, had tied an electrical cord to a rafter in his loft and was threatening to hang himself. He had been stopped from consuming tablets. Police attended, and Mr Gibb told them that he did not want to be there and wanted to die. Mr Gibb was persuaded to attend hospital.

Previous prison admissions

[22] Between 9 November 2015 and 16 February 2016, Mr Gibb served a prison sentence at HMP Addiewell. On admission, Mr Gibb was medically assessed by a nurse from the Healthcare Team. There were no indications that Mr Gibb was a suicide risk or that he had thoughts of deliberate self-harm at that time. This and other interactions between Mr Gibb and the Healthcare Team in HMP Addiewell were recorded in Mr Gibb's prison medical notes.

[23] On 10 November 2015, as a standard procedure, Mr Gibb was medically assessed by a prison GP. Mr Gibb denied any thoughts of deliberate self-harm.

[24] Between 26 May and 25 August 2016, Mr Gibb again served a prison sentence at HMP Addiewell. On admission, Mr Gibb was again medically assessed by a nurse from the Healthcare Team. Again, there were no indications that Mr Gibb was a suicide risk or had thoughts of deliberate self-harm. When asked if he had a history of self-harm, Mr Gibb advised the member of the Healthcare Team that he had tried cutting his fingers off approximately ten years previously. Mr Gibb, on one view misleadingly, informed the nurse that he had not done anything of that nature since.

[25] On 27 May 2016, Mr Gibb was, as previously, medically assessed by a prison GP. Mr Gibb denied any thoughts of self-harm.

[26] Between 12 September 2016 and 20 January 2017, Mr Gibb again served a prison sentence at HMP Addiewell. On admission, Mr Gibb was medically assessed by a nurse from the Healthcare Team. There were no indications that Mr Gibb was a suicide risk or that he had thoughts of deliberate self-harm at this time.

[27] On 13 September 2016, Mr Gibb was, as previously, medically assessed by a prison GP. Mr Gibb denied any thoughts of self-harm.

"Talk to Me" suicide prevention strategy

[28] On 5 December 2016, a new "Prevention of Suicide in Prison Strategy" known as "Talk to Me" was introduced throughout the Scottish Prison Service estate. Sodexo is contractually obliged to comply with this SPS "Talk to Me" strategy at HMP Addiewell. The intention of "Talk to Me" is, among other things, to provide a clear record of the involvement of all stakeholders when a prisoner is suspected of being in distress. It sets out a process for review and support for the prisoner if there are initial indicators of a prisoner being in distress. All front line Sodexo staff interacting with prisoners are trained in "Talk to Me" and have refresher training every three years.

[29] As part of "Talk to Me", all prisoners continue to be medically assessed upon entry or re-entry to prison, as aforesaid. In addition, any individual working with a prisoner may initiate a "Talk to Me" assessment should they have concerns about a prisoner at any other time. Staff are trained on 'cues and clues' and precipitating factors and to be alive to prisoners' moods changing when, for example, their circumstances change. In "Talk to Me", it is recognised that a more formal process is required to share information where a concern is raised to ensure appropriate action is taken, and a concern form was therefore introduced.

[30] Concerns can be raised by any means, including telephone, email or face to face. At HMP Addiewell, concerns are usually received by telephone. A concern form should

be used in most cases where a concern is received from an external source, such as from Families Outside (a charitable organisation that assists families visiting prisoners) or directly from a prisoner's family. In "Talk to Me", the concern form process should be followed upon receiving information that someone may be in distress. Examples of when a prisoner may be in distress include if they are upset, crying, showing aggression or speaking of hopelessness and/or suicide.

[31] At the top of the concern form utilised at the time of Mr Gibb's death, it stated, "[T]his form must be completed where there is a concern for an individual's mental health, behavioural changes or personal risk".

[32] Part 1 of the Consent Form is (subject to the after mentioned trial) completed by the Sodexo staff member who receives the concern. They record the concerned person's name, relationship to the prisoner, nature of the concern, and when it was received.

