SHERIFFDOM OF SOUTH STRATHCLYDE DUMFRIES AND GALLOWAY AT HAMILTON

[2023] FAI 14

HAM-B241-21

DETERMINATION

BY

SHERIFF ANDREW McINTYRE

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

into the death of

BRIAN CONNOR

HAMILTON, 8 March 2023

Findings

The sheriff, having considered the evidence presented at the Fatal Accident Inquiry into the death of Brian Connor, born on 11 September 1975, 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 2016 Act (when and where the death occurred):

Mr Connor died at 3:15 pm on 5 November 2019 within cell 1/55, Lamont Hall, at Her Majesty's Prison, Shotts.

(2) In terms of section 26(2)(a) of the 2016 Act (where and when any accident resulting in the death occurred):

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

(3) In terms of section 26(2)(c) of the 2016 Act (the cause or causes of death):

Mr Connor's death was the result of suicide caused by hanging.

(4) In terms of section 26(2)(d) of the 2016 Act (the cause of any accident resulting in the death):

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

(5) In terms of section 26(2)(e) of the 2016 Act (the taking of precautions):

There are no precautions which could reasonably have been taken and which, had they been taken, might realistically have resulted in Mr Connor's death being avoided.

(6) In terms of section 26(2)(f) of the 2016 Act (defects in any system of working):

There were no defects in the system of working within HMP Shotts which contributed to Mr Connor's death.

(7) In terms of section 26(2)(g) of the 2016 Act (any other facts relevant to the circumstances of the death):

There are no other facts relevant to the circumstances of Mr Connor's death.

Recommendations

The sheriff, having considered the evidence presented at the inquiry, makes no recommendations in terms of section 26(1)(b) of the 2016 Act.

NOTE

Representation

Procurator Fiscal: Guy, Procurator Fiscal Depute

NHS Lanarkshire: MacQueen, Counsel; Shippin, Solicitor, NHS Scotland

Scottish Prison Service ("SPS"): Philips, Solicitor, Anderson Strathern

Prison Officers' Association: Wallace, Solicitor; Rodgers, Solicitor, Thompsons

Introduction

[1] This is an inquiry into the death of Mr Brian Connor who died on 5 November 2019 within his cell at HM Prison Shotts. At the time of his death Mr Connor was 44 years old. As Mr Connor 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. The inquiry was conducted by remote link with participants' representatives appearing by video

conference using the WebEx platform. The inquiry was heard over five days between 2 March 2022 and 14 October 2022.

[2] A substantial body of evidence was agreed and affidavits from the following witnesses were admitted in evidence: (i) Elizabeth Holmes, Addiction Charge Nurse, Lanarkshire Health Board; (ii) Cheryl McMullen, Nurse, NHS Lanarkshire; (iii) Scott Cringles, Acting Head of Operations, HMP Shotts; (iv) Allister Purdie, Governor, HMP Shotts in 2019; (v) Elizabeth McNamee, Solicitor, Head of Legal Services, SPS; (vi) Greig Knox, Acting Head of Risk, SPS; (vii) Simon Scott, Prison Officer, HMP Shotts; (viii) Gregg Pearson, Head of Professional and Technical Services, SPS; (ix) Lindsay Baillie, SPS; and (x) David Wood, Mental Health Nurse, NHS Lanarkshire.

[3] The inquiry also heard parole evidence from four witnesses: (i) Dr Leah Jones, Consultant Forensic Psychiatrist, NHS Lanarkshire; (ii) Daniel Walker, Security Manager, HMP Shotts; (iii) Dr Ian Maidment, Pharmacist; and (iv) Dr Duncan Alcock, Consultant Forensic Psychiatrist, The State Hospital. The evidence of those four witnesses was concerned, primarily, with the question of what, if anything, should be drawn from the fact that Mr Connor had taken non-prescribed medication prior to his death.

[4] The circumstances surrounding Mr Connor's death were not in dispute and the evidence before the inquiry was not contentious. I found those witnesses from whom I heard to be both credible and reliable. That being so, I do not record here all that was

said in evidence. Instead, I provide, from paragraph 5 onwards, a summary of the relevant circumstances as disclosed by the evidence.

Mr Connor's circumstances

[5] At the time of his death Mr Connor was serving a life prison sentence in respect of a conviction in England for murder. The sentence comprised a custodial term (or "tariff") of 14 years and 7 months. In October 2018, Mr Connor was convicted of having an offensive weapon in prison and was sentenced to a further nine months imprisonment which was to run consecutively to his sentence for murder. Mr Connor's sentence was served in various prisons in England and Scotland until his final transfer to HMP Shotts in September 2011. Mr Connor had sought that transfer in order to be closer to his family.

