SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2024] FAI 31

EDI-B36-24

DETERMINATION

BY

SHERIFF RODERICK FLINN

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

into the death of

WILLIAM LOTHIAN

EDINBURGH, 13 August 2024

Determination

The Sheriff, having considered all the evidence presented at the Inquiry and the submissions of parties, determines, 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):

William Lothian, born 23 October 1954, died between 16.30 hours on 13 May 2021 and 07.30 hours on 14 May 2021 in cell 2/39, Glenesk Wing, at His Majesty's Prison, Edinburgh (hereinafter "HMP Edinburgh"), and his life was pronounced extinct at 08.19 hours on 14 May 2021.

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

Mr Lothian'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):

The cause of Mr Lothian's death was:

I (a) Suspension by ligature.

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

Mr Lothian'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 that might realistically have resulted in Mr Lothian'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 in place within HMP Edinburgh which contributed to Mr Lothian's death.

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

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

8. In terms of section 26(4) of the 2016 Act (recommendations (if any) as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, or (d) the taking of any steps which might realistically prevent other deaths in similar circumstances):

I make the following recommendations in terms of section 26(4)(b) (the making of improvements to any system of working):-

(i) ***The reception process should be reviewed by SPS at the earliest convenient opportunity (and if possible within the scope of the current review of prevention of suicide policy) with a view to considering whether there should be an automatic referral to the Talk to Me process where a new prisoner is a first time offender, an offender convicted of a sexual offence (or other offences which carry an increased risk of suicide) and an individual with a history of one or more suicide attempts;***

(ii) ***The Reception Risk Assessment Form should be reviewed by SPS, at the earliest convenient opportunity (and if possible within the scope of the current review of prevention of suicide policy) with a view to considering whether the following should be added:***

(a) *a specific record of whether the new prisoner is a first time offender, an offender convicted of a sexual offence (or other offences which carry an increased risk of suicide) and/or an individual with a history of one or more suicide attempts;*

(b) *a note for the guidance of SPS staff within the form that these factors, taken together, may indicate a higher risk of suicide than the norm;*

(c) *provision for the recording of factors relating to the specific consideration of risk in respect of gender, age, evidence of chronic and disabling physical illness, evidence of drug or alcohol misuse, evidence of social isolation, evidence of assessment of the prisoner's mental state, evidence of hopelessness, worthlessness, and feelings of guilt and/or unworthiness;*

(d) *a requirement for SPS staff to document the actions taken by staff following identification of such risk factors, or the rationale for not taking any action*.

(iii) *The reception process should be reviewed by SPS and Lothian Health Board at the earliest convenient opportunity (and if possible within the scope of the current review of prevention of suicide policy) with a view to considering whether it is feasible to establish a system for automatic referral to the prion's Mental Health Team, based on an established set of criteria.*

NOTE

Introduction

[1] This is a Fatal Accident Inquiry into the death of Mr William Lothian, who died between 13 and 14 May 2021, within his cell at HMP, Edinburgh. At the time of his death he was 66 years old. As Mr Lothian 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 legal framework

[2] This Inquiry is held under section 1 of the 2016 Act. In terms of section 1(3) of the Act, the purpose of an Inquiry is to establish the circumstances of death and consider what steps, if any, might be taken to prevent other deaths in similar circumstances. The Inquiry is an inquisitorial process. In terms of section 1(4) of the Act, it is not the purpose of this Inquiry to establish civil or criminal liability.

Background

[3] Preliminary hearings in this matter were held on 26 February, 2 April, and 2 May 2024. The Inquiry was held on 21 and 22 May 2024, in person, at Edinburgh Sheriff Court.

[4] At the Inquiry Mr Gregor, Procurator Fiscal Depute, represented the Crown. The Scottish Ministers, for the Scottish Prison Service, were represented by Ms McDonald,

Solicitor. Lothian Health Board were represented by Mr Holmes, Solicitor. The Prison Officers' Association of Scotland were represented by Ms McIlwhan, Solicitor.

[5] Although Mr Lothian's family were not formal participants at the Inquiry, members of his family attended Edinburgh Sheriff Court to observe the Inquiry.

[6] The essential circumstances surrounding Mr Lothian's death were not in dispute. Much of the evidence before the Inquiry was not contentious. A great deal of the evidence was agreed in advance in a substantial Joint Minute of Agreement, running to 57 paragraphs. The facts set out in the Joint Minute of Agreement were of course agreed facts.

[7] Three witnesses gave parole evidence at the Inquiry. These were Prison Officer [SW], Senior Nurse [L McC] and Dr Alastair Palin, Consultant in Adult Psychiatry.

[8] Also before the Inquiry was the following information:

1. Crown Production 1: Intimation of Death form of William Lothian dated 24 May 2021.
2. Crown Production 2: Death Certificate of William Lothian dated 20 May 2021.
3. Crown Production 3: Final post-mortem report by Dr Ralph BouHaidar, Consultant Forensic Pathologist.
4. Crown Production 4: the Death in Custody Folder of documentation and records maintained by the Scottish Prison Service in relation to Mr Lothian.
5. Crown Productions 5, 6, and 7: the medical records of Mr Lothian.

6. Crown Production 8: a handwritten note authored by Mr Lothian found within his cell on 14 May 2021.
7. Crown Production 9: the SPS Talk to Me: Prevention of Suicide in Prison Strategy.
8. Crown Production 10: the Death in Prison Learning Audit Review (known as the DIPLAR) report carried out at HMP Edinburgh following Mr Lothian's death.
9. Crown Production 11: the Local Case Review Template carried out by Lothian Health Board following Mr Lothian's death.
10. Crown Production 12: an independent expert report authored by Dr Alastair Palin, Consultant Psychiatrist, dated 5 July 2023.
11. Crown Production 13: a statement given by Prison Officer [AO], dated 14 May 2021.
12. Crown Production 14: a statement given by Dr Ganesh Puri, dated 30 July 2021.
13. Crown Production 15: a statement given by Prison Officer [KG], dated 14 May 2021.
14. Crown Production 16: a statement given by Prison Chaplain Vasyl Kren, dated 30 September 2021.
15. Crown Production 17: a statement given by Prison Officer [ML], dated 14 May 2021.