[33] Part 2 is also completed by the Sodexo staff member who receives the information. They complete the prisoner's name, prison number, date of birth. They then check the prisoner's records ("PR2") for previous ACT 2 Care (the previous suicide prevention strategy) or "Talk to Me" history to ascertain if an earlier concern form or other "Talk to Me" procedures are recorded.

[34] Part 3 is completed by the PCO or First Line Manager, who interviews the prisoner. A summary of the meeting is recorded, including the prisoner's presentation at the time. Usually, the conversation is between the officer and the prisoner, but it can also be between an officer and a manager, should the prisoner not choose to attend the meeting.

[35] Part 4 is completed by the PCO or a First Line Manager who attended the meeting with the prisoner. The outcomes recorded are: (1) no apparent risk; (2) no apparent risk with referral to, for example, mental health; or (3) there is a risk and "Talk to Me" is initiated.

[36] Part 5 is again completed by the PCO or the First Line Manager who attended on the prisoner. It is only required if the individual is deemed at no apparent risk with a referral, under outcome (2) above. This section records what referrals, if any, are being made. For example, the PCO might state that the prisoner is not assessed as being at risk of suicide but that as their mood is low, a referral should be made to mental health or social work personnel.

[37] Part 6 is then completed by the First Line Manager. It asks at the end of Part 6 to confirm actions have been taken. The PCO or First Line Manager will tell the prisoner what has been agreed and confirm any referrals which will be made. A concern form should be actioned within 30 minutes of receipt. The concern form is uploaded to and stored in the prisoner's PR2 records.

Latter period in custody

[38] On or about 27 February 2017, Mr Gibb was detained by police regarding an allegation of rape. At this time, Mr Gibb's mother made police aware of his low mood and his background of attempting suicide. These incidents were already in relative police records, as aforesaid.

[39] On 27 February 2017, Mr Gibb was remanded in custody to HM Prison Addiewell on a petition containing, among other things, a charge of rape. On admission, Mr Gibb was medically assessed by a nurse from the Healthcare Team. There were again no indications that Mr Gibb was a suicide risk or had thoughts of deliberate self-harm. Mr Gibb refused to attend an admission core screening interview or complete the "Core Screen Form". There was nothing within the medical screening that did take place to suggest that Mr Gibb should then have had contact with the Lothian Health Board Mental Healthcare Team ("Mental Healthcare Team").

[40] Up until March 2017, Families Outside were responsible for the visitor centre operation at HMP Addiewell. The visitor centre supports families visiting a family member in custody. Employees and volunteers are provided with necessary and appropriate training to ensure that local and national policies, procedures and protocols are followed as required within the visitor centre.

[41] On 26 March 2017, Mr Gibb's mother and partner visited him at HMP Addiewell. After this visit, Mr Gibb's mother and partner were worried about Mr Gibb appearing to have a low mood, not being himself and wringing his hands, as he could not "see any point in things". They accordingly spoke with an employee of Families Outside. Mrs Gibb advised that she felt that Mr Gibb was displaying quite a low mood and needed someone to chat with. She reported that Mr Gibb had been suicidal in the past, and although she did not feel he was at that stage then, she thought that if Mr Gibb did not have anyone to talk to and continued on a downward spiral, he would become that way again.

[42] The Families Outside employee indicated that she would contact the prison chaplain and ask him to "look in" on Mr Gibb. The Families Outside employee then reported these concerns to the then Sodexo First Line Manager within the visitor centre. The said Families Outside employee completed an attendance note and *pro forma* detailing all said discussions. The Sodexo line manager then contacted the PCOs within the Douglas Alpha Wing of HMP Addiewell, where Mr Gibb was accommodated. He advised them of these concerns and asked them to check on Mr Gibb. Douglas Wing PCOs then repeatedly checked on Mr Gibb, inquiring if he was "alright".