[6] On 21 February 2019 the parole board deemed Mr Connor to be unsuitable for release due to his high risk of future violent offending. His next date for review by the parole board would have been September 2020.

[7] Mr Connor had a long-standing history of mental ill-health which included diagnoses of: a personality disorder, drug induced psychosis and paranoid schizophrenia. Mr Connor's ill-health continued to manifest itself throughout his time in prison and, on several occasions, resulted in disclosures of low mood, instances of erratic behaviour, instances of self-harm and multiple attempts at suicide.

[8] During his imprisonment in both England and Scotland, Mr Connor received substantial and regular intervention by medical professionals. Prior to his death he

received fortnightly support from the prison based addictions team and had daily contact with nursing staff who dispensed Methadone. He also saw the prison general practitioner. In addition, his care was overseen by a psychiatrist. In this connection, the inquiry heard evidence from Dr Leah Jones, a consultant forensic psychiatrist who saw Mr Connor as part of a series of routine psychiatry appointments. Dr Jones was familiar with Mr Connor's psychiatric history. She explained that Mr Connor's schizophrenia had fluctuated over the years but had been stable since his move to HMP Shotts. Nonetheless, Mr Connor was not fully well. He continued to have some residual symptoms of what was described as low grade paranoia. He would hear and see things that others did not, and would interpret those things, leading to an increase in his paranoia. However, Dr Jones considered that, prior to his death, his symptoms were managed well by medication.

[9] As has been noted, Mr Connor had a history of harming himself while in prison and during the period between April 2019 and July 2019 he was found to have cut his own wrists on at least five occasions. On various occasions, Mr Connor was monitored in terms of the SPS suicide prevention strategy known as "Talk to me". Talk to me is a multiagency suicide prevention strategy which aims to identify, and provide support for, people in prison who are at risk of self-harm or suicide. All people working within Scottish prisons who have unescorted contact with prisoners are trained in the Talk to me strategy and are responsible for implementing the strategy if a person is considered to be a risk. Where a risk of self-harm or suicide is identified, an appropriate care plan is implemented with a view to managing the identified risk. Measures taken include

agreeing a minimum level of contact with the person at risk and, in appropriate cases, placing the person in a "safer cell" which has been designed to eliminate ligature points or items which might be used as a ligature. As a result of his mental health, Mr Connor was frequently subject to such measures and all of the evidence before the inquiry suggested that staff within HMP Shotts were well aware of Mr Connor's history of self-harm, and were familiar with the strategies and measures which required to be implemented at times when he was at risk of such behaviour.

The period leading to Mr Connor's death

[10] In the period prior to his death Mr Connor was believed to have been experiencing a period of relative stability. There were no recorded instances of self-harm by Mr Connor in the three and half months prior to his death and, at the time of his death, he was not regarded as being at risk of self-harm or suicide. Against that background, he was not subject to special anti-suicide measures in terms of the Talk to me strategy and he was accommodated in a standard cell. The inquiry considered whether those who interacted with Mr Connor prior to his death could have identified that his risk of suicide had increased. To that end, the inquiry considered the evidence of a number of witnesses who engaged with Mr Connor over the weeks and months prior to his death.

[11] The inquiry received evidence from Ms Holmes, an addiction charge nurse, employed by Lanarkshire Health Board. Ms Holmes saw Mr Connor at his appointments with the addiction service. She described Mr Connor as having engaged

positively with his treatment from the service. He received both psychosocial and medical support for his opiate addiction and he had managed to attain periods of stability with little or no illicit opiate use. The psychosocial support provided to Mr Connor was focused on motivation for change, relapse prevention and management, harm reduction, poly drug misuse, personal recovery goals and self-management strategies. According to Ms Holmes, Mr Connor engaged well and had a good insight to his drug issues. Mr Connor had his last session with Ms Holmes on 25 September 2019, around six weeks prior to his death. At that time Ms Holmes had no concerns about Mr Connor.

[12] Dr Jones was also able to give evidence about Mr Connor's presentation in the period prior to his death. Her last appointment with him was on 17 October 2019, around three weeks prior to his death. She noted that, at that time, Mr Connor presented as "much younger and more well kempt" than he had been during her previous appointment with him. She also noted that

> "There was no evidence of any significant mood disturbance. He did not report any suicidal thoughts and it is noted that his acts of self-harm have reduced over the past month."

Dr Jones found no indication that Mr Connor was suffering from depression or that he had had suicidal thoughts during the period over which she was reviewing his mental health and she noted that no concerns had been documented by other healthcare staff in respect of his mental state or presentation in the period prior to his death.