16. Crown Production 18: a statement given by David Lothian, brother of the deceased, dated 25 August 2021.
17. Crown Production 19: a statement given by [E McA], Advanced Nurse Practitioner, dated 7 September 2022.
18. Crown Production 20: a statement given by [S McC], Residential Unit Manager dated 4 September 2023.
19. Crown Productions 21 and 22: statements given by Senior Nurse [L McC], dated 14 May 2021 and 22 September 2021, respectively.
20. Crown Production 23: a statement given by [GS], SPS Non-Executive Director dated 26 June 2023.
21. Crown Production 24: a statement given by [ST], SPS Policy Lead on Suicide Prevention, dated 6 June 2023.
22. Crown Production 25: a statement given by Paramedic Maya Walker, dated 31 October 2022.
23. Crown Production 26: a book of photographs taken from CCTV footage at HMP Edinburgh on 14 May 2021 (16 photographs).
24. Production 1 for the Scottish Ministers on behalf of the Scottish Prison Service: the Talk to Me, Prevention of Suicide in Prison Strategy, Guidance Part 1 2016, revised in 2021.
25. Production 2 for the Scottish Ministers on behalf of the Scottish Prison Service: the Talk to Me, Prevention of Suicide in Prison Strategy, Guidance Part 2 2016, Revised in 2021.

26. Production 3 for the Scottish Ministers on behalf of the Scottish Prison Service: the Reception Risk Assessment Form in respect of William Lothian dated 11 May 2021.

[9] The documentary productions listed in para [8] above were agreed in the Joint Minute of Agreement to be true and accurate copies of the originals, the contents of which were agreed.

[10] Whilst it is not necessary for me to make findings in fact in a fatal accident inquiry determination I consider it is helpful to do so in this determination. In this Note I will, firstly, set out the relevant facts that I have found proved. Secondly, I will set out a summary of the submissions made by the Crown and the other parties. Thirdly, I will consider the circumstances identified in section 26(2)(a) to (g) of the 2016 Act and explain, with reference to the evidence before the inquiry, my findings and my reasons for them. Finally, I will set out the recommendations that I consider to be appropriate.

Findings in fact

[11] I found the following facts admitted or proved. I deal with matters, for convenience, under headings A to G below.

A. Mr Lothian's trial and his suicide attempt during trial

1. Mr Lothian was charged on indictment with a number of sexual offences. His trial, at Edinburgh Sheriff Court, commenced on 23 March 2021.

Defence evidence was concluded on Friday 26 March 2021 and the adjourned until Monday 29 March 2021 for speeches to the jury to be heard.

2. In the morning of 29 March, David Lothian, the deceased's brother, attended at his house to collect him and take him to court. Mr Lothian disclosed that he had taken a quantity of pills, was feeling depressed and that things had got on top of him. An emergency ambulance was summoned and Mr Lothian was taken to the Emergency Department at Edinburgh Royal Infirmary.

3. Later during the day of 29 March, Mr Lothian was examined by Dr Ganesh Puri, within Edinburgh Royal Infirmary. Dr Puri noted the patient's history to be that the previous evening he had awoken around 0400 hours and made a concoction of alcoholic drinks and took up to 80 tablets of paracetamol, co-codamol and sleeping tablets with the intention of ending his own life.

4. Upon examination, Mr Lothian had a respiratory rate of 14, his oxygen saturation level was 97%, his blood pressure was 122/78, temperature was 36.5 degrees Celsius, his heart rate was measured at 55 beats per minute, and he was very unsteady on his feet.

5. A treatment plan was agreed to administer acetylcysteine in line with the protocol for a paracetamol overdose. Mr Lothian was transferred to the Acute Medical Unit for a period of observation and for mental health assessment.

6. On 30 March 2021, whilst in hospital, Mr Lothian was reviewed by Lorraine MacKinnon, a Registered Mental Health Nurse. Mr Lothian described the episode of self-harm as fairly impulsive. He had not made any plans or carried out any research and the tablets and alcohol were already in his house. He described no history of psychiatric conditions, no previous self-harm and denied ever seeing his GP in relation to his mental health. He reported poor sleep and no ongoing thoughts of self-harm.
7. Nurse MacKinnon noted that due to the gravity of the charges Mr Lothian was at risk of further self-harm or completed suicide. However, she noted no signs of mental illness and noted that he denied ongoing thoughts of self-harm or suicide. He felt safe to go home. He reported that his family was a protective factor against suicide. Nurse MacKinnon provided Mr Lothian with advice on steps to take if his feelings became worse, and crisis phone numbers, and discussed his case with the on-call consultant.
8. On 30 March 2021, Mr Lothian was deemed medically fit for discharge and he returned home.
9. On 31 March 2021 the trial resumed and concluded, resulting in the conviction of Mr Lothian. The case was adjourned until 11 May for sentence.
10. On 11 May 2021 Mr Lothian was sentenced to 45 months in custody, to run from that date.

B. Arrangements for the reception of prisoners into HMP Edinburgh

11. Arrangements were made to transfer Mr Lothian to HMP Edinburgh by GEOAmey, who provide escort services to and from prisons on behalf of the Scottish Prison Service.

12. GEOAmey, the escort provider, categorised Mr Lothian as a suicide risk upon transporting him from Edinburgh Sheriff Court to HMP Edinburgh and noted this on his Person Escort Record. On his Person Escort Record, under the box headed "Risk Additional Information" the escort provider noted "Previous suicidal – NGT".

    NGT is an acronym of "Not Got Thoughts", implying that the subject concerned had no current thoughts of suicide.

13. GEOAmey completed their own New Admissions Prisoner Risk Assessment signed by Mr Lothian. -This indicated he had also completed Suicide Form SCCPES 023 which was completed prior to transfer to HMP Edinburgh. On this suicide form, there was a note of self-harm carried out in March 2021 via overdose.

14. The Person Escort Record, New Admissions Prison Risk Assessment, and Suicide Form were handed from GEOAmey to SPS upon Mr Lothian's transfer to HMP Edinburgh as part of the admission process.