[43] After said contact between Mr Gibb's mother and partner and Families Outside, Mr Gibb spoke to his mother on the telephone. Mr Gibb asked her, "What have you told them?" and explained, "They keep asking me if I'm alright". Mr Gibb was annoyed with his mother and partner for raising said concerns with Families Outside.

[44] There was, however, no concern form or other notes recorded in Mr Gibb's PR2 records, recording such contact between Mr Gibb's family, the Families Outside employee, the Sodexo Manager, and the PCOs, or the actions taken as a result of such. However, it can be reasonably inferred from the terms of said attendance note, *pro forma* and telephone call between Mr Gibb and his mother, that appropriate action had been taken to check on Mr Gibb.

[45] Having received said concerns that Mr Gibb had been suicidal in the past, had then been of low mood and had indicated to family members at that time that he could not "see any point in things", (that is having received information that Mr Gibb may be in distress by speaking of hopelessness), a concern form should patently have been

completed to, at least, provide a record of the relative considerations and actions taken by Sodexo.

[46] Unfortunately, the said Families Outside attendance notes and *pro forma* were also then misfiled. These were only located during this inquiry after further investigations were carried out at the instigation of Mr Gibb's family.

[47] On 23 June 2017, Mr Gibb's had his last appointment with the Healthcare Team. He had attended triage with a bloodshot eye and inflamed eyelids. Mr Gibb's eye was examined, and he was advised to inform staff if it got any worse. The nature of this consultation was such that it would have taken some time to interact with Mr Gibb, albeit related to a physical health need. It would have been possible for Mr Gibb at that time to divulge any issues he had concerning his mental health. Equally given that this interaction would have taken some time, it would have been possible, should it have been evident by the reviewing member of the Healthcare Team, to notice any significant change in Mr Gibb's mental health. Such a change was not noted.

[48] Other than during the said admission process, Mr Gibb had not been involved with the Mental Healthcare Team. During all of the stated periods of custody within HMP Addiewell, Mr Gibb had engaged with the Healthcare Team and attended treatment when suffering from physical ailments.

Death of Mr Gibb

[49] On 17 July 2017, at 07:18 hours, some four months after said concerns were expressed and investigated, two PCOs conducted a numbers check and unlock in the

Douglas Alpha Wing of HMP Addiewell. Upon opening cell 12, they observed Mr Gibb hanging from the shower door by a ligature made from a bedsheet. One PCO activated her personal alarm. Mr Gibb showed no signs of life and was cold to the touch. At 07:21 hours, a Healthcare Team nurse confirmed that Mr Gibb was deceased. At 11:19 hours, a prison GP then formally pronounced Mr Gibb's life extinct.

[50] Shortly after Mr Gibb's death, intelligence was received by Sodexo. This intelligence was that Mr Gibb had been in the cell of another prisoner before his death. Mr Gibb had been visibly upset and crying due to the large amount of debt he owed both in prison and outside. These feelings and actings were 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 such intelligence.

[51] Therefore, there was nothing to indicate to HMP Addiewell staff that Mr Gibb, during his latest admission to HMP Addiewell, should have had contact with the Mental Healthcare Team or Social Work. There were no significant signs that Sodexo missed concerning Mr Gibb's death.

[52] On 19 July 2017, Mr Gibb's body was taken to Edinburgh City Mortuary, Cowgate, Edinburgh, and was examined by a Consultant Forensic Pathologist. The pathologist certified the cause of death as hanging.

[53] Several factors present at the time of Mr Gibb's death culminated in him taking his own life. These included the nature of the offence for which he had been remanded and convicted and his consequential incarceration. These also included his said financial debts both inside and outside prison. For those providing care to Mr Gibb and

his family members, it would have been extremely difficult to know that these matters would have led him to take his own life at the time he did. The care and treatment that Mr Gibb received from the Healthcare Team and Sodexo staff whilst within the prison environment was adequate. They could not have reasonably prevented Mr Gibb's suicide.

