SHERIFFDOM OF NORTH STRATHCLYDE AT GREENOCK

[2022] FAI 23

GRE-B152-20

DETERMINATION

BY

SHERIFF ANDREW McINTYRE

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

into the death of

RICHARD ANGUS SCOTT FARQUHAR

Greenock, 8 June 2022

Findings

The sheriff, having considered the evidence presented at the Fatal Accident Inquiry into the death of Richard Angus Scott Farquhar, born on 6 May 1957, Finds, in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths Etc. (Scotland) Act 2016 ("the 2016 Act"), that:

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

Mr Farquhar died at 1am on 14 March 2019 at Inverclyde Royal Hospital as a result of an injury sustained within a cell at Her Majesty's Prison, Greenock, between the hours of 3:30pm and 4pm on 13 March 2019.

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

Mr Farquhar's death did not result from an accident.

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

Mr Farquhar's death was caused by complications following a self-inflicted sharp force injury to his neck, using a razor blade.

(4) **In terms of section 26(2)(d) of the Act (the cause of any accident resulting in the death):**

Mr Farquhar's death did not result from an accident.

(5) **In terms of section 26(2)(e) of the Act (the taking of precautions):**

The following are precautions which could reasonably have been taken and which, had they been taken, might realistically have resulted in Mr Farquhar's death being avoided:

(a) The setting, by the Risk Management Team within HMP Greenock, of timescales for the completion of actions which formed part of Mr Farquhar's progression plan following the withdrawal of his temporary release;

(b) The invitation of Mr Farquhar to meetings of the Risk Management Team held following the withdrawal of his grant of temporary release; and

(c) The undertaking, by the Risk Management Team, of an assessment of the risks to Mr Farquhar's welfare arising from its decision to withdraw his grant of temporary release.

(6) **In terms of section 26(2)(f) of the Act (defects in any system of working):**

The practice within HMP Greenock of permitting recommendations and decisions about temporary release to be made other than by a fully constituted Risk Management Team and without the presence of a medical member, was a defect in the system of working within HMP Greenock which contributed to Mr Farquhar's death.

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

The probable cause of Mr Farquhar's decision to commit suicide was the news that he would remain suspended from his community placement.

Recommendations

The sheriff, in terms of section 26(1)(b) of the 2016 Act, and having regard to the matters mentioned in section 26(4) of that Act, Recommends that the Scottish Prison Service:

(1) Require Risk Management Teams to agree, and keep under review, timescales for the completion of actions which form part a prisoner's progression plan, including those actions which are agreed following an adverse circumstance.

(2) Review practice and guidance on communication between Risk Management Teams and prisoners to ensure that Risk Management Teams provide prisoners with sufficient, accurate and timely information about their progression, and that information is provided in the manner which best safeguards the prisoner's wellbeing. I recommended that, as a minimum, Risk Management Teams be required to agree, and keep under review at each meeting, a communication plan addressing:

(a) The prisoner's attendance at Risk Management Team meetings;

(b) The means through which the prisoner can communicate with, or make representations to, the Risk Management Team;

(c) The means through which the Risk Management Team will, as a matter of routine, keep the prisoner advised of progress; and

(d) The arrangements for communicating individual decisions of the Risk Management Team to the prisoner.

(3) Require Risk Management Teams to: undertake an assessment of the risks to a prisoner's welfare arising from decisions affecting the prisoner's progression; and agree, and keep under review, a risk management plan in respect of any identified risks.

(4) Require that assessments and decisions related to progression, including risk assessments and decisions following an adverse circumstance, are made only by a fully constituted Risk Management Team which includes a medical member.

NOTE

Representation

Procurator Fiscal: Fauré, Procurator Fiscal Depute.

NHS Greater Glasgow and Clyde: Henderson, Solicitor, NHS Scotland.

Scottish Prison Service ("the SPS"): McCabe, Solicitor Advocate, Anderson Strathern LLP.

Prison Officers' Association: Wallace, Solicitor, Thompsons Solicitors.

Introduction

[1] This is an Inquiry into the death of Mr Richard Farquhar. Mr Farquhar died at Inverclyde Royal Hospital on 14 March 2019 as a result of a self-inflicted wound. The fatal wound was inflicted with a razor blade within a prison cell at Her Majesty's Prison Greenock where Mr Farquhar was serving a sentence of imprisonment. As Mr Farquhar was in legal custody at the time of his death this is a mandatory Inquiry in terms of section 2(4)(a) of the 2016 Act.

[2] The Inquiry was conducted "virtually" with participants' representatives appearing by video conference using the WebEx platform. Evidence was heard over four days and submissions were heard on 2 February 2022. A substantial body of evidence was agreed in the form of three joint minutes of agreement. In addition, the Inquiry heard from the following witnesses: (i) Gerry Watt, Deputy Governor, SPS; (ii) Alan Brown, Prison Officer and First Line Manager, SPS; (iii) Lesley McDowell, Former Head of Health Strategy, SPS; (iv) Mary Tran, Substance Misuse Worker, NHS Greater Glasgow and Clyde; and (iv) Gordon Hannah, Nurse Team Lead, NHS Greater Glasgow and Clyde.

[3] I found those witnesses from whom I heard to be both credible and reliable. I believe that they were, without exception, doing their best to assist the Inquiry and their evidence gave no cause to doubt the circumstances which were being described. The facts surrounding Mr Farquhar's death were broadly uncontentious. That being so, I do not record here all that was said in evidence but provide, from paragraph 5 below, a narrative of the relevant facts which I find established.

Summary

[4] I have found that Mr Farquhar committed suicide following a decline in his mental health contributed to by his suspension from a community placement. I have found that in the days and weeks prior to his death his imminent risk of suicide could not have been detected. I have also found that, as a result of the systems of working in place within HMP Greenock, and as a result of certain other factors, opportunities to safeguard Mr Farquhar's mental wellbeing in the period before his death were missed. In particular I have found that: delay, a lack of joined-up working, and insufficient communication with Mr Farquhar, all contributed to him becoming distressed by his lack of progress, and to opportunities to avert that distress being missed. I find that those omissions contributed to his death. I find no cause for criticism of any of the professionals involved; it has only been possible to identify how things could have been done differently with the benefit of hindsight. I have made recommendations which I believe, if implemented, might realistically prevent other deaths in similar circumstances.

The Facts

[5] At the time of Mr Farquhar's death, he was a prisoner at HMP Greenock. He was serving a sentence of life imprisonment with a punishment part of twelve years for the murder of his wife.

Mr Farquhar's Mental Health

[6] Mr Farquhar had a history of anxiety and depression which was first documented in 1981, when he was aged twenty-three, but his medical history disclosed no serious concern about his mental health until he was admitted to prison in 2008 for the murder his wife. At that time it was recorded that he had "suicidal tendencies". His records also make mention of previous suicide attempts prior to his admission to prison. Despite reporting no active suicidal ideas, he was assessed in terms of the SPS suicide prevention strategy at the time (known as "ACT 2 Care") as being at high risk of suicide or self-harm.

[7] In April 2008 (three months after his admission to prison) Mr Farquhar attempted suicide by cutting his wrists and by using a ligature to hang himself. According to his medical records he was monitored over the months that followed and, for a period, he was placed in an anti-ligature cell. He continued to have close contact with medical professionals for a period thereafter and by August 2009 was reporting no feelings of self-harm. Thereafter, his medical records disclose no significant concerns about his mental health, for over a decade, until the period prior to his death in 2019.