C. Mr Lothian's reception into HM Prison Edinburgh on 11 May 2021

15. Upon Mr Lothian's arrival at HMP Edinburgh, a Reception Risk Assessment was carried out on him by SPS and NHS staff.

16. This is standard procedure in HMP Edinburgh. All prisoners admitted into prison participate in an assessment of their risk of suicide, whether new admissions, returning prisoners or transfers from other prisons. Assessments are also carried out following any appearances in court, including video-link appearances and applications for parole. The reception staff at HMP Edinburgh can often process around 35 – 40 prisoners per day and it can be up to 60 or 70.

17. The Reception Risk Assessment for Mr Lothian was carried out by Prison Officer [SW]. Prison Officer [SW] was at that time an operations officer, and in particular a reception officer. Prison Officer [SW] was a member of a team of four prison officers who jointly conducted Reception Risk Assessments of prisoners. That included checking the information in the warrant for the prisoner's detention, the formalities of admission on the SPS computer system, searching and listing the prisoner's property and asking for specific information about potential risks involving the prisoner.

18. The reception officer's role in the process is includes completion of Parts 1 - 5 of the Reception Risk Assessment Form. The process generally takes around 15 – 20 minutes depending on the prisoner. A reception officer would check the Person Escort Record and PR2 (the prison computer system) for useful

information. A reception officer makes every effort to open a conversation and build rapport with a prisoner, as part of the exercise in assessing whether a prisoner is a risk to himself or others. This is often done by finding common ground, or a topic of interest, such as family or football.

19. In relation to Part 3 of the form the reception officer is looking for issues in relation to drugs and alcohol, and visible disabilities. In Part 4 he will ask specific questions about whether the prisoner has thoughts about self-harm. It is important to assess the response; it may flippant or based on bravado, or a prisoner may be reserved and avoiding eye contact. These are negative factors in assessing risk. Positive factors include an acknowledgment that there is life outside of prison, and familial support.

20. Part 5 of the Form noting the outcome is solely in relation to risk of suicide, with no attempt to quantify that risk, only to note it is present or absent. If there was such a risk the box marked "Initiate Talk to Me strategy" would be ticked. In every case the prisoner would be passed to a nurse for a Healthcare Risk Assessment.

21. The induction training is the same for all prison officers. Training is provided on the Talk To Me strategy during induction. There are yearly refreshers.

22. For first-time prisoners (that is to say, those who have received a first custodial sentence, or first remand) it is important to try to break down any barriers, to be "hyper vigilant" about any risks, and to address prisoners'

concerns or fears. It is essential to probe more with prisoners of this type. There is no distinction in the guidance for assessing first time prisoners.

23. In Mr Lothian's case, Prison Officer [SW] was able to get an "in" with him because he had a Rangers tattoo. That led to some laughing and joking, between him and another prison officer, also a Rangers fan. They talked about Rangers and football. Mr Lothian did not disclose any previous suicide attempt to him, and he had not noted it from the GeoAmey paperwork, nor did he note the sentence was longer than the prisoner expected, which was also noted on the GeoAmey paperwork.

24. Prison Officer [SW] noted in Part 4 of the Form "William expressed no thoughts of self harm or suicide" and "William made good eye contact throughout". He did not think there was anything abnormal about Mr Lothian's admission. He did not assess him as being at risk of self-harm or suicide. He ticked the box in Part 5 to that effect.

25. As part of the reception process, prison medical staff carry out a health check on the prisoner. That health check deals with the prisoner's physical and mental health. Part of the health check is to make an assessment of suicide risk or tendencies. Where a prisoner has previously been in a Scottish prison, it may be possible to access has prison health records during the reception process. Attempts to confirm with a prisoner's GP such matters as his current medication generally meet with very limited success. Some GP surgeries reply promptly, some belatedly, and some not at all.

26. Mr Lothian's health check was carried out by Acting Senior Charge Nurse [L McC]. That health check took place between approximately 2.00pm and 3.00pm in the afternoon of 11 May 2021.

27. As Mr Lothian was a new prisoner, and had been convicted of a sexual offence, Nurse [L McC] spoke to him for longer than usual. She specifically spoke to him about self-harm and suicide. Mr Lothian said that he had no thoughts of suicide. He said that while he had tried to self-harm after conviction, but before sentence, he would not now consider suicide because he had a good family support network. He seemed open and genuine about that. In assessing a prisoner's risk of suicide, Nurse [L McC] would consider not merely information about the prisoner, but body language, eye contact and general presentation. From her interaction with Mr Lothian, Nurse [L McC] did not have cause for concern that he was at risk of suicide.

28. The Reception Risk Assessment carried out by Prison Officer [SW] was thorough and person-centred. He achieved a rapport with Mr Lothian. On the information available to him, there was no reason to assess Mr Lothian as being at risk of suicide.

29. The health check carried out by Nurse [L McC] was thorough and person-centred. On the information available to her, there was no reason to assess Mr Lothian as being at risk of suicide.

30. If a prisoner is assessed as being at risk of self-harm or suicide, during the reception process, this will be recorded. As part of the Talk to Me strategy

he will be sent for assessment by the Mental Health Nursing Team, and there will be an early case conference and further case conferences for as long as the individual is at risk. He may be placed in a "Safer Cell" (a cell with restricted opportunities for committing suicide) if the risk of suicide justifies a safer environment.

D. Mr Lothian's time in HMP Edinburgh from 11 to 13 May 2021

31. Mr Lothian's time in prison from 11 to 13 May was, on the face of it, uneventful.

32. Upon admission into custody, Mr Lothian was placed in cell 34, Glenesk Hall Level 3, for a 48 hour period of isolation as a protection against Covid-19. He did not seek any healthcare support or come to the attention of healthcare services during this time.

33. On 13 May 2021 Mr Lothian was relocated, after his period of isolation, to cell 39, Glenesk Hall, Level 2. Prison Chaplain Vasyl Kren spoke with Mr Lothian to advise of HMP Edinburgh's chaplaincy services. This was a short interaction, lasting less than a minute but Mr Lothian made good eye contact and Father Kren had no concerns about Mr Lothian.

