**SHERIFFDOM OF NORTH STRATHCLYDE AT KILMARNOCK**

**[2024] FAI 20**

KIL-B200-22

DETERMINATION

BY

SHERIFF MURDOCH MACTAGGART

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

into the death of

**WILLIAM PATTERSON**

KILMARNOCK, 10 MAY 2024

The Sheriff having considered the information presented at the inquiry into the death of William Patterson, born 3 September 1990, finds in terms of section 26(1)(a) the Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (the "Act") as follows:

(i) in terms of section 26(2)(a) that Mr Patterson died at 23:49 hours on 23 December 2019 at University Hospital Crosshouse, Kilmarnock Road, Crosshouse, Kilmarnock, KA2 0BE;

(ii) in terms of section 26(2)(c) that the cause of death was 1a: Hanging;

(iii) in terms of section 26(2)(b) and (d) that no accident occurred;

(iv) in terms of section 26(2)(e) that there are no precautions which could reasonably have been taken and which, had they been taken, might realistically have resulted in Mr Patterson's death being avoided;

(v) in terms of section 26(2)(f) that there were no defects in any system of working which contributed to Mr Patterson's death; and

(vi) in terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death), that there are no other facts which are relevant to the circumstances of the death.

**NOTE**

**Introduction**

[1] This is a mandatory Inquiry into the death of Mr William Patterson in terms of section 4(a) of the 2016 Act. Mr Patterson was a prisoner within HM Prison Kilmarnock, who died on 23 December 2019 at the University Hospital Crosshouse.

[2] The following parties were represented: the Crown in the public interest, represented by Mr Ali, Procurator Fiscal Depute; NHS Ayrshire and Arran Health Board represented by Mr Fitzpatrick, advocate; the Scottish Prison Service ("SPS"), represented by Mr Bell, solicitor; SERCO represented by Mr Lothian and Gwen Patterson, the deceased's mother who was represented by Ms Dalgleish.

[3] Preliminary hearings took place, by Webex video conference, on a number of occasions before the inquiry itself which was held on 4 April 2023 with a hearing on submissions on 15 May 2023.

[4] Parties agreed a significant amount of evidence in a Joint Minute of Agreement, the contents of which are largely contained in the summary of evidence below. This restricted significantly the requirement for oral evidence at the inquiry.

[5] Additional parole evidence was led from on behalf of the NHS Ayrshire and Arran Health Board from Dr Dawn Carson Consultant Forensic Psychiatrist, and, on behalf of the deceased's next of kin from, Dr David Hall, Consultant Forensic Psychiatrist.

[6] No witnesses were led by any other party.

[7] All parties submitted written submissions. I am grateful to the parties for their assistance in the preparation and conduct of this inquiry.

**The legal framework**

[8] The inquiry was held under section 1 of the Act. It was a mandatory inquiry in terms of section 2(1) and (4) of the Act because Mr Patterson was in legal custody at the time of his death. The purpose of the inquiry was to establish the circumstances of his death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances.

[9] Fatal Accident Inquiries and the procedure to be followed in the conduct of such inquiries are governed by the provisions of the Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. In terms of section 1(3) of the Act the purpose of an inquiry is to establish the circumstances of the death and to consider what steps, if any, may be taken to prevent other deaths occurring in similar circumstances. In terms of section 1(4) the purpose of an inquiry is not to establish civil or criminal liability. A determination is to be made which in terms of section 26(1)(a) and (2) is to set out findings in relation to: (i) when and where the death occurred; (ii) the cause or causes

of such death; (iii) any precautions that could have reasonably been taken, and if so might realistically have avoided the death; (iv) any defects in any system of working which contributed to the death; and (v) any other facts which are relevant to the circumstances of the death. Additional findings in relation to an accident are not relevant to this inquiry, as it is agreed that Mr Patterson's death was not the result of an accident.

[10] In terms of section 26(1)(b) and (4) of the Act, the inquiry is to make such recommendations (if any) as the sheriff considers appropriate as to: (i) the taking of reasonable precautions, (ii) the making of improvements to any system of working, (iii) the introduction of a system of working, and (iv) the taking of any other steps, to the extent in each case these might realistically prevent other deaths in similar circumstances.

[11] The procurator fiscal represents the public interest. An inquiry is an inquisitorial process and the manner in which evidence is presented is not restricted. The Court proceeds on the basis of evidence placed before it by the procurator fiscal and by any other party to the inquiry. The determination must be based on the evidence presented at the inquiry and is limited to the matters defined in section 26 of the Act. Section 26(6) of the Act provides that the determination shall not be admissible in evidence or be founded on in any judicial proceedings, of any nature. This prohibition is intended to encourage a full and open exploration of the circumstances of a death, while also reflecting the position that it is not the purpose of an inquiry to establish civil or criminal liability.

**Parties' submissions**

[12] The Crown's submission was to invite the Court to make the mandatory formal findings, in terms of section 26(2)(a) and (c) of the 2016 Act and to determine that Mr Patterson died at 23:49 hours on 23 December 2019 at Crosshouse Hospital, and that the cause of death was hanging.

[13] As this death was not the result of an accident the Crown made no submissions in terms of section 26(2)(b) and (d) of the 2016 Act. The Crown invited the Court to make no finding in terms of Section 26(2)(e) and (f) of the 2016 Act. Acknowledging that the representatives of Mr Patterson's next of kin made submissions relative to finding in terms of section 26(2)(g) of the Act the Crown specifically invited the Court to make no such finding so far as it related to access to medical records or access to psychiatric assessments. So far as such a finding related to Mr Patterson not being seen by a medical professional or nurse following his removal from association the Crown took a neutral position.