Mr Farquhar's progression

[8] In 2017 Mr Farquhar was nearing the end of the punishment part of his sentence and became eligible for "progression" to less secure conditions. The Scottish Prison Service progression strategy is intended to prepare prisoners for their eventual release.

Progression can involve a prisoner moving to less secure conditions within a traditional prison setting and may also involve a grant of temporary release into the community.

[9] In line with SPS policy, decisions about Mr Farquhar's progression were taken by the Risk Management Team (RMT). The Risk Management Team is a multi-disciplinary team of professionals convened to assess risk and take decisions about prisoners who are being considered for progress to less secure conditions, or for temporary release.

[10] In early 2017 the RMT assessed Mr Farquhar as suitable to move to less secure conditions at the "National Top End" accommodation within HMP Greenock (Chrisswell House). Chrisswell House is a national facility for long term male prisoners who are detained in less secure conditions and who are preparing for transfer to open conditions prior to being released into the community. Prisoners detained at Chrisswell House enjoy greater freedom than those in "closed conditions" on the main wings of Greenock prison.

[11] In December 2017 the RMT considered Mr Farquhar's case again and assessed him as suitable to commence a placement in the community, working in a charity shop. It is evident that Mr Farquhar enjoyed his community placement. In August 2018, he reported that he "loved" the placement and was enjoying the feeling of normality that it provided. He reported feeling motivated to progress with his sentence and was looking forward to a meeting in November 2018 at which he hoped to be approved for progress to open conditions.

Mr Farquhar's withdrawal from placement

[12] Unfortunately, problems arose in October 2018. The placement supervisor had reported a number of concerns relating to Mr Farquhar's behaviour. A change in his demeanour and work ethic had been perceived and the placement supervisor reported feeling increasingly uncomfortable when alone in his company. The issues raised by the placement supervisor were discussed with Mr Farquhar and he admitted the behaviour reported. On 11 October 2018, as a result of the concerns raised, an immediate decision was taken to suspend the placement. A meeting of the Risk Management Team was then scheduled for 26 October 2018 in light of the concerns raised.

[13] Mr Farquhar was upset by the decision to suspend his placement. On 12 October 2018 (the day following his withdrawal from placement) he referred himself to the health centre reporting that he was experiencing low mood and low energy. Six days later, on 18 October 2018, a mental health review was held. Mr Farquhar was seen by Mary Tran. Ms Tran is a substance misuse worker with a background in nursing and qualifications in counselling. She is employed by the NHS and has worked in Scottish prisons for over twenty years. Mr Farquhar reported that his low mood was a result of being removed from his placement; he was concerned that he might be downgraded to closed conditions. He explained that, while on placement, he had been preparing the shop for Christmas. That had triggered memories about what he had lost as a result of his offence. He had felt sad and had "closed in on himself" and become less communicative. As part of Ms Tran's review an assessment for anxiety and depression was undertaken using a recognised assessment method. Mr Farquhar scored "5" for

depression and "7" for anxiety. There scores, although disclosing levels of anxiety, were within an acceptable range. It was agreed that the situation would be reviewed after the RMT scheduled for 26 October 2018.

[14] On the next day Mr Farquhar made a second referral, again mentioning the issue of low mood, and asking that he be taken off his prescribed Amitriptyline. On the same day he had a consultation with Dr Ahmed who reviewed his medication and recorded that he was "doing well".

The "adverse circumstance" RMT

[15] As planned, an RMT took place on Friday 26 October 2018. In the circumstances it was known as an "adverse circumstance" RMT. A number of concerns about Mr Farquhar's behaviour were recorded. Those included:

> *"Evidence of withdrawal from support networks, behaviours that would indicate issues with emotional control and behaviours that would indicate difficulties with coping and [in] stressful situations . . ."*

In line with RMT guidance, the RMT reviewed its risk assessment. That was an assessment of the risks arising from Mr Farquhar's temporary release. The RMT confirmed its earlier decision of 11 October 2018 to suspend Mr Farquhar's placement. The RMT wanted to be satisfied that he was able to use support networks and maintain effective professional relationships before recommending his return to the placement. To that end it was decided that he should undertake work with a psychologist and that the matter would be reviewed thereafter. Mr Farquhar was in attendance for part of the RMT and was advised of its decision on the same day. At that time the RMT did not

know that Mr Farquhar had reported feelings of low mood in connection with his removal from placement and did not consider it necessary to undertake any formal assessment of the risks to Mr Farquhar arising from the recall of his temporary release.

[16] As agreed, there was a further review of Mr Farquhar's mental health, with Ms Tran, following the adverse circumstance RMT. That review took place five days after the RMT, on 31 October 2018. Mr Farquhar reported that he found the experience to have been very stressful, and that he was glad it was over. Since he had stopped taking Amitriptyline, things had improved; he felt as though *"a fog had been lifted"*.

The "discussion" RMTs

[17] In the five months that followed, there was a series of RMT meetings which were described as "discussion" RMTs. The first was on 7 December 2018. That was attended by Mr Farquhar and his behaviour on placement was discussed. Ms Tran then met with Mr Farquhar around a week later, on 13 December 2018. Mr Farquhar again reported low mood as a result of his placement having been withdrawn; he felt he had too much time to think and brood. There were other factors contributing to his mood: he felt that the hall was not a pleasant place to be at the time; he reported feelings of guilt; and he spoke about his brother's suicide and the death of his parents while he was in prison.

[18] The second discussion RMT was on 19 December 2018. It was decided that further information was required from the placement provider before Mr Farquhar could undertake sessions with a psychologist. The third discussion RMT was on 28

February 2019. The placement provider attended to give the required further information. Mr Farquhar had not been invited to attend either of these meetings.

[19] Ms Tran had a further mental health review with Mr Farquhar on 7 March 2019. She noted that Mr Farquhar was waiting to engage with psychology and was awaiting the forthcoming RMT at which his progression plan would be discussed. He reflected on the time he had spent "off placement". He had found it to be cathartic and had found a "great feeling of release" from speaking about his emotions to others.

The day of Mr Farquhar's death

[20] The next discussion RMT was on 13 March 2019, the day on which Mr Farquhar took his own life. At that meeting it was agreed, again, that work with a psychologist was required and that Mr Farquhar should remain suspended from his placement meantime. It was thought that the psychologist would meet with Mr Farquhar within a week or two. The intention was to review matters after that work had been undertaken. The RMT meeting concluded at around 12:30pm. Again, Mr Farquhar was not in attendance.

[21] Around three hours later, at approximately 3:30pm, Mr Farquhar attended at the office of Mr Alan Brown. Mr Brown was the prison officer with responsibility for the overall management of Chrisswell House, the hall on which Mr Farquhar was a prisoner. Mr Brown had attended the RMT earlier that day. Mr Farquhar wanted to know what had happened at the RMT. Mr Brown explained that Mr Farquhar would require to work with a psychologist before being considered suitable for return to a

placement. Mr Farquhar was disappointed by this news. That was not what he had expected given that he had been off placement since October 2018. Mr Brown sought to reassure Mr Farquhar about the benefit of the work with the psychologist and that, notwithstanding the decision, he was still making progress. Mr Farquhar appeared to understand but remained disappointed. Mr Brown offered Mr Farquhar the opportunity to discuss the matter with him at any time. He also asked Mr Farquhar how he was feeling. Mr Farquhar said that he felt fine. He thanked Mr Brown and then left.