[13] The inquiry also considered affidavit evidence from Mr Wood, a mental health nurse within HMP Shotts. Mr Wood had worked with Mr Connor during 2012 to 2014

and again from 2017 until his death. He had consulted with Mr Connor on a regular basis. Mr Wood appeared to be very familiar with Mr Connor's mental health history and his treatment. Mr Wood explained that it had been necessary to implement the Talk to me strategy in respect of Mr Connor on a number of occasions, most commonly when he had cut himself. However, Mr Wood's evidence was that there were no concerns about Mr Connor's mental health during the period between his last incident of self-harm on 19 July 2019 and his death on 5 November 2019. Mr Connor was perceived to be stable during that period and was engaging positively with prison staff. Indeed Mr Wood recalled that, in his last consultation with Mr Connor, four days before his death, he had spoken positively about his wellbeing.

[14] Further insight into Mr Connor's presentation during this period was provided by an affidavit of Mr Scott, a residential officer within Lamont Hall at HMP Shotts at the time of Mr Connor's death. Mr Scott appeared to know Mr Connor well and saw him daily. Mr Scott was able to provide the fullest account of Mr Connor's circumstances in the period leading to his death.

[15] Mr Scott knew about Mr Connor's mental ill-health and knew that he had self-harmed over a long period of time. According to Mr Scott, Mr Connor did not discuss his mental health with staff but, from his own observations, Mr Scott thought that Mr Connor appeared to be in a better place in the period prior to his death. Mr Scott noted that, shortly before his death, Mr Connor had requested a drug test for the purposes of progression within the prison.

[16] Indeed, since Mr Connor had been removed from Talk to me in July 2019, he appeared to have turned a corner. He had been given a job within the prison which meant he was out of his cell carrying out duties during the day. Mr Scott understood that Mr Connor had been given this job to help him with his mental health by bringing him out of his cell and providing him a greater opportunity to interact with staff and prisoners. He appeared to be coming out of his shell and would interact more with staff, at times having a laugh and a joke with them. During the period prior to Mr Connor's death, Mr Scott saw no evidence of self-harming behaviour or violence.

The day of Mr Connor's death

[17] On the day of Mr Connor's death he was last known to have been seen by George Gourlay, a fellow prisoner. At around 12:38pm Mr Gourlay delivered a meal to Mr Connor in his cell. Mr Gourlay remained in Mr Connor's cell for approximately 20 seconds and noted nothing of concern in respect of his presentation at the time.

[18] At around 2:35pm, Mr Scott was clearing the north section of Lamont Hall when he noted that Mr Connor did not appear to be within his cell. This was not uncommon as Mr Connor was employed as a hall "pass man" and was known to carry out his cleaning duties at that time. Mr Scott completed clearing the section and, having not seen Mr Connor and having found that no one knew of his whereabouts, he decided to gain entry to his cell.

[19] When Mr Scott entered the cell the lights were off and he noticed that the bathroom door was slightly open. He saw a knot on the cell side of the toilet door.

Mr Scott pushed the toilet door and discovered Mr Connor hanging from the toilet door. Mr Connor had used his belt as a ligature around his neck, with the buckle around his neck. The belt had been threaded through a gap in the hinge which created a space between the door and the door frame. A knot had been tied on the cell side of the door to secure the belt in place. Mr Scott described that the hinge was sitting slightly squint, which he thought was either from the force of the belt being pushed through or from the weight of Mr Connor. Mr Scott said that he immediately lifted Mr Connor and unhooked the belt from the hinge. Mr Connor was lifeless. Mr Scott raised the alarm and additional staff attended to assist.

[20] Prisoner Officer Steven Hardie attended and both officers removed Mr Connor from the toilet to the main cell area where he could be laid flat. No sign of life was observed. A prison nurse, Michelle Darragh, attended immediately and could find no sign of life. Paramedics attended thereafter and paramedic Stephen Wemyss pronounced Mr Connor's death at 3:15pm.

[21] Mr Scott recalled a conversation he had had with Mr Gourley after Mr Connor's death. Mr Gourley had said that he couldn't believe what had happened because, when he had taken Mr Connor his lunch, they had been talking about a football coupon that Mr Connor had put on. The suggestion was that there was no sign that Mr Connor was on the point of suicide.

[22] Mr Scott confirmed that in the period prior to his death, there was nothing in Mr Connor's presentation which gave him cause for concern, rather he appeared to be presenting much better than he had done previously.

The cause of death

[23] A *post mortem* examination was undertaken by Dr Gillian Wilson, Consultant Forensic Pathologist, on 14 November 2019. Dr Wilson found that Mr Connor had suffered injuries consistent death having been caused by hanging. Two samples of post mortem blood were analysed for the presence of alcohol, prescription drugs and illicit drugs. The following drugs were detected: (i) Methadone; (ii) Pregabalin; (iii) Mirtazapine; and (iv) Amitriptyline. All were found to be within their respective therapeutic ranges.