Introduction of electronic concern forms and concern feedback

[54] There have been two updates to the concern form since Mr Gibb's death. On 27 July 2020, the SPS issued a revised concern form process throughout Scottish prisons, including HMP Addiewell. Concern forms are after that electronically recorded on the prisoner's PR2 records. A "Part 7" has also been added to the consent form. Part 7 relates to the level of consent that a prisoner is asked to provide for relaying information back to the person expressing the concern. This consent enables prison authorities to update the source of a concern once the concern has been actioned. The PCO or First Line Manager will ask the prisoner whether they wish to make a call to the individual who raised the concern to let them know they are "okay". Even if the individual prisoner gives no consent, the First Line Manager must still call back the concerned person to say that they have actioned the concern, but they cannot share any further information.

[55] In any event, the person who raised the concern should get a telephone call to assure them it has been received and acted upon. This process should not take longer than a few hours. This process is more reassuring for families than simply an electronic

auto-acknowledgement of any concern expressed by electronic means. Most concerns continue to be expressed by telephone calls, where the concerned person directly speaks to a prison staff member.

[56] From September 2021, there has been an ongoing trial by the SPS of a newer electronic concern form. A process whereby external parties can complete the first part of the concern form and send it to a prison designated email address is being trialled. The SPS will consider the results of this trial in due course. As part of this review, the SPS and Sodexo will also consider implementing an auto-acknowledgement email in response to any electronic concern forms submitted.

Submissions

Inquiry 27 July 2021

Initial submissions for Mr Gibb's family

[57] On 27 July 2021, Mr McGovern indicated that there were "chapters of evidence" falling within section 26(2)(g) (other relevant facts) of the Act, which he sought to address. The first issue related to the processing of Mr Gibb by the Healthcare Team on his admissions to the prison. Mr Gibb's response to questioning about previous self-harm on 16 May 2016 was inaccurate and misleading, as he had failed to provide information about the said incidents on 17 March and 20 October 2015. The accurate information which would have been available from Mr Gibb's community healthcare medical records was not in Mr Gibb's prison medical records. These only covered Mr Gibb's treatment while in prison. Therefore, the assessment that there was "no

apparent risk of suicide" on Mr Gibb's admissions was based on incomplete data due to Mr Gibb not having volunteered the same.

[58] Such missing data could have provided "clues" that Mr Gibb was "especially vulnerable", as is referenced in the Reception Risk Assessment Guidance produced and have better informed such assessments. It was submitted that the absence of community health records was a fact that could come within a finding in terms of section 26(2)(g) (other relevant facts) of the Act. While Mr McGovern did not "doubt accessing such records involved jurisdictional and other logistical concerns", having this data would be beneficial to the suicide prevention strategy. Mr McGovern conceded that if the provision of such data were a "consent-based process", this would present difficulties in obtaining any data which was at odds with that consented to by the prisoner. However, it should be considered whether that consent should be sought in a more formalised way allowing access through a third-party source. It was accepted that this issue had not previously been raised in prior preliminary hearings discussions.

[59] The second issue Mr McGovern raised was that any action taken within the prison regarding concerns about a prisoner was "solely a matter for Sodexo". It was submitted that the concern form should have been completed and held within Sodexo's systems. Mr McGovern was initially concerned in written submissions "that despite the strategy, the guidance, the training and the processes developed, all of this information was ignored by multiple members of staff of HMP Addiewell when" Mr Gibb's mother's "concern was communicated to them by Families Outside". Mr McGovern, however, revised this during his further verbal submissions to suggest that, while this information

had not been "ignored", the proper practice had not been followed by members of the Sodexo staff. Mr McGovern stated that if properly implemented, the strategy for preventing suicide in prison was a good one. The recent upgrading to an electronic process with Part 7 on the concern form was also welcomed developments.