[22] Around twenty-five minutes later, Mr Farquhar was found in his cell with a cut to his neck. He was bleeding profusely. He had inflicted the cut to his neck using a razor blade. He was taken to Inverclyde Royal Hospital where he underwent emergency surgery. He died as a result of his injury at 1am the following morning (14 March 2019). A post mortem examination, undertaken by Dr Julie McAdam, found that complications following a sharp force injury to his neck was the cause of death.

The police investigation

[23] The circumstances of Mr Farquhar's death were investigated by Police Scotland. CCTV footage confirmed that no other person entered Mr Farquhar's cell prior to his death. A broken plastic razor with traces of blood was found within the cell. The razor had been broken in such a way as to expose more of the blade. Mr Farquhar did not leave any note.

The SPS review

[24] Mr Farquhar's death was subject to an internal review (a Death in Prison, Learning, Audit and Review: DIPLAR). The DIPLAR was jointly chaired by the prison Governor, Ms Karen Smith, and Suzanne Taylor, the NHS Primary Care Lead. The review concluded that the decision of the RMT to recommend "further" work with a psychologist may have been be a contributing factor in Mr Farquhar's death. The DIPLAR report made no mention of Mr Farquhar's low mood in the months prior to his death or to any wider concerns about his mental health at that time.

Issues for the Inquiry

[25] The immediate circumstances surrounding Mr Farquhar's death were not in contention. The razor blade he used had been issued in line with SPS policy and the evidence disclosed no further precaution that could have been taken in that regard. Neither did the evidence give rise to concerns over Mr Farquhar's care following his injury.

[26] However, while parties were broadly in agreement about the facts, there was some contention over the findings and recommendations which should follow. The procurator fiscal invited me to recommend that: (1) Prisoners should be invited to attend RMTs; (2) Where a prisoner does not attend the RMT, an appointment should be made for the provision of feedback, as soon as possible after the conclusion of the RMT; (3) The RMT feedback should be delivered by an attendee; (4) Where the RMT's decision is likely to have a negative impact on the prisoner, a formal risk assessment should be

undertaken; (5) Medical notes should be reviewed prior each RMT to allow relevant medical information to be considered by the RMT; and (6) Any healthcare professionals who interacted with the prisoner should be invited to the RMT. These recommendations were resisted as either unnecessary, or as being unlikely realistically to prevent other deaths in similar circumstances. It was submitted that no criticism could be made of any prison officer and that the systems of working within the SPS and NHS Greater Glasgow and Clyde were sufficiently sound to permit relevant information sharing and risk assessment in appropriate cases.

[27] Against this background, the Inquiry focused on two questions: (i) Could Mr Farquhar's suicide have been foreseen, and avoided? and; (ii) Did the handling of Mr Farquhar's progression contribute to his death?

Could Mr Farquhar's suicide have been foreseen, and avoided?

[28] There were certain established factors in Mr Farquhar's history which, quite obviously, pointed to an elevated risk that he might, in a given situation, harm himself. He had a history of anxiety and depression, first recorded when he was aged twenty-four. He had a family history of suicide, his brother having taken his own life some years previously. Most notably, he had previously made a very serious attempt at suicide while in prison and, according to his medical records, had made an earlier suicide attempt while at liberty.

[29] Despite that history, no significant concerns over his mental health were recorded in the decade between 2008 and 2018. By August 2018 things appeared to be

going well. At that point his earlier mental health problems appeared to be historic. There was, however, a turning point in autumn 2018 when problems arose over his community placement. At that point the risks to his mental wellbeing increased. First, Mr Farquhar's presentation while on placement had suggested a concerning shift in his mental health. Following a period of apparent stability, that change was a cause for concern. And second, his suspension from placement represented a significant curtailment in his new-found freedom. He began, once again, to report feelings of low mood and he attributed that to his removal from placement. He was concerned that he might be downgraded to closed conditions. He also reported feelings of loss and guilt arising from the circumstances of his offence and had made mention of his brother's death by suicide.

[30] At that time, the prison health care team played an important role in assessing, and responding to, Mr Farquhar's developing mental health needs. There was a process in place which enabled him to refer himself to the health centre. He plainly felt able to make use of that system and, on two occasions, referred himself in connection with feelings of low mood. That referral prompted a series of mental health reviews with a substance misuse worker, Ms Tran. A formal assessment of his anxiety and depression was undertaken using a recognised assessment tool and that disclosed a score in the acceptable range. His medication was reviewed and he ceased to be prescribed Amitriptyline; he felt that that improved his mental health. Mental health reviews were scheduled at regular intervals to coincide with key decisions about Mr Farquhar's

placement. Over the months prior to his death those reviews provided Mr Farquhar with the opportunity to speak to Ms Tran about, and reflect on, his emotions.

[31] I was impressed by Ms Tran and she appeared to have a good relationship with Mr Farquhar. It was plain that Mr Farquhar had felt able to speak to her about a range of emotions, both positive and negative. The detailed records of those discussions suggest that Mr Farquhar was, at times, able to think rationally about his circumstances and keep matters in proportion. Throughout those reviews, while Mr Farquhar repeatedly spoke of feelings of low mood, he consistently reported having no suicidal thoughts. On 7 March 2019, which was around a week before his death, Mr Farquhar spoke of both positive and negative feelings about his time away from his placement which he described as having been *"a massive learning"*. Against this background, Ms Tran recognised the need to keep Mr Farquhar's mental health under review but concluded that he was not at risk of suicide at that time.

[32] The measures taken by the prison healthcare team did not, ultimately, prevent Mr Farquhar's death. In light of his subsequent suicide, it is now clear that his feelings of low mood prevailed over the more positive feelings which he was also reporting in the period leading to his death. That being so, a question for the Inquiry was whether those working with Mr Farquhar could have identified that he was at risk of suicide and, if so, whether further precautions could have been taken to prevent his death. In this connection, the evidence focused on whether the prison suicide prevention strategy, "Talk to Me", had been properly implemented and whether Mr Farquhar should have been placed under closer observation.

[33] I am satisfied that, in the circumstances presenting at the time, neither Ms Tran nor any other health care professional could have predicted Mr Farquhar's death. Mr Farquhar's presentation, taken together with: his reports of positive feelings; his willingness to engage with the healthcare team; his proactive approach to addressing his feelings; and his apparent self-insight into his feelings, all provided healthcare professionals with a reasoned basis on which to conclude that he was not at risk of imminent self-harm at the time of his death.

[34] While Mr Farquhar's death confounded the assessments made, those assessments were reasonable ones based on his presentation at the time. I am also satisfied that judgements about Mr Farquhar's risk of suicide were kept under careful review through a process of ongoing assessment over the months leading to his death. While there were, of course, obvious causes for concern, it was appropriate for those concerns to be addressed through the series of mental health reviews undertaken. That being so, the level of support provided by the healthcare team in the months prior to Mr Farquhar's death was appropriate.