**NHS Ayrshire and Arran Health Board**

[14] Counsel for the Health Board invited the Court to make the same determinations so far as sections 26(2)(a), (b), (c), (d), (e) and (f) were concerned. In relation to section 26(2)(g) Counsel for the Health Board invited the Court to find that there were no other facts relevant to the circumstances of the death.

[15] Counsel for the Health Board further submitted that no recommendations fell to be made in terms of section 26(1)(b) of the 2016 Act that is to say 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, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances

[16] Put shortly the submission on behalf of the Health Board was that Mr Patterson did not have an untreated or undertreated psychiatric illness. He had a personality disorder, for which he had received appropriate psychological intervention and support. Further, in the period leading up to his death there was no indication of a deterioration in Mr Patterson's mental health, or of any increased risk of suicide.

**The Scottish Prison Service**

[17] On behalf of the Scottish Prison Service the Court was invited to make determinations in relation to section 26(2)(a) and (c) in the terms set out in the joint minute and to make no other determination.

**SERCO**

[18] On behalf of SERCO the Court was invited to make the determinations in relation to section 26(2)(a) and (c) in the terms as set out in the joint minute and to make no other determination.

[19] The submission on behalf of SERCO made detailed reference to the evidence. In short, the submission identified three matters in respect of which the prison management may be criticised. These were:

[20] That the deceased ought to have been visited by a medical practitioner or nurse "as soon as practicable" after being removed from association on 20 December 2019;

[21] The deceased was not seen by a supervisor when he asked to see one on the night of his death.

[22] That having been given three days' cellular confinement on 23 December 2019 the deceased should have been visited by a medical practitioner or nurse within 24 hours ie by 24 December 2019.

[23] In relation to the first two points it was submitted that there was no evidence that any assessment on or about 20 December 2019 might have led to a referral to specialist psychiatric services. Even if such a referral had been made, there is no evidence that assessment by specialist psychiatric services might have led to any material change in the deceased's care or treatment. On prior occasions when the deceased felt suicidal, he told his mother. By contrast, when the deceased spoke to his mother on 23 December 2019, he appeared upbeat and in good spirits. The most likely explanation, as articulated by both Dr Hall and Dr Skilling, is that the deceased had decided to take his own life but was intent on not revealing that to anyone. In relation to the third it was submitted that the deceased had died before 24 hours had elapsed.

**Mr Patterson's next of kin**

[24] The solicitor for Mr Patterson's mother invited the Court to make findings in terms of section 26(2)(a) and (c) in the terms of the joint minute and also to make a finding in terms of section 26(2)(g) in relation to other facts which are relevant to the death.

[25] The matters which the submission invited to be considered were –

Deficiencies in access to, and sharing of, information between medical staff in the prison and other organisations;

Administrative/clerical deficiencies in the recording and storing of information which was relevant to the deceased's medical health;

That the deceased was not assessed by a medial practitioner after being awarded three days cellular confinement as such an assessment may have identified that he was feeling suicidal.

**Summary of evidence**

[26] On 25 May 2011 William Patterson, date of birth 3 September 1990 (the deceased) appeared at Dumfries Sheriff Court and pled guilty to five charges including assault on police officers, threatening and abusive behaviour, culpable and reckless conduct, culpable and reckless fire-raising. An extended sentence comprising a custodial period of 4 years and an extension period of 5 years was imposed. He had been on license for an earlier conviction for assault to severe injury, permanent disfigurement and danger to

life at the time of said offence and received a six month recall order to run consecutively with the extended sentence.

[27] On 6 May 2014 the deceased appeared at Kilmarnock Sheriff Court and pled guilty to a charge of assault to severe injury and permanent disfigurement for which he was sentenced to 14 months imprisonment to run consecutive to the sentence imposed on 25 May 2011.

[28] The deceased was released from prison on license at his Earliest Date of Liberation on 6 March 2015.

[29] His license was revoked on 24 November 2015 and he was returned to prison on 25 November 2015 with a sentence end date of 25 January 2022.

[30] Following recall to prison, the deceased was first imprisoned within HMP Kilmarnock, before being transferred to HMP Dumfries on 9 January 2019 and returned to HMP Kilmarnock on 11 January 2019. The deceased was transferred to HMP Perth on 11 August 2019 and returned to HMP Kilmarnock on 4 October 2019.

[31] At the date of his death on 23 December 2019 the deceased was a prisoner of HM Prison, Kilmarnock. He was accordingly in legal custody at the time of his death.

**Circumstances of death**

[32] The deceased was involved in a violent incident with other prisoners on 20 December 2019 and he was placed on a Rule 95(1) (removal from association) in his cell within E wing pending adjudication. The deceased attended adjudication on 21 and 23 December 2019 where he was found guilty and given three days cellular confinement.

[33] There is no record of the deceased being having been seen visited by a medical professional or nurse on after being he was placed on a removed from association in terms of Rule 95(1) or after he was placed in cellular confinement. In terms of paragraph 5(1) of the Health Board Provision of Healthcare in Prisons (Scotland) Directions 2011 the deceased ought to have been visited by a medical practitioner or nurse "as soon as practicable" after being removed from association on 20 December 2019, and his medical condition ought to have been reviewed at least every seven days thereafter. In terms of paragraph 4(1) of the Health Board Provision of Healthcare in Prisons (Scotland) Directions 2011, after being notified on 23 December 2019 that cellular confinement was imposed, he ought to have been visited by a medical practitioner or nurse within 24 hours ie by 24 December 2019. Mental health staff are reliant upon prison staff to notify them of any such event and to request such an assessment or visit. There is no record of any such notification or request in the deceased's case.