[60] This, however, begged the question, "What use all of this strategy if the staff simply ignore it?" and failed to initiate the process by completing a concern form. The misfiling of the attendance notes and failure of any prison staff to record any information was a fundamental failing. This failure undermined the prevention of suicide strategy and, as such, was a relevant circumstance in the death of Mr Gibb by suicide. This omission was a fact that should come within a finding in terms of section 26(2)(g) (other relevant facts).

[61] Mr McGovern then raised a third issue: the concern form process did not provide for the concerned person to receive an electronic auto-acknowledgement of the receipt of any concern made electronically. This acknowledgement would confirm that the "correct procedure had been commenced and provid[e] some check against proper practice being ignored from the outset. This process would be a way to stop the whole process from not starting in the first place. It does not undermine prisoner confidentiality or require a prisoner's consent as it simply offers confirmation from the investigating body that the concern has been acknowledged." Part 7, where the concerned person is contacted, takes place at the end of the process. It depends on the level of consent from the prisoner. An auto-acknowledgement would be an

improvement to the system of working in terms of section 26(1)(b) (recommendations) of the Act.

Initial submissions for the Crown

[62] Ms Swansey for the Crown submitted that there should be formal findings in terms of section 26(2)(a) (when and where death) and (c) (cause of death) of the Act. It was of concern that the Families Outside attendance note and form from 26 March 2017 had been misfiled. However, despite no formal record of such concern in prison records, it appeared from the evidence that such concerns had been communicated to Sodexo personnel and actioned. Nothing further would have been done, even if the concern form had been completed. There accordingly appeared to be no basis for findings under section 26(2)(b) (when and where accident), (d) (cause of an accident), (e) (reasonable precautions), (f) (system defects) or (g) (other relevant facts) of the Act.

[63] Since the death of Mr Gibb, concern forms have been completed electronically and recorded on the prisoner's PR2 records. This new procedure also includes a section for recording the prisoner's consent to relaying information back to the source of the concern. Whether there was an individual failing rather than a system failing, or whether the said changes made to the concern form system should be recorded in terms of section 26(2)(g) (other relevant facts) of the Act was a matter for the inquiry. There appeared to be no requirement to make any recommendations in terms of section 26(1)(b) of the Act.

Initial submissions for Lothian Health Board

[64] Mr Holmes for Lothian Health Board submitted that there should only be formal findings in terms of section 26(2)(a) (when and where death) and (c) (cause of death). There appeared to be no basis for any further findings under section 26(2)(b) (when and where accident), (d) (cause of an accident), (e) (reasonable precautions), (f) (system defects) or (g) (other relevant facts) of the Act, or a requirement to make any recommendations in terms of section 26(1)(b) of the Act.

[65] As regards Mr McGovern's submissions regarding the Healthcare Team having access to Mr Gibb's community medical records, this is not a relevant matter for the purposes of section 26(2)(g) (other relevant facts) of the Act, as it was not relevant to Mr Gibb's death. Mr Gibb did not see any medical staff at or about the time of his death who could have engaged the "Talk to Me" process. There was also no evidence of what medical records could and could not be accessed by the Healthcare Team. Further investigations would be required to fully respond to this issue, only now being raised by Mr McGovern.

Initial submissions for Sodexo

[66] Ms Houliston for Sodexo submitted that the precise content and tone of the conversation between Families Outside and Sodexo's former first-line manager remained unknown as the latter was no longer in Sodexo employment. If communicated in terms of the note, then "a concern form should *perhaps* have been completed". While a formal concern form was not completed, Mr Gibb must have been

checked on by Sodexo staff, as Mr Gibb had questioned his mother about what she had been saying to prison staff.

[67] These events are however not related to Mr Gibb's death, as this interaction took place four months beforehand. Accordingly, there appeared to be no basis for findings under section 26(2)(b) (when and where accident), (d) (cause of an accident), (e) (reasonable precautions), (f) (system defects) or (g) (other relevant facts) of the Act or a requirement to make recommendations in terms of section 26(1)(b) of the Act.