[35] In addition to the support provided by the NHS healthcare professionals, the prison officers responsible for Chrisswell House played an important role in safeguarding Mr Farquhar's welfare. The witness Alan Brown, a prison officer at HMP Greenock, provided a detailed account of Mr Farquhar's presentation on receipt of the news that he could not yet return to his community placement. Despite Mr Farquhar's disappointment, he presented no obvious sign of upset, anger or distress. There were no "cues or clues" which caused Mr Brown concern for Mr Farquhar's immediate

wellbeing. All of the evidence before the Inquiry suggested that Mr Farquhar's nature within the prison environment was such that he was unlikely to present strong displays of emotion, even at times of low mood. It is evident that his suicide took those within the prison by surprise and I am satisfied that they could not have anticipated that he would take his own life at that point in time.

[36] I am also satisfied that all of those who engaged with Mr Farquhar had a clear understanding of the measures which should be taken in the event that a person was identified as being at risk of suicide. It was evident that they were familiar with the "Talk to Me" suicide prevention strategy and there was no reason for which they would have failed to implement it had they considered Mr Farquhar to be at imminent risk of suicide. I am also satisfied that, in the circumstances presenting, it would have been disproportionate to place Mr Farquhar under closer observation at that time. Indeed, such further impositions on his liberty are likely to have been counter-productive and would have risked compounding his low mood at a time when his distress was apparently linked to his loss of a degree of freedom.

The handling of Mr Farquhar's progression

[37] The evidence before the Inquiry suggested that Mr Farquhar's decision to take his own life was influenced, at least in part, by the suspension of his community placement. Decisions about Mr Farquhar's placement were decisions about "progression" and, as such, were taken by the Risk Management Team (the RMT). Mr Watt, the Deputy Governor of HMP Greenock, explained how the RMT operates in

practice. When a prisoner is first considered for a move to less secure conditions, or for his first grant of temporary release, the matter is referred to the RMT. The RMT undertakes a comprehensive risk assessment and makes a recommendation on the matter. Mr Watt referred to this as a "full RMT". In some cases there may at some point be an "adverse circumstance RMT". Those are meetings of the RMT convened to review matters when something goes wrong while the prisoner is accommodated in less secure conditions or on placement. Mr Watt explained that it is common also to have "RMT discussions". These are meetings, subsequent to a full or adverse circumstance RMT, at which specific aspects of an offender's management are discussed and kept under review. They appear to be a pared-down version of the RMT. They are held when it is felt that the very comprehensive risk assessment which is prepared in advance of a "full" RMT is not required. As a matter of practice, only the outcome of the discussion and those in attendance are recorded and, as happened in this case, sometimes no record of the RMT is retained. The Inquiry was also provided with the SPS guidance on RMTs: *Risk Management, Progression and Temporary Release Guidance*[1] ("the guidance"). The guidance covers, amongst other things, the circumstances in which an RMT should be held and its membership.

[38] With this background in mind, I address my findings about the RMT's handling of Mr Farquhar's progression under the following five headings: (i) Timescales;

[1] Version 1, August 2018, Scottish Prison Service.

(ii) Communication; (iii) Information Sharing; (iv) Record Keeping; and (v) Risk Assessment.

(i) Timescales

[39] I find that the period during which Mr Farquhar was suspended from his community placement without progress being made to support his return was unduly long. I find that that was a factor which contributed to his low mood in the period prior to his death and, in turn, to his death.

[40] The RMT decided, in October 2018, that Mr Farquhar required to undertake sessions with a psychologist before it would consider his return to placement, but by the time of his death some five months later those sessions had neither taken place nor been scheduled.

[41] It is recognised that addressing the kind of concerns that arose from Mr Farquhar's placement was not a straight-forward matter. The risks involved in granting temporary release to a person with a history of serious violence are obvious, and RMTs should not feel under pressure to recommend progression until they are fully satisfied that it is appropriate to do so. It may be impossible to predict how long it will take to address an underlying issue of a psychological nature. For that reason, it will not always be possible, or desirable, for the RMT to set a timescale within which a particular intervention will be completed, or within which a prisoner will be ready to progress.

[42] Notwithstanding these considerations, I find that in Mr Farquhar's case no substantial progress was made to support his return to placement during the five

months which followed the adverse circumstance RMT. There appears to have been no good reason for which the decision that Mr Farquhar should see a psychologist was not implemented soon after the adverse circumstance RMT in October 2018. Instead, the RMT was followed by a series of discussion RMTs which, on 13 March 2019, simply confirmed the decision which had been taken five months earlier.

[43] The absence of records from those RMTs means that it is not possible to discern with confidence the precise reasons for the delay but the evidence suggests that the RMT decided to obtain further information from both Mr Farquhar and the placement provider about what went wrong with the placement. That seems perfectly reasonable, but I am satisfied that that need not have become such a protracted exercise nor need it have delayed the commencement, or at least the scheduling of, the psychology sessions.

[44] It is probable that the delay in making progress towards Mr Farquhar's return to placement had a number of adverse consequences which, ultimately, contributed to his death. First, it deprived him, for five months, of the therapeutic benefit which the psychology sessions were likely to provide. It also meant that, for a prolonged period, he was left in position of uncertainty and apparent anxiety over his position. Most significantly, it delayed his return to placement. That was, obviously, a source of considerable disappointment to him, and I find that it was a factor which contributed to his decision to take his own life. In reaching these conclusions I have had regard the fact that Mr Farquhar had been sufficiently resilient to cope with his initial removal from placement. Despite his disappointment and low mood, he tholed those feelings for the period of five months prior to his death, and had begun to report more positive feelings

when he came to believe that his return to placement was imminent. But it is clear that, by March 2019, he was unable to bear the unexpected news that his suspension would continue indefinitely. That was evident from: his obvious disappointment on hearing the news of further delay; his surprise at the news; his comment that the duration of his time off placement led him to think that he would now be allowed to return; his suicide immediately after hearing the RMT's decision; and a report from one of his visitors (after his death) that he had been feeling down about the duration of his suspension from placement.

[45] As a precaution against delay, the RMT could have agreed, at the outset, a timescale within which Mr Farquhar's sessions with the psychologist would be undertaken, or at least commenced. If such a discussion had taken place following the suspension of his placement, it seems unlikely that the RMT would have regarded a period of over five months as reasonable or necessary. If timescales had been agreed, delay would have been less likely to have crept in. It is, however, impossible to know what course matters would have taken if the psychology sessions had commenced. They may not have resulted in Mr Farquhar returning to his placement any sooner. That said, it is clear that during the mental health reviews Mr Farquhar was engaging with Ms Tran in an open and reflective manner. Their discussions had reassured Ms Tran that he was doing well and he had been proactive in seeking out her help. I find it highly unlikely that, once commenced, the sessions with a psychologist would have substantially delayed Mr Farquhar's progress. But even if the psychology sessions had identified further work and delayed Mr Farquhar's return to placement, he would, at

least, have been able to see that progress was being made and he would have had greater clarity over the plan for his progression.

[46] Furthermore, if agreed timescales had been kept under review by a fully constituted RMT (including a medical member), then there would have been an opportunity for the wider group, and in this case Ms Tran, to comment on any delay and to assess what that would mean for Mr Farquhar. In particular, a greater focus on timescales would have ensured that, whatever timescales were involved, steps could have been taken to ensure that Mr Farquhar's expectations were realistic, thereby avoiding the apparent surprise and disappointment he felt when he heard of further delay on the day of his death.