[34] At approximately 16:00 hours on 23 December 2019 the deceased was within cell 11 in E wing of the prison (hereinafter referred to as "the cell"). Prison Custody Officer JAC allowed the deceased out of the cell for around 10 to 15 minutes, he appeared to be in good spirits, joking and engaging in conversation with her.

[35] The deceased spoke with his mother, Gwen Patterson at around 16:30 hours by telephone. Mrs Patterson reported no concerns about the deceased. He appeared upbeat and in good spirits, making plans for when he would be released from prison. The deceased and Mrs Patterson arranged for the deceased to telephone her again the following day to allow him to speak with his son, Daniel.

[36] At around 19:30 hours, Prison Custody Officer BB attended the deceased's cell in response to a cell call and the deceased requested to speak with a supervisor. BB noted that there was nothing unusual in the behaviour or demeanour of the deceased. BB reported to the Custodial Operations Manager CR that the deceased wished to speak with a supervisor. CR advised that he would speak with the deceased later when on his rounds. CR had intended to speak with the deceased but had not managed to that evening. BB said that he informed the deceased that the supervisor would speak with him later. This is a contradictory statement to that of Prison Custody Officer AG who stated that BB was regretful he had not informed the deceased that the supervisor would come and speak to him later.

[37] At 21:00 hours JAC and BB were conducting a cell count to ensure all prisoners were accounted for. JAC entered the cell and thought the deceased was standing at the back of the cell before discovering that he was hanging from a ligature made from bedding tied to the cell window.

[38] JAC called for assistance, using her radio to call a "Code Blue" to alert medical staff that they were urgently required to attend at the cell. BB assisted in supporting the weight of the deceased whilst JAC used a cut down tool to cut the ligature from the deceased's neck. AG attended the cell and assisted in lowering the deceased to the floor.

[39] Prison Custody Officer JR and Prison Custody Officer RA attended at the deceased's cell in response to the "Code Blue" and commenced Cardiopulmonary resuscitation (hereinafter referred to as CPR). There was no sign of a pulse or breathing

from the deceased. PM, Prisoner Custody Officer and CR attended and assisted with CPR. They continued CPR until responding nurses took over.

[40] HMcA, a Mental Health Nurse and HG, a Nurse Practitioner continued with CPR until AHY, an Ambulance Technician and LH, a Paramedic arrived at the prison at 21:17 hours and cannulated the right arm of the deceased. AHY and LH noted the deceased to be attempting to breathe on his own and observed some electrical activity in the heart. AG, an Ambulance Technician and JW, a Paramedic arrived at 21:25 hours to assist and established intraosseous access to the deceased's limbs to administer drugs. A neck brace was applied as the deceased may have sustained a neck injury. It was established that there was electrical activity within the deceased's heart but no output.

[41] At 21:38 hours a decision was made by LH and JW to transfer the deceased to Crosshouse Hospital for further treatment. The ambulance carrying the deceased left the prison at 21:50 hours with AHY, LH and JW with AG following in another ambulance.

[42] The deceased was taken to Crosshouse Hospital, Accident and Emergency Department, where Doctor MD stopped any further attempts to resuscitate the deceased and pronounced death at 23:49 hours.

**Police investigation**

[43] Police Scotland were made aware of the aforementioned incident and the death of the deceased. BM, Detective Constable and RB, Detective Constable attended HMP Kilmarnock on 23 December 2019. These officers seized the ligature used and the

suicide note left by the deceased. Within his suicide note, the deceased indicated that being away from his mother and his son was "killing" him and that he did not feel that he could trust the staff or other convicts and had no hope for the future both in and out of prison (as shown at Crown Production 2).

[44] On 24 December 2019 Detective Sergeant PS and Detective Constable KH attended the prison at 09:45 hours to search the cell with SB, Scene of Crime Examiner who took photographs of the inside of the deceased's cell (as shown at Crown Production 5). Photographs of material which formed part of ligature were obtained (as shown at Crown Production 5, pages 15-20).

[45] Detective Constable H spoke with AF, a prisoner who was friendly with the deceased. The deceased had told to him, around a fortnight earlier, that he was suicidal and revealed that he had a knotted piece of material concealed within a pillowcase. AF wished to alert prisoner officers, but the deceased dissuaded him. He also revealed that the deceased would self-harm using a razor blade concealed in a bible and that he appeared to enjoy self-harming.

[46] Consequently, Detective Constable H requested that a further search of the cell be carried out. A razor blade concealed within a bible was located and seized.

**Provision of healthcare in Scottish prisons**

[47] On 1 November 2011, the responsibility for the provision of healthcare to prisoners transferred from the SPS to the NHS. Since then the individual regional NHS health boards have been responsible for the delivery of healthcare services within

prisons in Scotland which fall within their geographical ambit for the provision of medical care (as shown at Crown Production 13).

**Medical history and treatment**

[48] The deceased arrived at HMP Kilmarnock on 25 November 2015 following his recall to prison. The deceased was assessed as displaying no apparent risk of suicide and no deliberate thoughts of self-harm, though a previous history of psychiatric disorder was offered by the deceased and was noted. He was noted to say he had a diagnosis of anxious personality disorder and had been seeing a "psychiatrist", BK. Dr BK was a Consultant Forensic Clinical Psychologist at the Crichton Royal Hospital in Dumfries. He was also noted to say he had bipolar disorder, ADHD (attention deficit hyperactivity disorder), and psychotic tendencies. The deceased was seen by the Prison General Practitioner, Dr Skilling, on 26 November 2015 as a new admission consultation with no issues noted and noted the deceased to be listed for a mental health nurse (as shown at Crown Production 3 page 42).