[68] As for Mr McGovern's submissions regarding an auto-reply being sent to the source of an electronic concern received, this could have broader implications for prison authorities. There had been no evidence led in this respect. Further investigations would be required to consider this thoroughly. The "Talk to Me" initial process is completed in a concise time scale, after which the concerned person is personally contacted, making an auto-acknowledgement unnecessary.

Initial submissions for the SPS

[69] Ms Thornton for the SPS submitted that it was a matter for the inquiry as to whether, on 26 March 2017, a concern form should have been completed. The new electronic concern form would reduce the risk of such forms being misfiled or misplaced. A PCO and possibly the Chaplain spoke to Mr Gibb, and no further actions would have stemmed from completing a concern form at that time. As Mr Gibb's death came almost four months after the expression of said concern, on balance Mr Gibb was not at risk of self-harm or suicide at that earlier time. The events of March 2017 are not

related to Mr Gibb's death, and they should be treated as distinct events. Mr McGovern's suggestion regarding an auto-reply would require evidence regarding its impact on prison resources and its practicability, if to be considered further.

[70] There accordingly appeared to be no basis for findings in terms of section 26(2)(b) (when and where accident), (d) (cause of an accident), (e) (reasonable precautions), (f) (system defects) or (g) (other relevant facts) of the Act or any requirement to make recommendations in terms of section 26(1)(b) of the Act.

Adjournment of inquiry

[71] I expressed regret that the issues of access to community medical records and whether an auto-reply should be sent had only been raised at the inquiry, despite several preliminary hearings beforehand having taken place to focus the issues to be considered. However, I accepted Mr McGovern's position that in the particularly challenging times of this coronavirus pandemic, he had endeavoured to investigate matters timeously.

[72] I, therefore, took the view that it was in the public interest and particularly important for the family of Mr Gibb that any such issues should be thoroughly inquired into. Accordingly, I adjourned the inquiry for Lothian Health Board and Sodexo, in particular, to make the further investigations and present the further evidence they considered necessary to respond to these new issues being raised.

Adjourned inquiry 16 November 2021

Further submissions for Mr Gibb's family

[73] At the adjourned inquiry on 16 November 2021, Mr McGovern firstly expressed gratitude for being permitted to explore the issue of whether access should be available to a prisoner's community medical records by the Healthcare Team. Mr McGovern accepted that Dr S had explained how the Healthcare Team would realistically provide medical care to prisoners. He now understood that the Healthcare Team sends forms for community GPs to complete and return. Having considered the evidence of Dr S, Mr McGovern accepted that it was neither necessary nor proportionate for the Healthcare Teams to have access to all historical community medical records of a prisoner. Accordingly, Mr McGovern no longer insisted on any findings in terms of section 26(2)(g) (other relevant facts) or 26(1)(b) (recommendations) of the Act in this respect.

[74] Regarding the issue of an auto-acknowledgement, Mr McGovern emphasised that Mr Gibb's mother had not heard anything in response to her said expression of concern. There had been no record of Mrs Gibb's concern for it to be considered by the DIPLAR investigation or Dr CA in providing his opinion to the inquiry. Mr McGovern suggested that an auto-response would only be required where a concern had been made by electronic means. It was not suggested that such should be made from the PR2 system or after face-to-face concerns were expressed. Such was an appropriate improvement to the system of working in terms of section 26(1)(b) of the Act.

[75] Finally, the failure to complete a concern form was relevant to the circumstances of the death of Mr Gibb in terms of section 26(2)(g) (other relevant facts) of the Act.

Further submissions for Crown

[76] Ms Swansey for the Crown broadly relied on her previous submissions, submitting that only formal findings were required.