[47] For these reasons, I find it probable that the delay in making progress with Mr Farquhar's psychology sessions (if not in achieving his return to placement) contributed to his distress prior to his death when he discovered that he could not yet resume his placement and there remained no clear timescale within which he could expect so to do. I find that that delay would probably have been avoided if the RMT had taken the precaution of setting timescales for the commencement of Mr Farquhar's psychology sessions. I find that, had that precaution been taken, together with other precautions recommended in this determination, it might realistically have resulted in Mr Farquhar's death being avoided.

[48] I believe that other deaths in similar circumstances might realistically be prevented if the Scottish Prison Service were to introduce a requirement that Risk Management Teams agree, and keep under review, timescales for all actions which form

part a prisoner's progression plan, including those actions which are agreed following an adverse circumstance.

(ii) Communication

[49] I find that the problems with delay were compounded by the fact that Mr Farquhar was not kept sufficiently informed about the plans for his progression in the months prior to his death. That was particularly evident from his lack of understanding of both the timescales involved and the significance of the work with a psychologist.

[50] According to Mr Brown, on the day of Mr Farquhar's death he had been expecting to be told that he could resume his placement. Ms Tran had also formed the view, from her discussions with Mr Farquhar, that he was expecting to return to placement soon. Indeed, that was one of the reasons for which she concluded that he was *"in a much better place"* than before. There was, however, no prospect that the RMT would have recommended his return to placement at that time. It had been decided in October 2018 that work with a psychologist was a prerequisite for further progression and by the time of his death that work had not yet commenced.

[51] It is not clear why Mr Farquhar had expected to return to placement at that point. He had known, at one point at least, that he required to see a psychologist prior to resuming the placement. He had discussed the matter with Ms Tran. Yet he had come to misunderstand, or lose sight of, what had been agreed. It may be that he had not properly understood what the psychology sessions would involve. Ms Tran's note of

her discussion of the topic with Mr Farquhar was that, *". . . a report [was] to be completed by [a] psychologist before he can continue with progression"*. Mr Farquhar may not have realised that he required to see the psychologist over a number of sessions before such a report could be prepared. Alternatively, he may have believed that the work would be undertaken quickly, or that it was no longer required given the passage of time.

[52] Divergent interpretations of Mr Farquhar's progression plan at that point were also evident within the RMT. On the one hand, Mr Watt anticipated that the psychology sessions would be completed within a matter of weeks. He considered that the message from the RMT was that Mr Farquhar *"was going back to placement"* and he saw that as *"really positive"* news. Mr Brown, on the other hand, appeared to recognise that Mr Farquhar's return to placement remained contingent on him making satisfactory progress in the sessions with a psychologist. These different interpretations of the RMT's decision highlight the scope for confusion that existed and suggest that, even within the RMT, there was a lack of clarity over the implications of its decision for Mr Farquhar's progression at that time.

[53] For one reason or another, by the date of his death, Mr Farquhar did not have a clear understanding of the RMT's plan for his progression, and was under the misapprehension that he was about to return to his placement. It is a matter of considerable regret that such confusion arose because it resulted in the outcome of the final RMT being unexpected by Mr Farquhar. I find that that undoubtedly contributed to the disappointment he experienced immediately prior to his death and, in turn, to his death.

[54] It is impossible to know how Mr Farquhar's confusion came to pass, but the fact that it did is, in my view, indicative of a lack of adequate communication between the RMT and Mr Farquhar. That does not mean that key decisions were not communicated to Mr Farquhar, but it does suggest that, with the benefit of hindsight, such communication as there was, was insufficient to ensure that he maintained a clear understanding of his route to progression over the course of what was, ultimately, a protracted period.

[55] I have considered how Mr Farquhar's confusion could have been avoided and, in particular, whether he should have been invited to attend each of the RMTs which were held between October 2018 and his death in March 2019. He was invited to attend two of those RMTs. The first was in October 2018 when he was told about the plan for his progression, namely that he would require to see a psychologist prior to being reassessed for temporary release. The second was on 7 December 2018 when the RMT wanted to find out more about the problems that had arisen with the placement. There was then a period of three months during which there were three further RMTs to which Mr Farquhar was not invited. I find that Mr Farquhar's absence from those meetings contributed to his ultimate confusion over his progression plan. And while there may have been other forms of communication with him during that period, I find that the reliance on informal and unplanned communication with Mr Farquhar was insufficient to ensure that the RMT's key messages were communicated effectively.

[56] Had Mr Farquhar attended the RMTs between December 2018 and March 2019 then it is probable that: (i) he would have known that he could not be granted temporary

release until he had undertaken sessions with a psychologist; (ii) he would have known the timescale within which that was likely to happen; (iii) his understanding would not have become distorted over time; (iv) he would not have been surprised by the news he received on the date of his death; (v) any misunderstanding between the RMT and Mr Farquhar would have been identified and corrected; (vi) there would have been a shared understanding, amongst RMT members, of the RMT's key decisions and messages, and of Mr Farquhar's expectations; (vii) the RMT would have detected Mr Farquhar's disappointment over the delay in his placement resuming; (viii) the RMT would have been more aware of the impact of the delay; and (ix) the RMT would have been better able to assess Mr Farquhar's risk to himself and to others. Had these outcomes been achieved, then it is probable that the distress and disappointment Mr Farquhar experienced immediately prior to his death would have been avoided as, in turn, would his death. For these reasons I find that the invitation of Mr Farquhar to the Risk Management Team meetings was a precaution which could reasonably have been taken and which, had it been taken together with other precautions recommended in this determination, might realistically have resulted in Mr Farquhar's death being avoided.

[57] I now turn to the manner in which the outcome of the final RMT (on the morning of Mr Farquhar's death) was communicated to him. The procurator fiscal submitted that the delay in communicating the RMT's decision and the failure to provide Mr Farquhar, in advance, with an appointment for that purpose were instances of poor practice. I was invited to recommend that prisoners who have not been invited to attend an RMT

should be given a pre-arranged appointment, at a time as soon as practicable after the meeting, for the purpose of communicating the RMT's decision.

[58] I agree that there was delay in the outcome of Mr Farquhar's RMT being communicated to him on the day of his death. With the benefit of hindsight, it is clear that the decision of the RMT was a matter of serious concern to Mr Farquhar. He was anxiously awaiting the decision and the delay will have done little to mitigate the distress which had developed by the time of his death. It would certainly have been better if Mr Farquhar had been advised of the decision of the RMT sooner. But I am not confident that the outcome would have been any different if Mr Farquhar had been told of the RMT's decision earlier on the day his death. I find that it is most likely that it was the news and its unexpectedness, rather than the delay in hearing it, that were the prevailing sources of Mr Farquhar's ultimate distress. I also have reservations about recommending an overly rigid approach to communication. In Mr Farquhar's case I have found that better communication would have been achieved if he had been invited to attend the RMT meetings but that may not be the best approach in every case. Different approaches are required in different circumstances. It might be judged that a particular prisoner does not want frequent updates from the RMT; another prisoner may be anxiously awaiting news of every development. In some cases, delivering news at a pre-arranged time may be very important; in other cases it may not be possible to predict the best time to deliver a particular message to a particular person. For these reasons I decline the procurator fiscal's invitation to recommend that, in every case, the prisoner should be given a pre-arranged appointment for the delivery of RMT decisions.