34. On the same date, at about 11.50 am after moving cells to cell 39, Mr Lothian spoke with Prison Officer [AO] requesting his telephone be activated. He appeared to be fine and was engaging with others. Thereafter, Prison Officer [AO] confirmed with Mr Lothian that he had made a request for the

telephone to be activated. Later that day Prison Officer [AO] saw Mr Lothian leave his cell to collect his dinner. He spoke with other prisoners and appeared to be fine. Prison Officer [AO] he had no concerns for Mr Lothian. That same day, at around 4.30pm, Mr Lothian asked how he went about cleaning his cell and Prison Officer [AO] advised that he would bring mop and cleaning materials the following morning. Prison Officer [AO] had no concerns for the deceased at this stage; he did not seem panicked or worried, and seemed to be planning how he would get through prison life.

35. During the evening lockdown Prison Officer [ML] also spoke briefly with Mr Lothian in his cell whilst eating his meal. He noted Mr Lothian as being polite. He seemed to be content. Prison Officer [ML] had no concerns. Around 15-20 minutes later Prison Officers [ML] and [KC] conducted the final head count, checking on Mr Lothian albeit neither spoke with him. Again nothing of concern was noted by them.

E. The events of 14 May 2021

36. On 14 May 2021, at 7.30am, Prison Officers [AO] and [KG] conducted the morning head count of prisoners on Glenesk Wing. When reaching Mr Lothian's cell, cell 39, they unlocked and opened the door and observed Mr Lothian slumped against the bottom bunk, fully clothed, with a noose

around his neck which was also tied around the railing of the top bunk bed. He appeared blue in colour.

37. Prison Officer [KG] radioed a "Code Blue" to summon assistance and medical staff. A "Code Blue" signifies an individual who is experiencing severe breathing difficulties and may or may not be unresponsive. It is an emergency call used in prisons to convey quick and specific information and to initiate a timely and effective response.

38. Nurses [L McC], [C McM], and [KS] responded to the code blue. When they arrived, they observed Mr Lothian hanging from the top bunk with a ligature around his neck made from polythene bin bags tied together. Mr Lothian was cut down from the ligature. He was observed to be stiff, with mottled skin, fixed pupils and a dark substance in his mouth. Nurse [L McC] was of the opinion Mr Lothian was deceased.

39. Scottish Ambulance Service paramedics Maya Walker and Calum Sutherland attended HMP Edinburgh at 8.01am and attended Mr Lothian's cell. Paramedic Walker confirmed through observations that Mr Lothian was deceased. He was cold to the touch, post-mortem staining was present, his pupils were fixed and dilated, and there were no heart or breathing sounds. Upon applying an ECG ("electrocardiogram") Mr Lothian was asystolic; that is to say, his heart was not pumping. At 8.19am, Paramedic Walker pronounced Mr Lothian's life extinct.

F. *Subsequent investigations into the circumstances of Mr Lothian's death*

40. A post-mortem examination was carried out by Dr Ralph BouHaidar, Consultant Forensic Pathologist, on 20 May 2021. There was a ligature mark around Mr Lothian's neck with features consistent with the ligature provided. No other injuries of note were identified on the body. The cause of Mr Lothian's death was recorded as "1(a) suspension by ligature". The medical certificate completed and signed by Dr BouHaidar on 20 May 2021, confirmed suspension by ligature as the cause of death.

41. There were two in-house reviews in the sense of reviews carried out within the Scottish Prison Service, or NHS Scotland, with contributions from SPS and NHS staff.

42. The first of these was the DIPLAR review; DIPLAR being an acronym for "Death in Prison, Learning, Audit and Review". The review was carried out on 3 August 2021 and the DIPLAR Report signed by the responsible officials on 17 and 27 October 2022. The review covered Mr Lothian's reception into prison, his presentation to the NHS duty nurse, and the circumstances surrounding his death. The conclusion was that:

> "All efforts were made to support Mr Lothian during his time in custody and there was no indication that he was considering taking his own life or harming himself".

43. The second of these reviews was an NHS Local Case Review. That review took place on 8 February 2022. The review noted that a wider review of circumstances surrounding Mr Lothian's death was needed but the DIPLAR

process should lead on this. There were discussions around the organisation of further training for staff, including triage, CPR ("cardiopulmonary resuscitation") and ILS ("immediate life support"). It was noted that nursing staff should not remove a ligature from a deceased patient's neck or place a pillow under, or cover over, the individual as that can interfere with the police investigation.

44. There was one external review, an Expert Report prepared by Dr Alastair Palin, M.B., Ch.B, F.R.C. Psych., on the instructions of the Custody Death Unit of the Crown Office and Procurator Fiscal Service. Dr Palin was instructed on 8 June 2023 and reported on 5 July 2023.

G. Other relevant reviews

45. The Scottish Prison Service is currently developing a new suicide prevention policy within the Scottish prison system. [ST], Policy Lead Suicide Prevention for SPS, is presently leading a review team tasked to develop that new policy. [ST] was appointed to that post given her previous experience working on a review of the SPS suicide prevention strategy between 2015 and 2017 and her extensive experience in coordinating DIPLARs.

Submissions by the parties represented at the Inquiry

[12] Submissions were made on behalf of the Crown, the Scottish Prison Service, Lothian Health Board, and the Prison Officers' Association for Scotland

Submission for the Crown

[13] The Crown addressed me on the approach taken by Prison Officer [SW] and Nurse [L McC] during Mr Lothian's reception into HMP Edinburgh. The Crown's submissions were read out in open court, in full, and need not be repeated in detail. The Crown noted that the standard process using the Reception Risk Assessment form was followed, and that Prison Officer [SW] approach was to open up a conversation with the prisoner, and to build a rapport. In particular, for first time prisoners, he considered it important to break down barriers and be "hyper-vigilant" in addressing first time prisoners' concerns or fears. It was significant that Part 5 of the form requires an assessment of the risk of suicide, with no attempt to quantify that risk, only to note whether it is present.

[14] Nurse [L McC] evidence was to the effect that the nurse's role was to gather information about a prisoner's physical health including any prescribed medications, and a mental health assessment, and that assessment should be based not merely on information about the prisoner, but on body language, eye contact and general presentation. She was aware that sex offenders were more tearful, and that with such prisoners there is a greater risk of social isolation from family and friends. She would probe carefully where a previous suicide attempt had been made. Because Mr Lothian was both a first time prisoner and a sex offender, she went into more depth than usual. He mentioned a supportive family.