[49] The deceased was noted to have stated he has a history of personality disorder and hyperactivity, and was referred to the mental health team on 3 December 2015. He and was assessed by a mental health nurse on 8 December 2015. The assessment noted Mr Patterson's history of self-harm 3 months previous and suicide attempts but noted he had no thoughts of deliberate self-harm and there was no apparent risk of suicide (as shown at Crown Production 3 pages 41- 42). It was noted that contact would be sought with BK to obtain information on the deceased's previous management, to be followed

by a discussion with the prison psychiatrist (as shown at Crown Production 3 pages 41-42). There is no note within the deceased's Prison Medical Records (Crown Production 3) of any discussion with Dr BK having taken place prior to 16th February 2016. There is also no record noted within the said deceased's Prison Medical Records of the mental health staff having received a written report or assessment from Dr BK.

[50] On 13 January 2016, the deceased is noted to have told HMcA, Mental Health Nurse, that he had been diagnosed with Bipolar Disorder and Anti-social personality disorder following a formal assessment at Crichton hospital in Dumfries, which is where Dr BK was based. He was also noted to have stated he was awaiting an appointment to be assessed by a consultant Psychiatrist (as shown at Crown Production 3 page 41).

[51] On 19 January 2016 a mental health nurse assessed the deceased after he was placed on ACT (which was the SPS suicide preventions strategy at that time) due to concerns raised by his mother and writing a suicide note. The deceased stated he had been diagnosed with depression and anti-social personality disorder but felt he was not receiving any help. He denied any suicidal intent and wanted to be taken off ACT as night observations disturbed his sleep. An ACT case conference was held and he was maintained on ACT with 60 minute observations. He was kept on ACT until the following day when another case conference as held, it was noted the deceased engaged well and appeared happy and a decision taken to remove him from ACT. On 20 January 2016 the mental health nurse discussed the deceased with the prison GP, and he was started on an oral antidepressant medication, mirtazapine (as shown at Crown Production 3, pages 40-41).

[52] On 29 January 2016, the deceased was reviewed by a prison GP who made a referral to the MHT (mental health team). It was also noted that the deceased had stated that he had been diagnosed with bipolar disorder in October at the Crichton Royal Hospital in Dumfries. The said prison GP requested for the deceased's notes, and any recent letters from the Crichton Royal Hospital to be obtained and reviewed. There is no record within the deceased's prison medical records to any notes or other documentation from the Crichton Royal Hospital having been obtained.

[53] Dr DC, a Consultant Forensic Psychiatrist at Ayrshire Central Hospital was the sole psychiatric doctor providing psychiatric services at HMP Kilmarnock at this time. Dr Carson had considerable experience working in the prison estate. In advance of a multi-disciplinary team (MDT) meeting scheduled for 16 February 2016 contact was made on behalf of Dr Carson (by her secretary) with Dr BK, to ascertain the nature of any previous diagnosis in the deceased. Dr Carson states that it was reported by Dr K that the deceased had not been diagnosed with any psychiatric illness and that Dr K reported that he had diagnosed the deceased with borderline personality disorder, but that he did not have bipolar disorder or any other form of mental illness. This information was considered by Dr Carson to be in keeping with how the deceased was presenting with nursing staff and the reports they were receiving from prison staff. Dr Carson states that she relayed that information to the nursing team at the next team meeting, although she does not recall the detail of that conversation and has been unable to locate the minutes. Dr Carson believed it is likely that they discussed ways in which

the nursing team could offer him support to manage his distress and awareness of the disorder (Statement by Dr Carson and Ayrshire and Arran Health Board Production 1).

[54] On 16 February 2016 it was agreed following a MDT meeting that the deceased was to have no further input from the mental health team (as shown at Crown Production 3, page 40). Dr Carson never met with the deceased directly.

[55] The deceased received a further assessment by HMcA, mental health nurse on 30 May 2016 and it is recorded that he stated that his main concerns were violent thoughts he had towards others and anxiety. He stated he did have fleeting thoughts of suicide but no plan to complete suicide. He stated that he had self-harmed 3 months previous. The mental health nurse referred the deceased to psychiatry. Meanwhile, on 11 August 2016, the deceased is noted to have stated that his head was "bursting" and that he was due to "kill someone". The deceased was noted by HMcA to have appeared agitated and having reported ongoing anxiety and paranoia. HMcA liaised with Dr Carson, who advised that anxiety management would be the best therapy for the deceased and a further appointment was to be arranged, however there is no note within the deceased's prison medical records of a follow-up appointment with the mental health team.

[56] A referral was made to the mental health team by the deceased's addiction worker on 2 December 2016. An appointment took place on 10 January 2017 where he was assessed by a mental health nurse. It was established he was not suffering from low mood and was not acutely mentally unwell. Moreover, that he was functioning well but had issues with addiction and anger, for which he was receiving support. It was agreed

to offer the deceased literature to support him regarding anger and low mood (as shown in Crown Production 3, page 38).

[57] Mental health appointments took place on 23 and 30 November 2017 and 19 December 2017 with HMcA. The deceased reported issues with sleep, anger management and trauma. A referral to anger management was made and sleep promotion support provided (as shown at Crown Production 3, pages 34-35).