Further submissions for Lothian Health Board

[77] Mr Holmes for Lothian Health Board submitted with regard to the Healthcare Team having access to community medical records that such data sharing should only be where necessary and proportionate. Even if practical, the evidence was that prison GPs would not access historical community medical notes, as time is limited and notes are often voluminous with a great deal of irrelevant material in them. As stated by Dr S, the best available evidence of a patient's current condition is the patient sitting in front of a member of the Healthcare Team. If a prisoner denies suicidal ideation and appears to be well, that will not result in a trawl through any volumes of records to see whether there are any notes to the contrary. Even a note to the contrary within the last year or two years would not activate the "Talk to Me" suicide prevention procedures. The forms sent to Mr Gibb's community GP by the Healthcare Team were in Mr Gibb's medical records and contained the essential medical history that the Healthcare Team required. Only formal findings in terms of section 26 (2)(a) (when and where death) and (c) (cause of death) of the Act were required.

Further submissions for Sodexo

[78] Ms Houliston for Sodexo submitted that HMP Addiewell was now trialling an automated response being provided upon receiving an electronic concern form. This response would only confirm that the designated email address had received the concern form. An automatic response being in place at the time of Mr Gibb's death would not have altered the specific circumstances or avoided his tragic death. The interaction between Mr Gibb's family and Families Outside was four months before Mr Gibb sadly took his life.

[79] It was clear from the evidence produced at the inquiry that the family's concern was acted upon. The events in March 2017 are not facts relevant to Mr Gibb's death, and they should be treated as distinct events. Sodexo staff go through a rigorous training regime. They then receive ongoing training, continuous development programme, have a mentorship programme, regular review and appraisal programme, and are subject to a recognition programme, all to encourage excellence in the workplace. "Talk to Me" staff are trained to recognise risks when an individual is experiencing difficulties and be alive to change in prisoners' moods.

[80] There should be no findings against any participant in this inquiry. Ms Houliston referred to her previous submissions concerning section 26(2) (a) - (g). Specifically, concerning section 26 (2)(g) (other relevant facts), an automated response when an electronic concern form is received does not constitute "any other facts relevant to the circumstances of the death". No findings should be made under subsections 26(2)(e)

(reasonable precautions), (f) (system defects) and (g) (other relevant facts) or section 26(4) (recommendations) of the Act.

Further submissions for SPS

[81] Ms Thornton for the SPS submitted that an auto-acknowledgement to a concern form being received would not have avoided Mr Gibb's tragic death. It was not reasonably practical to so respond to all modes of concern being expressed. An auto-acknowledgement in any event only confirms that the concern had been received. In this case, the concern was received on or around 26 March 2017, which is almost four months before Mr Gibb's death. It is clear from the evidence lodged to date that the concern was acted upon. In relation to section 26(1)(g) (other relevant facts), an auto-acknowledgement does not fall under "any other facts relevant to the circumstances of the death". Formal findings should be made in respect of section 26(2) (a) (when and where death) and (c) (cause of death). Section 26(2)(b) (when and where accident) and (d) (cause of an accident) do not apply. No findings should be made under subsections 26(2)(e) (reasonable precautions), (f) (system defects) and (g) (other relevant facts). No recommendations are necessary in terms of section 26(4) of the Act.

Discussions and conclusions

Failure to complete a concern form

[82] There had been a failure by Sodexo to record in Mr Gibb's PR2 prison records the concerns communicated to them on 26 March 2017. These concerns were that Mr Gibb

had been suicidal in the past, had then been of low mood and had indicated to family members at that time that he could not "see any point in things". "Talk to Me" required that upon receiving information that a person may be in distress, for example by speaking of hopelessness, as here, that a concern form be completed to, among other things, provide such a record.

[83] In this inquiry, significant further investigations were required to be carried out at the instigation of Mr Gibb's family to confirm that such concerns had indeed been communicated to Sodexo. The concern form should have recorded such concerns and the subsequent decisions taken relative to such. These facts should have been more readily available to fully inform this and previous internal prison inquiries investigating the death of Mr Gibb.