[15] The Crown turned to Dr Palin's evidence, largely contained within his Expert Opinion Report but supplemented by oral evidence. Dr Palin was critical of the Reception Risk Assessment process. He felt that the assessment was too generic, and lacked focus on the individual. He considered that Mr Lothian had several prominent risk factors, for suicide, though he lacked others. He felt that the RRA form placed too much reliance on the individual's presentation on the day. In his practice, he would attempt to verify information from the individual via medical records or information from family members. He considered that being a first time prisoner and a sex offender were important risk factors to consider when doing an assessment.

[16] On the basis of the evidence, the Crown addressed me on the findings I should make in terms of sections 26(2)(e), 26(2)(f) and 26(2)(g), and on the recommendations I should make in terms of section 26(4).

[17] On section 26(2)(e), (the taking of precautions) the Crown's position was that Mr Lothian had a number of significant risk factors and it might have been reasonable in the circumstances to declare that he was at risk of suicide. However, the Crown accepted that it is very difficult to predict whether someone is likely to complete suicide or not; it is unpredictable by its nature. Thus while Mr Lothian could have been placed on the Talk to Me programme that may or may not have assisted him, and it was not possible to determine whether there was a real or likely possibility that the introduction of Talk to Me procedure would have prevented his death. In these circumstances, the Crown submitted that placing Mr Lothian on the Talk to Me programme was

reasonable, but it was not a precaution which might realistically have prevented his death.

[18] On section 26(2)(f) (defects in any system of working which contributed to the death) the Crown's position was that the relevant system of working, in the present case, was the completion of the RRA form. The Crown again founded on Dr Palin's criticism of the assessment process, which Dr Palin had held to be too generic, both in relation to general assessment of risk and specifically in relation to sex offenders. He considered that it relied too heavily on an individual's presentation at the time and did not confirm the need for consideration of potentially significant risk factors. It did not require the review of an individual's medical records. The Crown's position was that these criticisms taken together, amount to a defect in the operation of the Reception Risk Assessment process which contributed to (rather than caused) Mr Lothian's death. The Crown accepted that such a defect was currently being compensated for by the actions of diligent staff. The Crown's position was that the current system of working was too generic, that it failed to properly assess that Mr Lothian was at risk of suicide, not just in an immediate sense but on an ongoing basis, and that it therefore failed to place him on Talk to Me observations, in the short term, and to make attempts to manage his risk of suicide over a longer term. In effect, by not placing Mr Lothian on Talk to Me observations the risk of suicide, which in hindsight was evident, was not mitigated in any way.

[19] On section 26(2)(g) (any other facts which are relevant to the circumstances of the death) the Crown's position was clear cut. The Crown suggested that (1) the Reception

Risk Assessment paperwork made no specific accommodation for first time prisoners; (2) that the Reception Risk Assessment paperwork made no specific accommodation for offence specific risk factors, such as sexual offences, although sex offenders are at a higher risk of suicide, and (3) that the Reception Risk Assessment process does not mandate a review of a prisoner's medical records.

[20] On section 26(4) (recommendations) the Crown noted that if I were to make findings under section 26(2)(e), (f) or (g) I had the power to make recommendations under section 26(4) - and that I might do so, regardless of any such findings, in any event. It was suggested that I make a recommendation under section 26(4)(a) to the effect that the Scottish Prison Service should adopt a position that, by default, first time prisoners (ie those who have never before received a custodial sentence) *and* who have been convicted of a sexual offence should *automatically* be considered to be a high risk of suicide for the purpose of the reception risk assessment process. The Crown suggested that I should recommend under section 26(4)(b) that there should be improvements to the Reception Risk Assessment form in a number of ways. Firstly, the RRA form should include specific consideration of risk in relation to a range of matters such as gender, age, chronic and disabling physical illness, drug or alcohol misuse, social isolation, self-harm or suicide attempts and a range of other key factors; these should include the nature of the index offence as it applies to potential risk of suicide. Secondly, the RRA form should clearly list the relevant risk factors and document the actions taken by staff following identification of such risk factors. Conversely, the RRA form should also require documentation of the rationale for taking no such action after identification of

relevant risk factors. Thirdly, the RRA should rely less on the self-reporting or presentation of the individual being assessed, and information provided by the individual should be verified by other means as far as possible. Fourthly, the RRA should include a review of the prisoner's medical records, both existing prison healthcare records (if previously in custody) and medical records in the community. The Crown suggested that I should make the recommendations under section 26(4)(c) that the Scottish Prison Service and Lothian Health board should, for certain prisoners, introduce a system of automatic referral to the prison mental health team by default, allowing the mental health team to assess the full circumstances of the prisoner.

Submission for the Scottish Prison Service

[21] The submission for the Scottish Prison Service ("SPS") dealt with the evidence available to the enquiry, in the affidavits and orally, and suggested that Mr Lothian received appropriate care whilst in the custody of the SPS, and that no actions of any SPS staff could have prevented his death.

[22] The SPS position was that the reception arrangements for prisoners, within HMP Edinburgh, were thorough, and person-centric. There could be no criticism of the actions of Prison Officer [SW] and Nurse [L McC] in carrying out their assessments and finding that Mr Lothian was at "no apparent risk" of self-harm or suicide.

[23] The SPS submission was critical of Dr Palin's recommendations. His suggestions on how specific categories of prisoners should be assessed should be approached with caution. He had no experience of working in prisons and with prisoners. He had no

practical knowledge of the Talk to Me policy beyond the information shared with him by the Crown. His proposals did not take account of the holistic nature of the process described by Prison Officer [SW] and Nurse [L McC]. It suggested that there was no evidence before the court that the holistic approach of these individuals was not taken by all members of staff undertaking reception duties. Dr Palin was not able to comment on how the regime he proposed would work, given the large number of prisoners requiring to be assessed on a daily basis.

[24] The SPS position was that on the information available, it would not have been appropriate to institute the Talk to Me policy upon Mr Lothian's admission on 11 May 2021, and accordingly that there were no precautions that SPS staff could reasonably have taken that would have prevented his death, and no defects in the system of working within HMP Edinburgh which contributed to his death. Accordingly I was invited to make no findings in respect of sections 26(2)(e), (f) and (g).