[58] Anger management sessions were commenced on 9 February 2018. On 18 April 2018 it was noted within a mental health nurse review by HMcA noted that the deceased was distressed following a telephone call with his mother where she apparently stated she would commit suicide. The deceased is also noted to have felt suicidal during the previous week.

[59] A GP appointment on 20 April 2018 was arranged to review the deceased's antidepressant, which was continued. Weekly mental health reviews were planned until the deceased settled down. He declined an appointment on 2 May 2018 as he stated he was feeling unwell.

[60] A further anger management and mental health nursing reviews took place on 15 May 2018, during which the deceased is noted to have stated he had suicidal thoughts a couple of days previous.

[61] On 20 July 2018, a further anger management and mental health nursing review took place and it is noted by HMcA that a further appointment would be arranged in approximately two weeks' time, however there is no note of any follow-up appointment having taken place around this time (as shown at Crown Production 3, page 33).

[62] On 11 September 2018 a further anger management and mental health nursing review took place and it is noted by HMcA that the deceased reported feeling suicidal over the weekend. It was planned that the mental health nurse would keep the deceased's self-help book to work through with him and that a further appointment would be arranged for 2-3 weeks' time. There is no record within the prison medical records to any follow-up appointment having taken place around this time. The deceased is not recorded to have met with the mental health team again until over three months later on 2 January 2019.

[63] On 23 April 2019, the deceased attended a mental health assessment appointment following him being involved in an assault with another prisoner. The deceased is noted to have expressed disappointment in not having been seen by a Consultant Psychiatrist. He spoke about his past traumas, abuse, possible diagnosis of PTSD (Post Traumatic Stress Disorder) and that he had recently been finding it difficult to manage his emotions. The deceased was noted to have discussed having infrequent fleeting thoughts of deliberate self-harm however he reported not to have acted on these since November 2018. It was planned that this would be discussed at the next MDT meeting.

[64] The deceased engaged with the Addictions Service at the prison consistently since May 2019. He attended an initial addictions assessment and reported he was consuming non-prescribed drugs such as Subutex, illicit methadone, tramadol and cannabis daily. However, an oral screen for these substances was returned negative.

[65] He was commenced on 10mgs of methadone on 4 June 2019, which was increased to 30mgs from 21 June 2019. A reduction plan was initiated, at the request of the deceased, from 7 November 2019. He collected the last dose of 5mgs on 23 December 2019.

[66] The deceased attended regular appointments with the Addictions service where he engaged in therapeutic and support work in relation to anxiety management, self-esteem and coping strategies. His last meeting with his Addictions caseworker was on 3 December 2019 where he said he would likely not attend further appointments as he believed his caseworker had been talking about him to other staff.

[67] The deceased was placed on Talk to Me measures on 7 May 2019 after informing prison officers he was having suicidal thoughts daily. In response, he was placed in a safe cell with strong clothing and 15-minute observations. The following day, he was assessed by HMcA and he denied having any suicidal thoughts. His observations were reduced to 60 minute observations (as shown in Crown Production 3, page 30 and Crown Production 6).

[68] Case conferences were held on 8 May 2019 and 10 May 2019 where the deceased was assessed at apparent risk of suicide and maintained on Talk to Me protocols. A further case conference was held on 13 May 2019 where the deceased was assessed by HMcA and appeared bright and well engaged, stating he was not having any ongoing suicidal thoughts. He was assessed as no apparent risk and taken off Talk to Me (as shown at Crown Production 3, page 30 and Crown Production 6, pages 455-462 and page 487).

[69] The deceased was seen by MM, Mental Health Nurse who was the duty nurse on 8 August 2019 after prison staff had reported the deceased was very distressed. The deceased reported he had attempted suicide three days earlier, but the ligature had snapped. He was emotional and crying, and though denied any ongoing suicidal thoughts but stated that there were days where he was feeling suicidal and would self-harm to cope with the emotions. He was also noted to have stated that every day he "doesn't want to wake up". MM assessed there was no immediate risk of suicide at that time. The deceased requested to speak with his named nurse, HMcA and the prison psychiatrist Dr Carson. MM arranged for HMcA to assess the deceased and says she informed Dr Carson the following day. Dr Carson has no record or recollection of being informed but accepts this may have occurred. In any event, 9 August was a Friday and Dr Carson states that she would not have been able to schedule the deceased into one of her clinics prior to Monday 12 August, when he was transferred to Perth prison.
Dr Carson considers it likely that she asked MM to relay the information she had elicited to the deceased's allocated worker HMcA, with a request for her to review the deceased as soon as possible and then to discuss any ongoing concerns with Dr Carson, however there is no note of this within the deceased's prison medical records.

[70] On 11 August 2019 the deceased was seen by a mental health nurse. HMcA but was unable to be assessed due to heightened presentation. He had been involved in an episode of concerted indiscipline with other prisoners and had become violent. He was also placed on Talk to Me by prison officers due to prison intelligence that he had made a call to his mother that he was going to commit suicide that evening.

[71] Due to the violent incident at the prison, the deceased was transferred to the Separation and Re-integration Unit (SRU) at HMP Perth on 12 August 2019. At the mental health team meeting on 13 August 2019 both Dr Carson and HM were present, and no issues or concerns about the deceased were raised, although by then, the deceased had been transferred to Perth. It was noted that the deceased knew that he should inform staff if he feels that he is starting to struggle again. Following the transfer, he was reviewed by a mental health nurse on the day of his arrival and a case conference held. He presented in a highly agitated state and voiced paranoid thoughts of prison staff poisoning his food. He was continued on Talk to Me with 60-minute observations. A further review was held on 15 August 2019 by a mental health nurse, the deceased presented better and more settled. He was removed from Talk to Me at this point.