[24] At the time of his death, Mr Connor was prescribed 4ml of Methadone daily and 300mg of Pregabalin BD twice daily. Mr Connor was also prescribed Flupenthixol Decanote, an anti-psychotic medication which was administered by depot injection every two weeks. Mr Connor was not prescribed Mirtazapine or Amitriptyline.

The Scottish Prison Service review of Mr Connor's death

[25] Mr Purdie was the Governor at HMP Shotts in 2019 and the joint chair of the Death in Prison Learning, Audit & Review (DIPLAR) following Mr Connor's death. The review took place on 8 January 2020. Mr Purdie visited the hall in which Mr Connor was accommodated and spoke with his prisoner friendship group on the day after his death. He described them as having been absolutely shocked and surprised that Mr Connor had taken his own life at that time. Having considered the circumstances Mr Purdie's review found no departures from practice that required to be addressed and

identified no specific learning points from the circumstances surrounding Mr Connor's death.

Issues for the inquiry

[26] Against this background, the issues for the inquiry focussed on the following four questions: (i) Whether Mr Connor ought to have been subject to additional suicide prevention measures prior to his death; (ii) Whether Mr Connor's consumption of non-prescribed medication contributed to his death; (iii) Whether bullying contributed to Mr Connor's death; and (iv) Whether the design of the door hinge to which Mr Connor affixed his belt required to be changed. I shall address each of these questions in turn.

(i) Should Mr Connor have been subject to additional suicide prevention measures?

[27] At the time of his death Mr Connor was not regarded as being at risk of suicide and was not subject to particular anti-suicide measures. In particular, he was not subject to an anti-suicide care plan in terms of the Talk to me strategy and was not accommodated in a "safer cell". In light of Mr Connor's long standing history of self-harm, it might be tempting to think that he ought to have been regarded as being at risk of suicide prior to his death. But while Mr Connor's history of poor mental health undoubtedly meant that his risk of self-harm had to be kept under careful review, it was equally important that that the measures taken in that regard were proportionate to his circumstances at the time and not unduly restrictive. Many anti-suicide measures, such

as those found in "safer cells", necessarily involve imposing limitations on the freedom and privacy otherwise enjoyed by prisoners; they are not intended to be a long term option. Those working within prisons require to strike a delicate balance between taking appropriate measures to prevent suicide, and avoiding unnecessary restrictions which might, ultimately, cause more harm than good. The consensus of opinion amongst the healthcare professionals from whom the inquiry heard was that, prior to his death, Mr Connor's mental health was relatively settled. They saw nothing to indicate that he was at risk of further self-harm. The opinion of the medical professionals was corroborated by the view of those who saw Mr Connor in the prison hall. All who provided evidence were consistent in their view that there was nothing in Mr Connor's behaviour, at the time, to suggest that his mental health had declined or that he was at risk of suicide. Indeed, the impression gained by those around Mr Connor was that he appeared more settled and positive than he had been before. Even viewing the matter with the benefit of hindsight, the evidence disclosed no circumstance which, had it been viewed differently, might have led to the conclusion that Mr Connor was at risk of imminent self-harm.

[28] All of the evidence before the inquiry disclosed good reasons for which it was reasonable for those around Mr Connor to believe that he was not at risk of self-harm or suicide in the period prior to his death. While it is now clear that Mr Connor's mental health must have been precariously balanced at that time, the evidence suggests that there was nothing in his demeanour, or in his behaviour, or in what he said, which could have alerted those around him to a decline in his mental health at the point prior

to his death. Indeed the opposite was true and, as such, I am satisfied that Mr Connor's suicide was not foreseeable.

[29] Against that background, there was no objective basis on which to have concluded that Mr Connor should have been subject to additional measures in terms of the Talk to me strategy, or otherwise. There were already considerable measures in place and those measures, which included the support Mr Connor received from prison based nursing staff and an experienced psychiatrist, reflected Mr Connor's particular mental health needs and were appropriate in the circumstances presenting at the time.

(ii) Did Mr Connor's consumption of non-prescribed medication contribute to his death?

[30] The inquiry considered whether Mr Connor's consumption of Mirtazapine and Amitriptyline might have contributed to his death. Evidence about the effects of both drugs was provided by Doctors Jones, Alcock and Maidment. While each of these witnesses had different areas of expertise, they were in broad agreement in their evidence about the likely effect these drugs would have had on Mr Connor. Overall, the consensus of opinion was that the presence of Mirtazapine and Amitriptyline was not a cause for serious concern, and none of the witnesses believed that the ingestion of either drug was a factor which was likely to have contributed to Mr Connor's death.