However, I do consider that other deaths in similar situations might realistically be prevented if RMTs were required to adopt a more considered approach to their engagement with prisoners through the agreement of a communication plan for prisoners who are being considered for progression. With these considerations in mind I recommend that the Scottish Prison Service review practice and guidance on communication between RMTs and prisoners. It is recommended that, as a minimum, Risk Management Teams be required to agree, and keep under review, a communication plan addressing:

(a) The prisoner's attendance at Risk Management Team meetings;

(b) The means through which the prisoner can communicate with, or make representations to, the Risk Management Team;

(c) The means through which the Risk Management Team will, as a matter of routine, keep the prisoner advised of progress; and

(d) The arrangements for communicating individual decisions of the Risk Management Team to the prisoner.

(iii) Information sharing

[59] The problems arising from delay and poor communication could have been avoided if there had been better information sharing between the professionals with whom Mr Farquhar was engaged. In particular, I find that there was insufficient communication between the RMT and the prison healthcare team. That situation arose because no healthcare professional was in attendance at any of the RMTs which handled

Mr Farquhar's progression between his removal from placement in October 2018 and his death in March 2019. That ought not to have been the case because, according to the RMT guidance (at paragraph 10), the core membership of the RMT should include a health professional. The purpose of the health professional's attendance is:

> *"to contribute to discussion and provide relevant information, where appropriate, from an offender's health records, including . . . mental health"* (Page 24).

[60] Notwithstanding that guidance, the Inquiry was told that healthcare professionals are not invited to attend either adverse circumstance RMTs or "discussion" RMTs; they only attend "full" RMTs. That is a departure from the guidance and is, in my view, the root cause of many of the problems encountered in this case. While there are different circumstances in which an RMT might be convened, the guidance envisages that the core membership will not change.

[61] The absence of a healthcare professional at Mr Farquhar's RMTs had a number of consequences. Overall, it deprived both the RMT and Ms Tran of the opportunity to give, and receive, information which should have informed the assessments which they each required to make. As a result, those addressing Mr Farquhar's potential risk to the community, and those safeguarding his health and wellbeing, were working with an incomplete picture of his overall circumstances. In Mr Farquhar's case, those two matters were inextricably linked because the concerns which had led to his withdrawal from placement were, in fact, concerns over his mental health. Rather than approaching these issues in a multi-disciplinary way, conform to the guidance, the system of working in operation meant that these matters were approach by the RMT and the healthcare

team separately. As a result, the RMT was unaware of Mr Farquhar's reports of low mood, and had only limited information about his history of suicide attempts. That being so, the RMT was unable to appreciate the risks to Mr Farquhar's mental health which were developing as progress towards his return to placement became increasingly protracted. Similarly, the healthcare team was unaware of the precise plan for Mr Farquhar's progression and, crucially, the likely timescales involved. Instead, Ms Tran appeared to rely on information from Mr Farquhar which, as I have found, was confused. That limited Ms Tran's ability to provide him with meaningful support appropriate to the circumstances he was facing at any given time.

[62] It was submitted, on behalf of the NHS, that information about Mr Farquhar's mental health could not have been shared with the RMT, even if members of the healthcare team had been in attendance. The suggestion was that such information could only have been disclosed if Mr Farquhar had been assessed as "at risk" of suicide. The Inquiry was not addressed on the law relating to the processing of sensitive personal data as it applies in this context. That is because there was no suggestion that Ms Tran had incorrectly withheld information, or that she had misunderstood the circumstances in which she would have been entitled to disclose information. She judged, from her assessment of Mr Farquhar, that he was not at risk of suicide and, for that reason, she did not consider it necessary to disclose his medical information to any other party. That being so, I reserve comment on the law in this connection but simply observe that it may be setting the bar too high to suggest that an immediate risk of suicide is the sole basis on which sensitive personal data may be shared in this context.

[63] Even if I am wrong about that, assessments of risk and decisions about information sharing are often finely balanced and require to be kept under review. This is highlighted in the suicide prevention strategy guidance: *"Assessment is a dynamic process, where levels of risk often change, sometimes very quickly"*[2]. By attending the RMT meetings Ms Tran would have been better able to keep her assessment of Mr Farquhar's risk of suicide under review in light of the information she received. She might have revised her assessment of risk if she had heard that his return to placement was likely to be delayed and that his expectation of an imminent return to placement was unrealistic. That would certainly have allowed her to share relevant medical information. Alternatively, Ms Tran could have sought Mr Farquhar's consent to share information with the RMT. I find it probable that she would have done so had she been asked to attend the RMT. She was aware of that possibility and indicated, in evidence, that she could see no reason for which such consent would have been withheld. On that basis, she believed that, if she had attended the RMT, she would have disclosed Mr Farquhar's report of low mood.

[64] I am in no doubt that, had the RMT known about Mr Farquhar's reports of low mood then, as a minimum, it would have recognised the need to keep Mr Farquhar's mental health under careful watch. According to Mr Watt, it was the (mistaken) belief that there were no concerns over Mr Farquhar's mental health which led him to conclude that a risk assessment was unnecessary. I find it probable, then, that he would

[2] "Talk to me. Prevention of Suicide in Prison Strategy 2016 – 2021", Scottish Prison Service, Page 5.

have undertaken such an assessment if he had known that Mr Farquhar had, on two occasions, sought medical help over feelings of low mood arising from his withdrawal from placement. I have addressed, at paragraph 84 below, a number of benefits which a risk assessment in these circumstances would have achieved but I am satisfied that, as a minimum, it would have identified the need to avoid delay and to keep Mr Farquhar fully informed of progress.

[65] Even if Ms Tran had felt unable to share medical information about Mr Farquhar, she could still have contributed to the RMT's discussion and decision making. She could have used her knowledge of Mr Farquhar's fluctuating mood, and his expectation of an imminent return to placement, to inform her advice and recommendations. In particular, she could have advised the group about the potential impact of delay and she could have urged the RMT to progress more swiftly in arranging the sessions with the psychologist. She could have encouraged better communication with Mr Farquhar. With the information available to her she was more likely than anyone else to recognise the importance of those matters to Mr Farquhar's wellbeing during that period. Those were all matters on which Ms Tran could have advised without having required to share confidential information about Mr Farquhar's health.

[66] Ms Tran could also have used the information she received from the RMT to inform her own work in supporting Mr Farquhar. She could have ensured that he understood, and had realistic expectations about, the RMT's plan for his progression. That, alone, would have averted the surprise and disappointment he experienced on the day of his death.

[67] Finally, it should be recognised that information about Mr Farquhar's mental health was not only required to assess the risks *to* him, it was also needed to assess any risk posed *by* him. The RMT had been concerned that he had withdrawn from support networks; that was seen to be a risk. It would, then, have assisted the RMT to know that Mr Farquhar had, in fact, been proactive in seeking out help in connection with his mental health in the months following his suspension from placement. Indeed it is difficult to understand how the RMT could have properly monitored the risk posed by Mr Farquhar without current information about his mental health. In terms of the RMT guidance, detailed information about the prisoner's mental health should be submitted to the "full" RMT for that very purpose and there appears to be no good reason for which that information should not be revisited following an adverse circumstance. That was another, and sufficient, reason for which a healthcare professional should have been in attendance at the RMT meetings.