[72] A further mental health review was held after prison staff at the SRU at HMP Perth reported that the deceased was struggling. A detailed review was held on 29 August 2019 where the deceased appeared bright and at times was able to display rational thought, however he would revert to paranoid thoughts that prison staff were contaminating his food and methadone. He stated when agitated he will feel like harming himself or others and will usually self-harm to avoid hurting others. The mental health nurse discussed doing some anxiety management and supportive work with the deceased.

[73] Prison staff placed the deceased on Talk to Me again on 2 September 2019 after he voiced thoughts of self-harm and suicide. A case conference under the Talk to Me

strategy was held on 3 and 6 September and it was agreed to maintain the deceased on Talk to Me for further support. A further conference on 13 September 2019 identified no apparent risk of suicide and he was removed from Talk to Me.

[74] On 29 September 2019 the deceased was removed from the SRU at HMP Perth after assaulting a member of staff and he was discovered self-harming by cutting his arms using wire from a radio. Accordingly, he was placed on Talk to Me and placed in a safe cell with anti-ligature clothing. He was placed on 15-minute observations. He was reviewed by a mental health nurse on 30 September 2019 who noted his mood seemed lower while there was evidence of paranoid thought. A case conference under the Talk to Me strategy was held on the same date where he was assessed as at risk of suicide. He was moved back to SRU and moved to 30 minute observations. A further mental health review and case conference was held on 3 October 2019 under the Talk to Me strategy where the deceased was continued on Talk to Me with 60-minute observations.

[75] On 4 October 2019 the deceased was transferred back to HMP Kilmarnock. On his arrival to the prison reception area, he was assessed in accordance with the Talk to Me policy. The deceased was risk assessed as no apparent risk by the prison staff member, but it was noted he was currently on Talk to Me still subject to the Talk to Me Strategy at that time. It was noted by a nurse that he had "no thoughts of deliberate self-harm". His Talk to Me book appears to have been missed by the reception staff and consequently remained "open".

[76] A case conference took place on 8 October 2019, which had been brought forward as the prison staff in the SRU located the open Talk to Me book from his time in

HMP Perth. The deceased was assessed as no apparent risk and removed from Talk to Me. CC, Mental Health Nurse noted the deceased's view that he was not suicidal and was pleased to return to HMP Kilmarnock as he did not enjoy his time at HMP Perth. He was of the opinion that staff had been interfering with his methadone but this did not happen at HMP Kilmarnock. It was agreed that CC would take the deceased onto his case load while the deceased was to approach prison Serco or NHS staff if he required support.

[77] The last mental health review took place on 22 October 2019 when the deceased had a meeting with his addiction case worker and requested to speak with CC. He reported no deliberate or intentional suicidal plan or intent but stated he would "slash" a prisoner officer in order to be transferred to the SRU as other prisoners were intimidating him on the hall. CC submitted an intelligence report regarding this to the Custodial Operations Manager. Consequently, the deceased was moved to the SRU.

[78] A mental health review was attempted by CC on 12 November 2019 but the deceased was verbally abusive and stated he wished for no further input from the mental health team. The deceased was to remain under the review of the mental health team, however, there was no further contact with mental health staff and the deceased between that point and his death.

[79] The deceased's last intervention with health care staff prior to his death was on 5 December 2019 in relation to chest, back, kidney and gut pain but the pain had resolved by the time of the appointment.

**Post mortem examination**

[80] A post mortem examination was carried out on 4 January 2020 at the Queen Elizabeth University Hospital, Glasgow by Forensic Pathologists SM and GK.

[81] The cause of death was certified as: 1a: Hanging

[82] Blood and urine samples were analysed with therapeutic concentrations of methadone found.

[83] The Death in Prison Learning, Audit and Review (DIPLAR) listed the extensive contact the deceased had with healthcare, mental health and addictions in the months and years leading to his death. It is noted that there is a well-documented history of paranoid thinking, self-harming, suicidal ideation and suicide attempts in his healthcare records while no formal mental health diagnosis is recorded but a diagnosis of borderline personality disorder is alluded to.

[84] The DIPLAR concluded at Crown Production 8, page 533: "The DIPLAR meeting found a number of clerical and process errors in terms of Mr Patterson's management following the rule and adjudication process that could have been managed better. There was no indication to staff that Mr Patterson was going to attempt to take his own life, neither was there any indication to his mother". Learning points were identified in the DIPLAR including the missed Talk to Me record in prison reception upon the deceased's return to HMP Kilmarnock from HMP Perth. Action points were raised to tighten the reception process to prevent missed documentation on transfer and to ensure prisoners are seen by a healthcare professional when removed from association or awarded cellular confinement.

[85] Dr GS is an NHS Consultant Forensic Psychiatrist. He was asked by the Crown to provide an opinion on the standard of mental health care and treatment provided to the deceased while he was a prisoner at HMP Kilmarnock. In preparing his report, Dr Skilling reviewed the Death in Prison Learning, Audit and Review (DIPLAR), the deceased's Scottish Prison Service File, the deceased's NHS medical records, the deceased's Talk to Me documentation, a suicide note written by the deceased and the witness statement of the Gwen Patterson, the deceased's mother. Dr Skilling report formed Crown Production 9.