[31] That is not to say that Mr Connor's use of these drugs did not cause some concern. Obviously, the use of non-prescribed medication presents certain risks, and so the inquiry heard evidence about the circumstances in which Mirtazapine and

Amitriptyline are prescribed, and their known effect. Dr Jones explained that both Mirtazapine and Amitriptyline are licensed for the treatment of depression and have a sedative effect. Amitriptyline can also be prescribed as an analgesic, and is prescribed by general practitioners for that purpose, albeit at lower doses. Both drugs are widely prescribed in the prison population.

[32] The evidence made plain that Amitriptyline presents a particular risk of harm when taken in overdose. For that reason, Dr Jones was not inclined to use it as an anti-depressant. Doctor Maidment also pointed to the risk of harm from Amitriptyline when taken in overdose and he explained that it would generally be used with caution in a patient with an identified risk of suicide. The concern was that the patient might take the medication in overdose. However, the toxicology results disclosed that, on death, the levels of both Mirtazapine and Amitriptyline in Mr Connor's blood were found to be within therapeutic levels. Accordingly, whilst neither drug had been prescribed to Mr Connor, there was no evidence to suggest that he had consumed either in overdose, or that their consumption had contributed directly to his death.

[33] The inquiry also considered whether the consumption of Mirtazapine and Amitriptyline was likely to have affected Mr Connor's mood and, thereby, contributed to his suicide. As a starting point, all of the witnesses observed that an increase in self-harm or suicidal tendencies is known to be a potential side-effect of most, if not all, anti-depressants. And within the British National Formulary, which lists the possible side effects of medication, suicidal behaviours are listed as possible side effects of an 'unknown frequency' of both Mirtazapine and Amitriptyline. However, the consensus

of medical opinion was that it is simply not possible to determine the effect the consumption of Mirtazapine and Amitriptyline would have had on Mr Connor. It was only known that, at the time of his death, both drugs were found to be within therapeutic levels, but it was not known what dose Mr Connor had taken, nor at what frequency, nor over what period. Those were all variable factors which could have determined the effect of the medication on Mr Connor's mood. Most of all, however, it was difficult, if not impossible, to separate out the extent to which Mr Connor's death was caused by his pre-existing mental health conditions, and the extent to which the consumption of anti-depressants was an additional, or contributing, factor.

[34] Dr Jones noted from Mr Connor's records that he had previously been prescribed both Mirtazapine and Amitriptyline notwithstanding his pre-existing mental health diagnoses. Amitriptyline had been prescribed as an analgesic, not at as anti-depressant. Those prescriptions did not give her cause for concern from a psychiatric perspective, and she explained that she would not have been concerned had she learned that Mirtazapine and Amitriptyline had been prescribed to Mr Connor in the period prior to his death. In the circumstances, Dr Jones was unable to find any basis on which to conclude that there was a link between Mr Connor's consumption of non-prescribed anti-depressants and his death.

[35] Dr Maidment considered that the medication prescribed to Mr Connor was typical of that prescribed to patients with a personality disorder such as Mr Connor's. He explained that the most likely effect of the additional consumption of Mirtazapine and Amitriptyline would have been to increase the overall sedative effect of

Mr Connor's medication but he found no basis on which to conclude that that would have contributed to a decline in his mental health prior to his death. In common with Dr Jones, Dr Maidment did observe that an increased risk of suicide was a possible side effect of taking Mirtazapine and Amitriptyline, as was the case with all anti-depressants. But his evidence was that the risk was thought to be very small and he observed that research which had attempted to examine the link between those drugs and suicide were of limited assistance in seeking to draw conclusions in Mr Connor's case. Overall, Dr Maidment concluded that, while it was impossible to eliminate Mr Connor's consumption of anti-depressants as a factor which contributed to his death, any attempt to draw a conclusion about the relationship between the non-prescribed medication and Mr Connor's death would be speculative in view of the number of unknown factors such as the dose, frequency and timing at which the medication was taken.

[36] Dr Alcock's evidence was consistent with that given by Doctors Jones and Maidment. The evidence provided no basis on which he could assert a link between Mr Connor's use of Mirtazapine and Amitriptyline and his death. And, having considered all of Mr Connor's circumstances, he did not believe that the presence of either drug had put Mr Connor at a higher risk of suicide. Dr Alcock pointed, in particular, to the benefit of such medication in saving lives by reducing self-harm which, in his experience, tended to outweigh the potential side-effects.