Submission for Lothian Health Board

[25] In their submission Lothian Health Board took a similar position to that of the SPS. It was suggested that the evidence of Nurse [L McC] disclosed a thorough assessment, in line with the one proposed by Dr Palin, despite the generic nature of the risk assessment document itself. Accordingly, there was no evidence before the court of any precaution which might reasonably have been taken, and which would have had a realistic prospect of preventing Mr Lothian's death, and that no finding in terms of section 26(2)(e) was appropriate. Similarly, there was no evidence of any defect in a

system of working which caused or contributed to Mr Lothian's death and therefore it was not appropriate to make a finding in terms of section 26(2)(f). Any finding in relation to the terms of the risk assessment document should be made in terms of section 26(2)(g).

Submission for Prison Officers' Association Scotland

[26] The Prison Officers' Association Scotland made no submission in relation to the healthcare provision in HMP Edinburgh, or on wider prison policy issues, all of which, it suggested, were matters for other parties to the enquiry. The Association asked for formal findings only to be made.

My findings and my reasons for them

Section 26(2)(a) of the 2016 Act (when and where the death occurred)

[27] There is no dispute with regard to when and where the death occurred. Mr Lothian died between 16.30 hours on 13 May 2021 and 07.30 hours on 14 May 2021 in cell 2/39 Glenesk Wing, HMP Edinburgh, and his life was pronounced extinct at 08.19 hours on 14 May 2021.

Section 26(2)(b) of the 2016 Act (when and where any accident resulting in the death occurred)

[28] There was no dispute that Mr Lothian took his own life between 16.30 hours on 13 May 2021 and 07.30 hours on 14 May 2021 in cell 2/39, Glenesk Wing,

HMP Edinburgh. In the circumstances, his death did not result from an accident and it is therefore not necessary to make a formal finding under section 26(2)(b) of the 2016 Act.

Section 26(2)(c) of the 2016 Act (the cause or causes of death)

[29] There was no dispute with regard to the cause or causes of death. The conclusions of Dr Ralph BouHaidar, Consultant Forensic Pathologist, have been set out at finding in fact 40 above. Dr BouHaidar carried out a post-mortem examination of Mr Lothian on 20 May 2021. There was a ligature mark around the neck with features consistent with the literature provided. No other injuries of note were identified on the body. The cause of Mr Lothian's death was recorded as "1(a) suspension by ligature". The medical certificate completed and signed by Dr BouHaidar on 20 May 2021, confirmed that as the cause of death.

Section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in death)

[30] There was no dispute that the incident that resulted in Mr Lothian taking his own life arose as a result of Mr Lothian fashioning a ligature from polythene bin bags tied together and tying one end of that ligature around the railing of the top bunkbed in cell 2/39 Glenesk Wing, HMP Edinburgh and using the remainder of the ligature to hang himself.

[31] In the circumstances, Mr Lothian's death did not result from an accident and it is therefore not necessary to make a formal finding under section 26(2)(d) of the 2016 Act.

Section 26(2)(e) of the 2016 Act

[32] Any precautions which (i) could reasonably have been taken; and (ii) had they been taken, might realistically have resulted in death or any accident being avoided.

[33] The Crown, in their written submission, suggested that any such precaution must be a *reasonable* precaution which if taken might *realistically* have prevented the death occurring. A precaution might realistically have prevented a death if there was a real or likely possibility, rather than a chance, that it might have done so; see the Explanatory Notes to the 2016 Act. As the Crown noted, Sheriff Dickson, in his *Determination into the death of Zach Banner* [2020] FAI 18, adopted that test, having regard to the wording of the Explanatory Notes, and also to Carmichael, *Sudden Deaths and Fatal Accident Inquiries*, 3rd Ed at paragraph 5-75, which considered the wording of section 6(1)(c) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976, the predecessor to section 26(2)(a) of the 2016 Act. I agree with, and adopt, that approach.

[34] The Crown's position was that it was reasonable to declare Mr Lothian was at risk of suicide, and to place him on the Talk to Me Programme. However, the Crown considered that it was *not* possible to determine whether there was a real or likely possibility that the introduction of Talk to Me would have prevented Mr Lothian's death. Accordingly, the Crown considered that that was not a reasonable precaution which might realistically have prevented his death.

[35] The Scottish Prison Service referred me to *Carmichael* at paragraph 5.75, above, and to other authorities, but offered no submissions, on the evidence, as to whether any

precaution, suggested by the Crown or otherwise, might have prevented Mr Lothian's death. The submission for Lothian Health Board simply argued that there was no evidence before the court of any precaution which might reasonably have been taken, and which would have had a realistic prospect of preventing Mr Lothian's death, and that no finding in terms of section 26(2)(e) was appropriate.

[36] I am satisfied, having considered the evidence, that the only conceivable precaution which might have been taken here would have been the placing Mr Lothian on the Talk to Me Programme. However, I share the Crown's view that while this might have been a reasonable precaution, it was not a precaution which might realistically have prevented Mr Lothian's death. It is simply not possible, on the evidence available, to determine whether there is a real or likely possibility that the introduction of Talk to Me would in fact have prevented his death.

Section 26(2)(f) of the 2016 Act (any defects or any system of working which contributed to the death or the accident resulting in death)

[37] On this issue, the Crown noted that in deciding whether to make any determination as to defects in any system of working which contributed to the death, I required to be satisfied that the defect in question did in fact cause or contribute to the death; see *Zach Banner*, at paragraph 66. The Crown's position was that the relevant system of working here was the reception risk assessment procedure conducted by Prison Officer [SW] and Nurse [L McC]. The Crown relied on Dr Alistair Palin's criticism of the assessment process. While I summarised Dr Palin's position in dealing

with the Crown's submissions, it is helpful to set out the Crown's arguments in short form, as follows:

- The assessment system is too generic, both in terms of general assessment of risk and in relation to dealing with sex offenders;
- It relies too heavily on the individual's presentation in the "here and now";
- It does not require review of an individual's medical records, either held by SPS, (if they exist) or from the prisoner's GP.
- The process relies upon those involved going beyond what the paperwork expects of them when dealing with first time prisoners and sex offenders;
- The system failed to properly assess that Mr Lothian was at risk of suicide not just in an immediate sense but on an ongoing basis. It failed therefore to place him on Talk to Me observations and thus it failed to mitigate the risk of suicide which ultimately led to Mr Lothian's death.
- Accordingly, these issues and the limited guidance in the Talk to Me paperwork amount to a defect in the operation of the reception risk assessment process.