[68] As Mr Farquhar's case shows, the decisions taken at an adverse circumstance RMT or at a discussion RMT may be just as important to an offender as those taken at a "full" RMT. The evidence disclosed no sound reason for which such meetings should be deprived of the contribution of a healthcare professional. Indeed it appears that the absence of a medical member could only render the tasks facing the professionals involved more difficult. It is, of course, impossible to be certain about how Ms Tran's contribution would have influenced the RMT but it is significant that, based on her experience of working with the SPS, she believed that while her advice would not have altered the RMT's decisions about temporary release, it would have been taken on board

by the RMT in its handling of those decisions. From the evidence before me, I am certain that Ms Tran is correct. The prison officers from whom the Inquiry heard left me in no doubt that, had they known more about Mr Farquhar's pre-existing and developing risk factors, they would have been concerned to ensure that those matters were addressed.

[69] With these considerations in mind, I find that the practice of permitting recommendations and decisions about temporary release to be made other than by a fully constituted Risk Management Team, limited the sharing of information between the Risk Management Team and NHS Greater Glasgow and Clyde, about: (i) Mr Farquhar's mental health; (ii) Mr Farquhar's suicide risk factors; and (iii) the Risk Management Team's plan for Mr Farquhar's progression. I find that that was a defect in the system of working which contributed to his death. I find that the approach recommended by the RMT guidance (namely, that a medical member forms part of the core group) remains sound but that, either: practice has drifted from that approach; or the recommended approach has not been sufficiently understood. I recommend that decisions related to progression, including decisions following an adverse circumstance and decisions currently taken by "Discussion RMTs", are taken or recommended only by an RMT comprised of a full core group which, for the avoidance of doubt, should include a medical member.

(iv) Record Keeping

[70] Related to the issue of information sharing is that of record keeping. The evidence suggested that key information about Mr Farquhar's pre-existing risk factors, such as his history of suicide attempts and his family history of suicide had not been known, or had not been obvious, to those dealing with his progression.

[71] The first issue related to Mr Farquhar's medical records. Ms Tran was certainly aware of Mr Farquhar's suicide attempt while in prison. She became aware of that as a result of, what she described as, a "minimal entry" in the medical notes. A volume of medical records was produced to the Inquiry. Those records did not make it easy to gain a clear picture of the salient, and established, risk factors which Mr Farquhar's history presented. The notes comprised a series of entries from an electronic record system (Vision) together with a series of scanned notes. The records revealed a number of inconsistencies and omissions in the information recorded about Mr Farquhar's mental health. That was particularly evident from six prisoner transfer forms used to pass important medical information from one prison to the next whenever Mr Farquhar had moved from prison to prison. Of those six forms, one has been signed but is otherwise blank; one records "no" against "history of suicide attempt"; and four record "yes" against "history of self-inflicted injury" but in two of those four the section relating to "suicide attempt" is blank. The Inquiry was informed that these records had been superseded by the electronic system, but it remained of concern that the original information was inaccurate and remained on file. It is self-evident that the existence of incorrect or incomplete information on a health record could easily mislead

the reader about a person's history, even if the correct information is recorded elsewhere.

[72] The medical records also contain reference to an earlier, apparently serious, suicide attempt by Mr Farquhar prior to his admission to prison. That is recorded in a form completed by the court social worker on the day of his admission to prison. That suicide attempt is not mentioned elsewhere in the records and was not mentioned by any witness in the course of the Inquiry. It had obviously been missed.

[73] Notwithstanding those observations, I am satisfied that sufficient information about Mr Farquhar's suicide risk factors was contained within the NHS Vision records. I find, however, that the system in place relied too heavily on the interrogation of, and interpretation of, multiple sources of information, some of which were inaccurate or misleading. It appears that, as a result, it was not known that Mr Farquhar had attempted suicide twice before, rather than once. It was plain that important information could easily be missed. These problems may go some way to explaining why the medical professionals who attended the DIPLAR review omitted to mention Mr Farquhar's low mood in the months prior to his death (see paragraph 86 below). Notwithstanding these observations, I do not believe that this was a factor which, ultimately, contributed to Mr Farquhar's death because Ms Tran had plainly undertaken a careful review of the records and had managed, notwithstanding their limitations, to identify the key risk factors necessary to enable her undertake a proper assessment of Mr Farquhar's immediate risk of suicide; there is no criticism of her conclusion in that regard. She would not, however, have been able to provide the RMT, had she been

invited to do so, with a complete account of the incidents of attempted suicide which formed part of Mr Farquhar's medical history. That would have undermined any risk assessment to which she had been invited to contribute.

[74] The second issue related to the information available to prison officers. For good reason, prison officers do not have access to medical records but can access information about a prisoner on the prisoner records system ("PR2"). According to the evidence, there was information on PR2 to alert prison officers to the fact that, in 2008, Mr Farquhar had been monitored in terms of the suicide prevention strategy. Reference was made to a "marker" which would highlight that history to a prison officer accessing Mr Farquhar's records. The officer would then require to access the relevant information to find out more about the circumstances.

[75] When asked about the available information, Mr Watt did not volunteer that Mr Farquhar had previously attempted suicide. I am in some doubt about whether he actually knew that at the time of the RMTs. His evidence was that he knew that Mr Farquhar had been placed in an anti-ligature cell and had been subject to observations for a period but he did not mention the previous suicide attempt. When asked, he said that he "would have" known about Mr Farquhar's previous attempted suicide at the time of the RMT because he had a practice of looking on PR2 to see the details of any previous suicide prevention measures taken, but he appeared unable to be certain about the matter. I was surprised that, by the time of the Inquiry, Mr Watt appeared not to be familiar with the fact that Mr Farquhar had previously attempted suicide while in prison. I am not certain that Mr Watt did know about the previous

suicide attempt at the time of the RMTs but, in general, I found him to be a credible and reliable witness and I am unable to reject his evidence that he would have known about the matter at the time. For that reason, I do not find, on the balance of probability, that Mr Watt was unaware of Mr Farquhar's previous suicide attempt at the time of the RMTs, and I make no finding in this connection in respect of the SPS system of record keeping.

[76] It is certain, however, that the RMT did not have access to information about Mr Farquhar's suicide attempt prior to his admission to prison, nor his family history of suicide, because those were matters which were held only in Mr Farquhar's medical records to which the RMT had no access.

[77] I accept that the information about Mr Farquhar's previous suicide attempts required to be viewed in the context of his recent years of stable mental health. Information about a previous act of self-harm, even a serious one, will not always lead to a conclusion that the person is at risk of suicide at a later date. Decisions require to be proportionate and based on the circumstances presenting at the time. That having been said, there are certain pre-existing risk factors which will remain relevant throughout a person's time in custody, and which should be well known to those who require to assess the risks facing the prisoner in light of developing circumstances. Mr Farquhar's previous suicide attempts and his family history of suicide are example of such factors. They were significant and established factors which required to be weighed in the context of his developing low mood. Without knowledge of those matters the starting point for any risk assessment by the RMT would have been flawed.