[37] Having considered all of the evidence in this connection, I have concluded that there is no basis on which to find that Mr Connor's consumption of Mirtazapine and Amitriptyline contributed to his death. I am satisfied that Mr Connor did not die as a

direct result of the ingestion of either drug. Thereafter, there is simply insufficient information about the period over which Mr Connor took either mediation, or about the dose or frequency with which they were taken, to draw any clear conclusions about their likely effect on his mood. Such evidence as is available suggests that, at least at the time of his death, the levels of Mirtazapine and Amitriptyline in Mr Connor's body were not unduly high and were not, in themselves, a cause for concern. More generally, however, the evidence discloses that Mr Connor had significant long-standing mental health conditions which were plainly the main factors contributing to his suicide. That being so, it is unsurprising that it is impossible to determine with any degree of confidence the extent to which, if any, individual drugs affected his mood in the period prior to his death. On the evidence, I am not satisfied on the balance of probabilities that Mr Connor's consumption of Mirtazapine and Amitriptyline contributed to his death.

[38] Nonetheless, the fact that Mr Connor was able to access non-prescribed medication is obviously a matter of some concern. In this connection, the inquiry heard evidence about the measures taken within HMP Shotts to tackle the trade between prisoners in prescription medication.

[39] It was said to be known that both Amitriptyline and Mirtazapine are commonly misused within prisons for their sedative effect. Both are in high demand and are traded between prisoners. Dr Jones explained that measures are taken to minimise the risk of prisoners taking non-prescribed medication. Certain medication, such as Methadone and Valium, is only dispensed on a supervised basis meaning that the prisoner is required to take the medication in the presence of a nurse; prisoners are

not allowed to keep their own supply. However, as might be expected, it was said in evidence that the volume of medication prescribed in prison meant that it was simply not possible to monitor the consumption of all prescribed medication. And quite apart from resourcing constraints, such an approach would be unworkable because prisoners require to take medication when it is needed rather than when its consumption can be supervised. That being so, medical staff require to make a judgement about the manner in which medication is prescribed, and the quantity prescribed. Those judgements are made having regard to the patient's whole circumstances and the nature of the medication in question. Most commonly, patients receive a weekly prescription. Prisoners have a medication safe in their cells and they are trusted to store their medication appropriately and to consume it as prescribed.

[40] The inquiry received affidavit evidence from Mr Scott Cringles, the Acting Head of Operations at HMP Shotts. Mr Cringles' primary role is in relation to security, which includes keeping prisons drug free. Mr Cringles explained that, while the manner in which medication is dispensed is a matter for the prison based medics, a number of steps are taken by prison staff to monitor the circulation of prescribed medication within the prison. During 2019, those measures included weekly "spot checks" undertaken in each hall and carried out jointly by NHS and prison staff with violations resulting in punishment, where appropriate, and a review by doctors of the prisoner's medication.

[41] While it was obviously a matter of concern that Mr Connor was able to obtain, and consume, non-prescribed medication, there was no evidence before the inquiry to disclose the identity of the person or persons to whom the medication was prescribed.

There was, therefore, no basis on which to reach any conclusion about the circumstances in which Amitriptyline and Mirtazapine came into his possession. It was clear from the evidence that the dispensation of medication within a prison entails an inevitable degree of risk of abuse by prisoners. Nonetheless, I am satisfied that in the period prior to Mr Connor's death, reasonable precautions were in place within HMP Shotts to ensure that those risks were properly assessed and, as far as practicable, managed. In reaching that conclusion I have kept in mind that the non-prescribed medication which Mr Connor was able to obtain and consume has not been found to have contributed to his death. I am also satisfied that stringent measures were in place to ensure that the most hazardous medication did not enter into general circulation. With these considerations in mind I find no defect in the system of working within HMP Shotts, relative to the dispensing and control of medication, which contributed to Mr Connor's death.

(iii) Did bullying contribute to Mr Connor's death?

[42] There was some limited evidence before the inquiry to suggest that Mr Connor may have experienced bullying during his time in prison. Two entries on the SPS system recorded information suggesting that Mr Connor had been bullied. One of those entries was recorded in August 2017, when Mr Connor was accommodated at a different prison. The second entry was dated June 2019, some four to five months prior to his death.