[86] Dr Skilling is satisfied that the general standard of mental health care provided to the deceased was reasonable. The frequency and consistency of input from mental health teams within the prison was of a reasonable standard while he states the standard of these contacts with mental health professionals were of a good standard and well documented. The deceased was identified as having a history of mental health difficulties as well as being a previous suicide risk and a history of addictions issues. Dr Skilling opines that the Talk To Me measures utilised to safeguard the deceased were proportionate and reasonable, meanwhile prison staff responded appropriately to concerns raised regarding the deceased's risk of self-harm. Dr Skilling states the deceased's suicide was not predictable and there were no reasonable precautions which could have prevented it. Indeed, he spoke to his mother just a few hours prior to his death and appeared well, typically in the past he would disclose to Ms Patterson if he was feeling suicidal.

[87] Dr Skilling notes the deceased should have been seen by a medical practitioner or nurse following cellular confinement, however he cannot conclude that had this visit taken place, that it would have prevented the deceased's death.

[88] Dr DJH is an NHS Consultant Psychiatrist with 28 years expertise in Forensic Psychiatry. He was asked, on behalf of Mr Patterson's next of kin, to provide an opinion on the standard of mental health care and treatment provided to the deceased while he was a prisoner at HMP Kilmarnock, including his psychiatric treatment, and to address concerns raised by the Next of Kin. His report is dated 1 September 2022. In preparing his report, Dr Hall reviewed the Notice of Enquiry and Inquiries into the Fatal Accident and Sudden Deaths etc. (Scotland) Act 2016, Post-mortem report, Deceased's suicide note, Prison medical records, Talk to Me suicide prevention documentation, Health Care in Prisons (Scotland) Directions 2011, Scottish Prison Service Records, Witness statement of GBRP obtained by Walker & Sharpe Solicitors on 3 May 2022 and the Report prepared by Dr GS, Consultant Forensic Psychiatrist dated 2 February 2021. Dr Hall's report forms Next of Kin's Production 1.

[89] Dr Hall is satisfied that deceased was able to access support around addictions and mental health in a reasonable way. He concluded that the deceased's difficulties were such that it is very hard to see how his death could have been prevented once he made the decision to take his own life. He did, however, highlight that whilst he did not consider that the deceased received wrong or inadequate treatment, the treatment was less than optimal because of difficulties accessing all relevant information, such as included in Dr K's report for example. Dr Hall was of the opinion that the deceased

would have perhaps been clearer as to why he was not receiving psychiatric treatment had he been offered at least an occasional review by a psychiatrist to reconfirm the nature of his difficulties were largely psychological, as opposed to psychiatric. He also stated that he did not believe that this would have resulted in any substantial change in the care, but the quality of that care would have been somewhat improved. He concluded that he did not consider that this would have prevented the deceased's death.

[90] Dr Hall was of the opinion that there was an issue in terms of the accessibility of medical records, particularly the mental health records of prisoners, to practitioners working within the prison system, which was worthy of emphasis and required to be addressed.

[91] In addition to the joint minute of agreement the inquiry heard evidence from Dr DC and Dr DJH.

**Dr Hall**

[92] Dr Hall's concerns, broadly, came under two headings – firstly, access to prisoners' previous mental health records where these are held by a different health board and, secondly, access by prisoners to a periodic psychiatric review.

[93] While Dr Hall did not believe that Mr Patterson's death could have been predicted or prevented, he expressed the view that Mr Patterson's overall care over the years would have benefitted from NHS staff based in the prison having greater access to expert assessments, such as that carried out by BK whilst he was in the community. He did not think that Mr Patterson received the wrong treatment or inadequate treatment,

but he thought that his treatment was less than optimal because of difficulties accessing all relevant information, such as included in Dr K's report.

[94] Dr Hall thought that Mr Patterson should been offered at least an occasional review by a psychiatrist to reconfirm the nature of his difficulties were largely psychological, as opposed to psychiatric. He did not believe that this would have resulted in any substantial change in the care Mr Patterson received, but felt that the quality of that care would have been somewhat improved.

[95] Dr Hall was to some extent challenged in cross examination on the issues of occasional reviews by a psychiatrist. Dr Hall had been the visiting consultant psychiatrist at Dumfries Prison when Mr Patterson was an inmate there. During that time Dr Hall did not personally assess Mr Patterson. However, Mr Patterson was seen on 12 November 2009 by a speciality doctor and was referred to psychology.
Mr Patterson then had psychological intervention in the form of CBT (Cognitive Behaviour Therapy) in 2010. There were no other records of periodic psychiatric assessment during Mr Patterson's time at Dumfries.

[96] Dr Hall said in evidence that in "an ideal world" an individual as such as Mr Patterson should be assessed annually. However, he appeared to accept that limited resources and time would determine what could be done.

[97] While Dr Hall thought that Mr Patterson would potentially have benefited from seeing a psychiatrist in prison to clarify and explain his diagnosis he did not believe that that seeing a psychiatrist would have prevented his suicide.

[98] In Dr Hall's opinion, Mr Patterson's difficulties were such that it is very hard to see how his death could have been prevented once he made the decision to take his own life. Specifically, he noted the information from Mr Patterson's mother that Mr Patterson had actually appeared to be in good spirits when she talked to him on the phone shortly before he died by suicide. Dr Hall felt that it would be reasonable to assume that Mr Patterson would have presented in a similar fashion to others who interacted with him - such a as supervisor or member of medical staff.