[78] In light of these findings I have considered whether I should recommend any change to the systems of record keeping within the SPS or NHS. In this regard, a distinction can be drawn between Mr Farquhar's suicide attempt while in prison, and the information about his earlier suicide attempt and his family history of suicide. The former related to something that happened while in prison and there are obvious reasons for which that should be recorded on PR2 to allow prison officers to guard against its recurrence. The latter factors, however, were only contained in Mr Farquhar's medical records. Their omission from PR2 is, therefore, a question of information sharing rather than record keeping. I am conscious that, if implemented, my recommendations (numbers 3 and 4) requiring risk assessments to be undertaken by a multi-disciplinary group (the RMT) would address the prospect of the RMT being unaware of established risk factors. That being so, I make no further recommendation in this connection.

[79] I now turn, briefly, to record keeping by the RMT. Despite repeated requests, the SPS was unable to provide the Inquiry with records of certain "Discussion" RMT meetings. It became evident that discussion RMTs do not always retain a record of their meetings. The many reasons for which that is an unsatisfactory practice are obvious and it is unnecessary to state them here. It is sufficient to state that it made the task before the Inquiry more difficult and caused delay while the matter was investigated.

[80] I am, however, satisfied that those were not matters which contributed, in any way, to Mr Farquhar's death and so I make only these observations but neither a finding nor a recommendation in this connection.

(v) Risk Assessment

[81] Following Mr Farquhar's death, the DIPLAR review agreed an action to:

> *"Discuss with National Suicide Strategy Group whether there should be policy changes [to require] an "At Risk" assessment on individuals following a RMT Outcome Meeting".*

No such change was introduced but the merit of such a policy was the subject of evidence and submissions to the Inquiry.

[82] Under the current system of working, the RMT is not required formally to assess such risks and it did not do so in Mr Farquhar's case. That may be unsurprising because the RMT's primary function is to identify any risk that the offender may abscond or cause harm to the public if granted temporary release. However, as Mr Farquhar's death demonstrates, another risk facing the RMT is that its decisions will have an adverse effect on the mental health and wellbeing of the offender. In this context, the risk which required to be assessed was not simply the risk of imminent suicide, but the risk that Mr Farquhar's removal from placement would elevate his risk of suicide by provoking a decline in his mental health.

[83] It was said in evidence, and submissions, that risk assessment is an ongoing part of the role of all of those working with prisoners. The suggestion was that a "formal" requirement to assessment risk in such circumstances was unnecessary. It would, of course, be undesirable for risk assessment to become overly bureaucratic or formulaic. And, obviously, the offender's potential disappointment is not a factor which should influence the RMT to release him if he is, otherwise, unsuitable to be released; the risk to

the prisoner should not cloud judgements about the risk he poses. On the other hand, decisions about progression are some of the most important decisions taken over the course of a prisoner's sentence and adverse decisions present obvious risks to a prisoner's mental wellbeing. While informal, ongoing, risk assessment is, of course, essential to prisoners' welfare, it is necessarily limited to an assessment of the risk factors known to the officer concerned and, in my view, requires to be supplemented by multi-disciplinary risk assessment, at least at key stages when risk may be expected to increase. An adverse decision about progression is one such stage.

[84] A requirement to undertake a risk assessment in Mr Farquhar's case would have had a number of benefits. First, it would have ensured that a risk assessment was done. Mr Watt explained that he saw no need to undertake a risk assessment because his understanding, at the time, was that Mr Farquhar had no history of mental health problems, apart from an "episode on remand". But the circumstances here show that risk assessments cannot be confined to those cases in which risks are patent. The process of assessing risk, by sharing information, is one way in which otherwise latent risks can be identified and addressed. Second, if a risk assessment had been undertaken by a fully constituted RMT, it would have provided an opportunity for relevant medical information to have been shared. That would have alerted the SPS members of the RMT to risk factors arising from Mr Farquhar's mental health of which they were otherwise unaware. That would have included both his developing low mood and his pre-existing risk factors. Third, it would have enabled the RMT to have assessed the risks in the knowledge of the decision it had taken. That would have avoided the situation in which

Ms Tran, or any other person, was assessing risk on the basis of a third-hand account of the RMT's decisions. Fourth, it would have prompted the RMT to take precautions against the risks identified. As I have found, the setting of timescales and better communication are two such precautions which could reasonably have been taken. Others, outwith the RMT, could only react to risks as they developed and if they became apparent. And finally, the RMT was best placed to keep its assessment of risk under review in light of any changes, including delays, to its plan for Mr Farquhar's progression.

[85] For these reasons, I am satisfied that a risk assessment undertaken by the RMT was a precaution which could reasonably have been taken in Mr Farquhar's case, and was one which, had it been taken along with other precautions recommended in this determination, might realistically have resulted in his death having been avoided. With these considerations in mind, I recommend that the Scottish Prison Service review practice and guidance in relation to progression to require that Risk Management Teams undertake an assessment of the risks to an offender's welfare arising from decisions affecting that offender's progression and agree, and keep under review, a risk management plan in respect of any identified risks. In making this recommendation I am conscious that, under existing procedures, very comprehensive information relevant to such an assessment is collated and reported to the RMT as part of the RMT referral form and minute. Implementing this recommendation should not be unduly onerous and should not require substantial changes in process.

The DIPLAR review

[86] Before concluding, it is necessary to deal, briefly, with an issue raised by the DIPLAR review. Mr Farquhar's history of low mood in the months prior to his death was not reported at the DIPLAR review despite the attendance of NHS healthcare professionals. That was plainly an omission. The DIPLAR report also records as *"not previously documented"* information about Mr Farquhar feeling down about: his suspension from placement; the length of time that was lasting; the consequences for his parole; working with psychology; and his brother's suicide. According to the DIPLAR report, that information was obtained after Mr Farquhar's death from one of his visitors. As is now clear, much of that information was known to Ms Tran and was recorded in Mr Farquhar's medical records. It was not, as the DIPLAR report suggests, new information. These omissions suggest that information sharing continued to be a problem even after Mr Farquhar's death. The absence of accurate information about Mr Farquhar's medical history deprived the DIPLAR group of the opportunity to undertake a meaningful review of the circumstances leading to his death. As a result, the review was guided away from many of the issues which are addressed in this determination.

[87] These apparent omissions were raised in the course of the Inquiry and recognised as an oversight by NHS Greater Glasgow and Clyde. The Inquiry was advised that the duty to disclose such information to the DIPLAR review had been addressed with healthcare practitioners. In addition, practice has been revised to require that only senior healthcare managers, who have undertaken a full review of the

deceased's medical records, shall attend DIPLAR reviews. In light of those changes I make no recommendation in this connection.

Conclusion

[88] I am grateful to all of those who assisted the Inquiry in its function. The findings imply no criticism of any individual. The Inquiry has had a considerable advantage over those involved at the time. It has had the benefit of hindsight and the opportunity to review in slow motion, and in detail, circumstances and decisions which faced busy professionals working in real time and, often, with only part of the overall picture. The recommendations made here are not intended to add to that burden; quite the opposite. Taken together, if implemented, they should support those working within prisons in their duty to safeguard the wellbeing of prisoners. They should make it easier to identify and address risk thereby relieving the inevitable distress caused when unforeseen risks materialise with tragic consequences. Most of all, however, it is hoped that the recommendations will avoid other deaths in circumstances similar to those of Mr Farquhar.

[89] I conclude by extending the condolences of the Court to all those affected by Mr Farquhar's death.