[43] In this connection the inquiry had the benefit of an affidavit from Mr Daniel Walker, a security manager at HMP Shotts. Mr Walker explained how the SPS handles intelligence information concerning prisoners. When information is provided to a prison officer, the officer should complete an intelligence report and submit it to the intelligence management unit. All such reports are then graded according to: whether the information was known directly to the source or was provided to the source by a third party; whether the information is corroborated; and the known reliability of the source. Mr Walker explained that the report of bullying received in June 2019 suggested that Mr Connor had been bullied in his prison hall for his medication and that he was self-harming. The information was not known personally to the source, and it could not be corroborated in any way. The source was untested meaning that the reliability of the information could not be judged. Mr Walker explained that the practice was for such information to be recorded on individual prisoner records on the SPS system. That made the information available to hall managers but not all prison officers. Such information is not more widely available because it is considered necessary to maintain the confidentiality of those reporting such matters as well as the subjects of such intelligence. I understood from Mr Walker's evidence that, while such information would be available to residential managers on the prisoner's record, the manager would not necessarily be advised that the information had been added. The manager would only know about the information if they saw it on the system.

[44] However, on receipt of such information, it is the practice of the intelligence management to assess the information and to decide what, if any, action requires to be taken. If action did require to be taken, the intelligence management unit would contact the local residential manager to discuss the matter. Mr Walker explained that the intelligence management unit does not record action taken in respect of individual reports and that, as such, it is not known whether any action was taken on receipt of the report of June 2019, but it was thought to be unlikely that action was taken in view of the practice adopted in respect of such entries. In practice, the intelligence management unit would tend not to take action on receipt of a single allegation of bullying, at least where the information was uncorroborated and came from an untested source. Instead, the unit would await receipt of a second, corroborative, intelligence report before raising the matter with the residential hall manager. From the evidence I understood that the position would have been different if the information had been more highly graded. For example, if the information had been from a reliable source who had seen bullying first-hand, then that would have resulted in a report to the residential hall manager.

[45] The procurator fiscal submitted that intelligence in relation to bullying, irrespective of its grading, should routinely be communicated to those with responsibility for the prisoner concerned. I agree with that general proposition but, having considered the evidence, I make no finding or recommendation in that respect. The most recent information about bullying dates from June 2019, a period some five months prior to Mr Connor's death. There was no evidence to suggest that any bullying, if it occurred, was continuing at the time of Mr Connor's death and there were

no subsequent reports of a similar nature. The information about the allegation was minimal and uncorroborated, and was provided by a source who did not know of the matter personally. The source was regarded by the SPS as "untested" meaning that there was, and remains, no basis on which to assess its reliability. Moreover, the remainder of the evidence suggested that Mr Connor was doing well in the period prior to his death and none of the witnesses who provided evidence described any reports or behaviours by Mr Connor which might have suggested that he was experiencing bullying. Against that background there is no basis on which the allegation of bullying can be tested and I am thus unable to make any finding that bullying was a factor which contributed to, or was relevant to, the circumstances of Mr Connor's death.

[46] Before moving on, however, I would observe that I was surprised to hear that a single allegation of bullying would not, as general rule, result in an alert to the alleged victim's residential hall manager. It is widely understood that prisoners are particularly vulnerable to the effects of bullying because of: (i) their isolation from family and friends; (ii) the limitation on their ability - by reason of their imprisonment - to avoid the source of any bullying; and (iii) the increased likelihood that they will be experiencing other mental health problems. Against that background, it seems reasonable to expect that even a single allegation of bullying will be brought to the attention of those with responsibility for the alleged victim, thereby allowing those with greater knowledge of the prisoner's immediate, and developing, circumstances to make a more informed judgement about the requirement, or otherwise, of taking any action. In this connection, it should be borne in mind that an untested or uncorroborated source

of intelligence may, nonetheless, be reporting accurate information. Such reports may, of course, be insufficient to take action against the alleged perpetrator but they need not prevent, or delay, action being taken to safeguard the interests of the alleged victim. This question was raised with Mr Walker who concluded that there was no compelling reason for which such reports could not be communicated to residential hall managers for consideration of such further action as was necessary. He did not believe that such a practice would be unworkable or unduly burdensome.

[47] Having found no connection between the allegations of bullying recorded in this case, or the handling of that information, and Mr Connor's death, I make no findings or recommendations in this regard but I record these observations to allow the Scottish Prison Service to consider whether any change should be made to this area of practice.

(iii) Should a different door hinge be specified for use within prison cells?

[48] The final matter considered by the inquiry related to the door hinge on which Mr Connor was able to secure a ligature. The inquiry was provided with information about the causes of suicide across the Scottish Prison Service over the course of the last 12 years. During that period there were 103 self-inflicted deaths in custody, the vast majority of which (93) were deaths by hanging. Around one third of those deaths by hanging (32) involved a ligature attached to a toilet cubicle door. The evidence provided did not disclose whether any of those 32 deaths had involved a ligature being inserted into a gap in a piano hinge as Mr Connor was able to do. Nonetheless, the data provided makes clear that a substantial proportion of people who have committed

suicide in prison over the last decade have done so by attaching a ligature to a toilet cubicle door. Against that background, the inquiry considered whether the design of the door hinge was a factor which contributed to Mr Connor's death and, specifically, whether any change should be recommended in that regard.