[38] The Scottish Prison Service, in their submission, noted that in order to make a finding under subsection 26(2)(f) the evidence must be sufficient on the balance of probabilities to justify the finding; *Carmichael*, at paragraph 5.76. I required to be satisfied that the defect in question did in fact, cause or contribute to the death. In their submission, Lothian Health Board suggested that there is no evidence of any defect in a system of working which caused or contributed to Mr Lothian's death. Accordingly no

finding in terms of section 26(2)(f) was appropriate. The submission for the Prison Officers Association Scotland is silent on the point.

[39] On this question I reject the Crown's arguments, and prefer those of SPS. I am not persuaded, on the evidence, that there was a defect in the system of working which contributed to Mr Lothian's death. I do not accept Dr Palin's evidence that the reception risk assessment process was unduly generic. It is true that the RRA Form is in short and generic terms. But the reality is that in Mr Lothian's case, the assessment was carried out by well trained and experienced staff who regarded the RRA Form as a starting point, and went beyond what the paperwork called for when dealing with first time prisoners and sex offenders. It is true also that the assessment process relies heavily on an individual's presentation at the time of reception, in the "here and now" but that is the reality of the prison system. Those arriving in prison for the first time, like Mr Lothian, will have no previous SPS medical records which can be accessed. It is not feasible to access a prisoner's GP records within the time constraints of the assessment process, even assuming the GP Surgery was willing and able to comply. The evidence suggests that the reception process was not generic, but person-centred, in so far as it could be.

[40] The fact remains that Mr Lothian was not placed on the Talk to Me Programme. This has not however, due to any defect in the Reception Risk Assessment programme or the RRA Form, but because he did not exhibit any of the markers that would have flagged him up as a suicide risk.

Section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death)

[41] In their submission, the Crown invited me to make certain findings relevant to the reception risk assessment process. These can be summarised as follows:

- The RRA Form makes no specific accommodations for first time prisoners;
- The RRA Form makes no specific accommodations for offence-specific risk factors, in particular convictions for sexual offences;
- The RRA process does not mandate a review of a prisoner's medical records.

[42] These proposed findings flow clearly from the Crown's position under section 26(2)(f) and the criticism of the RRA Form therein.

[43] The SPS submission notes that section 26(2)(g) requires me to determine "any other facts *which are relevant to the circumstances of the death*". The SPS position is that even if there are facts which give rise to concern, but which cannot properly be said to relate to the death, the substance should be embodied in a note appended to the formal determination rather than a finding under section 26(2)(g).

[44] The position of Lothian Health Board is that if there are any findings to be made in relation to the terms of the RRA Form, they should be made in terms of section 26(2)(g) rather than elsewhere.

[45] I am not persuaded that I should make any findings under section 26(2)(g). It cannot be said that the presence of such specific questions within the RRA Form would have necessarily resulted in Mr Lothian being placed on the Talk to Me Programme or mitigated the risk of suicide. The evidence demonstrates that he was subjected to

searching enquiries by an experienced prison officer and a highly experienced nurse, and on the basis of those enquiries was assessed as not being a risk of self-harm or suicide.

[46] The Crown's final point, under this heading, is that the reception risk assessment process did not mandate a review of a prisoner's medical records. Again, that would have made no difference in Mr Lothian's case. He had not previously been in prison, and had no previous SPS healthcare records. The evidence is that GP surgeries do not respond promptly to requests for information even for something as limited as a note of a prisoner's current medication, and the proposition that a GP surgery will consistently provide immediate access to a prisoner's medical records is simply not plausible. For all these reasons, any finding in fact relevant to the mandating of a prisoner's medical records would not be relevant to the circumstances of Mr Lothian's death.

[47] The question of whether any amendments should be made to the RRA Form is however addressed below, under section 26(4) - the recommendations section.

Recommendations

Section 26(4) of the 2016 Act (recommendations (if any) as to (a) 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).

[48] I have concluded that no findings should be made in terms of section 26(2)(e) to (g) of the 2016 Act.

[49] However, that does not preclude the making of recommendations regarding the matters set out in section 26(4) of the 2016 Act, if such recommendations might realistically prevent other deaths in similar or related circumstances. The purpose of a fatal accident inquiry is not merely to establish the circumstances of the particular death concerned, but to consider what steps might be taken to prevent other deaths in similar circumstances.

[50] It is relevant that the witness [ST], Policy Lead Suicide Prevention for SPS, is presently leading on developing a new suicide prevention policy within the Scottish prison system. Witness [ST] was appointed to that post given her previous experience working on a review of the SPS suicide prevention strategy between 2015 and 2017 and her extensive experience in coordinating DIPLARs. There is little information in her statement beyond the fact that there is an SPS review team looking at a new suicide prevention policy within the Scottish Prison System.

[51] In their submission, the Crown invited me to consider making a number of recommendations under section 26(4). I deal with each of them in turn, and offer my views on each:

Crown Recommendation 1. *In terms of section 26(4)(a) a recommendation for the Scottish Prison Service to declare, by default, that new admission prisoners entering the SPS estate who have been convicted of a sexual offence, have never received a custodial sentence before, and/or*

have previously attempted suicide to be a high-risk of suicide for the purposes of the Reception Risk Assessment.

[52] The evidence available to me suggests that first time prisoners and prisoners convicted of sexual offences each present a higher risk of suicide. That is likely to be higher still if there has been a previous suicide attempt. How much higher is something on which I have no information.

[53] The effect of the proposal would be to place such a prisoner within the Talk to Me process automatically. Of course, there may be prisoners within this cohort who are at no risk of self-harm or suicide whatsoever. The counter-arguments are that this removes discretion from the prison staff involved, and that the automatic referral to Talk to Me involves the use of resources, including a cell secured against self-harm/suicide, when those resources, within that particular prison, might already be scarce.