**Dr Carson**

[99] Dr Carson gave evidence in relation to Dr Hall's concerns. Dr Carson conceded that the system to access information from other health boards some years ago was time consuming, fallible and resource intensive, often not always resulting in accurate information being available. This has now improved greatly for the majority of the patients that are within HMP Kilmarnock. Dr Carson and her team now have access to remote clinical portals for some health boards across Scotland (NHS Greater Glasgow & Clyde, Lanarkshire, Dumfries & Galloway, Forth Valley and Golden Jubilee). These cover the majority of the areas from which prisoners at Kilmarnock originate.

[100] The remote portals allow to access most information held on the person from that area, including mental health records. These records are now used to determine the need for care, assessments and treatment. For records from all other health boards, not on the remote portals, there is still a requirement to contact medical records departments

or individual clinicians in these areas to ask for information, although the requirement to do so was said to be "quite rare".

[101] Now, all team meetings HMP Kilmarnock are minuted and the information relating to individual patients are uploaded to their Care Partner record (the mental health system used by NHS Ayrshire & Arran). All summaries of NHS records are discussed there and relevant information.

[102] Despite the historical difficulties in obtaining details of medical information from external sources Dr Carson was adamant that detailed information relative to Mr Patterson was obtained from Dr K and that this information was used in clinically assessing the appropriate care for Mr Patterson. She did, however, accept that it should have been robustly documented and stored, although she did not believe the failure to do so unduly impacted on the care Mr Patterson received within HMP Kilmarnock. She made the point that the information from Dr K related to period when Mr Patterson was at liberty and the stresses affecting Mr Patterson in prison would be different. Her opinion was that Patterson received care commensurate with his needs within the resources available to the mental health team at that time.

[103] Dr Carson explained that at during Mr Patterson's time at HMP Kilmarnock there was no clinical psychologist in post. This was due to limited resources. She herself had, in the past, provided some psychology treatment to prisoners but the extent of her workload in recent years mean that she could not offer such services herself. She explained that psychological interventions were particularly time consuming and that she had to prioritise her psychiatric patients.

[104] Dr Carson explained that the nursing team at HMP Kilmarnock had direct contact with Mr Patterson. They were trained to provide psychological therapy and she was satisfied that they were adequately able to provide support to Mr Patterson. The nursing staff acted a triage for any psychology or psychiatric issues. If there were any concerns about a patient's presentations these would have been discussed with Dr Carson and if appropriate referral to Dr Carson could have been made. Dr Carson was satisfied that Mr Patterson did not have a psychotic or psychiatric illness and did not require a referral to a psychiatrist.

[105] In response to Dr Hall's suggestion that, although Mr Patterson's needs were psychological, he may have benefited from some psychiatric input to reconfirm this, Dr Carson explained that the very restricted resources in prison healthcare over recent years, meant that was something that could rarely, if ever, provided. Her position was that she had to rely on discussions between colleagues – particularly the nursing staff to identify cases that required a psychiatric referral. Dr Hall's proposition had been her typical practice at the earlier part of her career but the increased levels of mental health need and static psychiatric resources meant that this could no longer be justified. She went on to say that meeting a patient and telling them that no psychiatric treatment would be offered (as would have been the case if she had met Mr Patterson in person) would have been likely to have been more stressful, and not useful, to Mr Patterson.

[106] Dr Carson explained that since Mr Patterson's death additional resources are now in place at HMP Kilmarnock. An addition consultant psychiatrist has been

appointed and a clinical psychologist took up post on 2020. Additional funding has also allowed the appointment of additional nursing staff.

**Conclusion**

[107] On the basis of the evidence before the Inquiry, I am satisfied it is appropriate to make the formal findings noted at the start of this determination in terms of section 26(2)(a) and section 26(2)(c).

[108] The evidence indicates that Mr Patterson did not have a psychotic or psychiatric illness. The differences in the evidence of Doctors C and H are quite narrow. Dr Hall has indicated that Mr Patterson's treatment at HMP Kilmarnock was less than optimal but he does not attempt to attribute any connection between this and his subsequent death. Dr Carson appears to accept that the services offered within HMP were limited by resources, however, her view was that Mr Patterson did receive appropriate intervention and support.

[109] The changes in information provision additional resources now available at HMP Kilmarnock appear to address the concerns raised by Dr Hall.

[110] The delay in obtaining information about Mr Patterson's previous history with Dr BK appears to have been a symptom of an issue which is now largely resolved. However, it appears to have no bearing on how Mr Patterson was treated at HM Prison Kilmarnock or indeed at HMP Perth. Had the information been available earlier it would not have altered how he was being treated by the nursing staff and it would not have caused Dr Carson to deal with Mr Patterson differently.

[111] On the evidence, I can establish no causal connection between the provision of psychiatric or clinical psychological services at HMP Kilmarnock and Mr Patterson's death. I had considered whether the absence of clinical psychology provision or the lack of a periodic psychiatric assessment ought to be include in my determination as matters relevant to Mr Patterson's death on terms of section 26(2)(g) of the Act. However, in my view the evidence would not support such a finding

[112] I further considered whether the absence of an attendance by a member of medical staff when Mr Patterson was removed from association could be considered as a matter relevant to Mr Patterson's death. However, as Dr Hall opined, it appears that once Mr Patterson had made a decision to take his own life there was really nothing that could have been done to prevent this. There was nothing about his presentation or demeanour, which would have alerted those in contact with him of his intention. There was accordingly nothing which the prison staff did or failed to do which could be said to have contributed to or caused Mr Patterson's death or which I could find was a matter relevant to his death.

[113] I offer my condolences to Mr Patterson's family and in particular to his mother Gwen Patterson.