[49] The inquiry was provided with four affidavits by Mr Gregg Pearson who is the Head of Professional and Technical Services at the SPS. Mr Pearson is a qualified architect and he oversees design standards across the Scottish prison estate. Mr Pearson examined the hinge on the toilet cubicle door in Mr Connor's cell. The hinge in question is known as a piano hinge which is a single hinge intended to span the full length of the door edge. Piano hinges are used on prison cell doors because they leave few gaps between the door and door frame thereby reducing the number of potential ligature points. Mr Pearson confirmed that these hinges are in use on all toilet cubicle doors within cells in the modern prison estate, which includes HMP Shotts.

[50] The hinge within Mr Connor's cell was in good order with no sign of defect or damage. Mr Pearson did observe, however, that the construction of the hinge was such that small gaps, of around 3 or 4 millimetres, exist between interlinked sections that form the hinge. The gaps are small and are not immediately apparent, being visible only when the hinge is viewed from certain angles. Mr Pearson considered that the hinge was not an obvious ligature point and I agree with that conclusion having viewed photographs of the hinge in question.

[51] Having considered all of the evidence in this connection, it is clear that the design of the door hinge installed within Mr Connor's cell provided a means by which

Mr Connor was able to attach a ligature to his cell toilet door. But it is equally clear that the ligature point created by the hinge was not obvious and would have required some investigation to find, and some effort to employ. I find that it was not reasonably foreseeable that a person would have been able to affix a ligature to the hinge in the manner achieved by Mr Connor. Indeed, the fact that Mr Connor succeeded in identifying the ligature point within the hinge, and attaching his belt in the manner he did, was indicative of his determination to take his own life.

[52] In the course of the inquiry, Mr Pearson investigated the availability of an alternative hinge constructed without gaps and confirmed that such hinges were available, but he explained that any alternative would require to be assessed for use within prisons. Considerations such as: robustness, potential use as a weapon, and health and safety standards all required to be assessed. In a subsequent affidavit, the position appeared to have moved on and Mr Pearson stated that he could find no direct alternative hinge which addressed the issue identified in this case, but it was unclear from his evidence why the potential alternative referred to in the earlier affidavit had been discounted. In particular, I was not given to understand that it had been ruled out following further assessment or testing. Nonetheless, it is clear that, as yet, no safer alternative hinge has been identified and approved for use within the Scottish prison estate. That being so, even with the benefit of hindsight, I am satisfied that, in the absence of a safe alternative having been identified, there was no precaution which could reasonably have been taken prior to Mr Connor's death which might realistically have resulted in his death being avoided.

[53] Finally, I have considered whether I should recommend the taking of any steps which might realistically prevent other deaths in similar circumstances in the future. In the absence of a safer hinge having been identified, I am unable to identify any further precautions, improvements or steps which might realistically prevent other deaths in similar circumstances. It may be that no better option exists. However, I do consider that the design of piano hinge currently specified for use across the SPS estate should be considered further by the SPS in light of the lessons learned from Mr Connor's death and the enquires made, thus far, by Mr Pearson. In particular, it would seem prudent for the potential alternative hinge identified by Mr Pearson in his affidavit of 28 February 2022 to be assessed for safe use within the prison estate if that has not already happened. In submissions it was stressed on behalf of the SPS that, even if a suitable alternative were identified and approved, replacing all of the piano hinges across the SPS estate would involve considerable cost and logistical challenge. That might be so, but that need not prevent alternatives being assessed and, if suitable, being introduced, at least, in the construction of new establishments or when undertaking refurbishment in existing establishments.

Conclusion

[54] Mr Connor's death was unforeseen and unavoidable. Despite a history of serious and enduring problems with his mental health, Mr Connor appeared to be enjoying a period of relative stability in the weeks and months prior to his death. During that period he continued to receive considerable support for his mental health

and, by all accounts, he was displaying a positive attitude and making progress. No one with whom Mr Connor engaged in the period leading to his death detected any sign that his mental health might be declining or that he was at risk of self-harm or suicide; his death appears to have been unexpected by all who saw him around that time. His death was obviously a source of shock to those who knew him within the prison. I am satisfied that, in the period prior to his death, Mr Connor was receiving appropriate, and indeed considerable, support from the both the Scottish Prison Service and NHS Lanarkshire. That being so, I have found no precautions which, had they been taken, might realistically have prevented Mr Connor's death and I have found no defect in any system of working which contributed to his death. I have no recommendations to make.

[55] I am grateful to all those who assisted the inquiry and I extend my condolences to Mr Connor's family and all those affected by his death.