[84] The failure to complete a concern form and record the subsequent decisions taken relative to such was, in the specific circumstances of Mr Gibb's death four months later, not a precaution which, had it been done, might realistically have resulted in the death being avoided. This failure was also not a defect in the "Talk to Me" process that contributed to Mr Gibb's death. Such a process had required such recording. The concerns that Mr Gibb's family had expressed were, in fact, appropriately actioned at that time, as hereinbefore referred to, despite not having been so recorded. There was no subsequent occasion when Mr Gibb's PR2 records were consulted and where such a record would have informed any decisions then being made, so as to make this administrative omission relevant to the actual circumstances of Mr Gibb's death, some four months later. This failure was, therefore, also not, in my opinion, facts that are

relevant to the circumstances of the death of Mr Gibb in this inquiry, as is required for section 26(2)(g) (other relevant facts) of the Act.

[85] This failure was relatively early in the introduction of "Talk to Me" and the associated introduction of the concern form process. From the foregoing circumstances, I consider it reasonable to infer that Sodexo staff had not fully recognised the need to record such concerns and subsequent decisions, even where no further 'Talk to Me' processes were considered necessary from their then repeated assessments of Mr Gibb. There are currently significant and adequate training processes in place to ensure, so far as can reasonably be expected, that all HMP Addiewell staff are now fully aware of this recording requirement as part of 'Talk to Me'. I accordingly do not consider it appropriate to make any recommendations in this respect in terms of section 26(1)(b) of the Act.

Access to community medical records

[86] All participants latterly and properly accepted that it was neither necessary nor proportionate for the Healthcare Team to have access to all of a prisoner's community medical records. Even if practical, the evidence from Dr S was that the Healthcare Team could not realistically be expected to trawl through potentially voluminous previous community medical notes in the limited time available for consultations. The best available evidence of a prisoner's current condition is the patient sitting in front of a member of the Healthcare Team. In any event, Mr Gibb's historical attempts at

self-harm would not have activated the "Talk to Me" process, even if known by the Healthcare Team.

[87] There are forms sent to and received back from community GPs to the Healthcare Teams which contain any essential medical history the Healthcare Team would otherwise require. As was latterly accepted by all parties, this issue does not need any particular findings after scrutiny, either in terms of section 26(2)(g) (other relevant facts), 26(1)(b)(recommendations) or otherwise.

Auto-acknowledgement of concern forms sent electronically

[88] Regarding the submission that there should be an auto-acknowledgement for all concerns forms sent electronically, such certainly appears to be practically feasible. Such an auto-acknowledgement, however, merely confirms receipt and not that the same has been actioned.

[89] In the circumstances of Mr Gibb's death, there had been no concern communicated using such electronic means. The concern was expressed in-person to a Families Outside staff member. Such is therefore not a change to a working system that might realistically prevent other deaths *in similar circumstances*, as is required in terms of section 26(1)(b) (recommendations) of the Act. As it now exists, the Talk to Me process requires a personal response within a very concise time scale to the person who had expressed concern, substantially more effective than a simple auto-acknowledgement of an electronic concern. It is not for this inquiry to endeavour to micro-manage the prison

service on issues unless relevant to the *circumstances of Mr Gibb's death* or which might realistically prevent deaths *in similar circumstances*.

[90] While the said ongoing review may find administrative advantages in having auto-acknowledgements sent to emails received as is commonplace in other organisations, such will be a matter for the respective establishments, after a full consideration of the review. This issue, therefore, also does not require any particular findings after scrutiny, either in terms of section 26(2)(g) (other relevant facts), 26(1)(b)(recommendations) or otherwise.

Conclusion

[91] I have therefore concluded that formal findings, as aforesaid, are appropriate.

Any other Information, observation or comment

[92] I would finally like to repeat my sincere condolences, which I also gave at the inquiry, as likewise were shared by all participants, to the family and friends of Mr Gibb, for their loss.