[54] I am satisfied that the Crown's proposal has merit. There is evidence that these three factors - a first custodial sentence, a conviction for sex offences and a previous suicide attempt - are factors which increase the likelihood of suicide. They can reasonably be regarded as warning factors. I am therefore satisfied that there may well be value in considering, in terms of Crown Recommendation 1, whether the reception risk process should be modified, such that if these three factors are present, there should be an automatic referral to the Talk to Me process.

[55] However, that is in my view a decision which should properly be made by SPS, as part of their current review of the prevention of suicide process. There is insufficient evidence before me for me to be able to form a view as to whether these are the only

critical factors in triggering automatic placing on Talk to Me, or whether other factors, such as age, social isolation or lack family support might in some cases be equally important. The decision on whether to introduce a "three-factor test" such as this is a task best performed by SPS staff, with access to the statistics on prison suicides, the learning outcomes from DIPLARs across the whole prison estate, and psychiatric advice.

Crown Recommendation 2. *In terms of section 26(4)(b), a recommendation (a) that the RRA Form should include specific considerations of risk (insofar as it currently does not) in relation to gender, age, evidence of chronic and disabling physical illness, evidence of drug or alcohol misuse, evidence of social isolation, evidence of consideration of previous episodes of self-harm or suicide attempts, evidence of assessment of the prisoner's mental state, evidence of hopelessness, worthlessness, feelings of guilt and/or unworthiness, nature of the index offence as it applies to potential risk of suicide, and whether the individual is a first-time prisoner; (b) that the RRA should clearly list relevant risk factors and document the actions taken by staff following identification of such risk factors, and (c) that the RRA should also require the documenting of the rationale for taking no action after identification of relevant risk factors.*

[56] The RRA Form is short, and generic. The reception process is dependent upon experienced reception staff going beyond the terms of the form, in appropriate cases, establishing a rapport, probing more deeply, and forming a considered view as to the risk of self-harm or suicide. If due to staff shortages or training deficits a less experienced prison officer or prison nurse is involved in reception duties there is scope, given the paucity of the form, for something significant in a prisoner's background or

presentation to be overlooked. I heard no evidence as to the level of experience of prison reception staff across the whole of the prison estate, and cannot form a view of the risks of that happening. But there is a vulnerability in the process. There may well be value in a more detailed form which includes specific considerations of risks in relation to the factors identified by the Crown and which specifically identifies as risks the factors that an individual is a first time prisoner, that the nature of the index offence is one which contributes to the risk of suicide, and that there has been a previous suicide attempt.

[57] If the RRA Form is to be amended to cover these factors, it follows that it should provide for a clear listing of the relevant risk factors, and for reception staff to document what actions they have taken following the identification of such risk factors, or the rationale for taking no action in such circumstances.

[58] I am accordingly of the view that it would be helpful for the RRA Form to be reviewed, with a view to possible amendment along those lines.

[59] However, any revisal to the form should in my view be carried out by SPS as part of their current review of the prevention of suicide process. There is insufficient evidence before me for me to be able to formulate specific amendments to the RRA Form, nor do I have the expertise to do so. Again, this is a task best performed by SPS staff with access to the statistics on prison suicides, the learning outcomes from DIPLARs across the prison estate, and psychiatric advice as to the weight which should be attached to particular risk factors.

<u>Crown Recommendation 3</u>. *In terms of section 26(4)(b) a recommendation (a) for the RRA process to rely less on the self-reporting or presentation of the individual being assessed, and that information provided by him or her should be verified by other means as far as possible; and (b) that the RRA process should include a review of the prisoner's medical records, both existing prison healthcare records (if previously in custody) or obtaining and review of the prisoner's GP medical records in the community.*

[60] I am not persuaded by these proposals. The number of prisoners coming through the reception process in HMP Edinburgh, is substantial. There is no evidence that the position in other Scottish prisons is different.

[61] On the evidence, it is not in my view feasible to verify the self-reporting by every prisoner by other means, whether that be existing SPS prisoner records or records from the prisoners own GP surgery or, perhaps, a mental health institution. The SPS prison records may be out of date, and potentially misleading. The evidence is that GPs do not respond promptly to such simple requests as confirmation of a prisoner's current medication, and it is unlikely that they will respond with the prisoner's whole GP records within any meaningful timescale, if at all. The reality is that in practice the only sources of information will be the Prisoner Escort Record (which can nevertheless be helpful in many cases) and the self-reporting and presentation of the individual prisoner. It is preferable in my view to leave the question of verifying the prisoner's self-reporting, from other sources, to the reception staff. There may well be particular cases where an experienced prison nurse may deem that to be essential, and take extra

time and care in obtaining that additional information. However, to make that compulsory, in every case, is simply not feasible or a good use of resources.

Crown Recommendation 4. *In terms of section 26(4)(c), a recommendation that the Scottish Prison Service and Lothian Health Board Team introduce a system of automatic referral to the prison Mental Health Team, as part of the admissions process. These referrals should be by default, allowing the Mental Health Team to assess the full circumstances of the prisoner. The criteria for referral, which prisoners will have to meet before a referral is made, should be considered by SPS and Lothian Health Board, having consideration of the wide spectrum of prisoners within prisons, but should include all prisoners where the index offence is a sexual offence, all first-time prisoners, and all prisoners with previous suicide attempts.*

[62] This proposal aligns with Crown Recommendation 1. It proposes the establishment of a set of criteria which, if met by a new prisoner, would trigger an automatic referral to the Mental Health Team. It is suggested that the criteria should be established by SPS and Lothian Health Board, but should in any event include all prisoners where the index offence is a sexual offence, all first-time prisoners, and all prisoners who have made previous suicide attempts.

[63] The arguments for and against this proposal are similar to those for Crown Recommendation 1. Once again, it seems likely that one can identify certain criteria within a particular prisoner's background and presentation which, taken together, justify an automatic referral to the Mental Health Team. However, to introduce a system of automatic referral for such prisoners removes discretion from experienced

reception staff, and again there is a risk that the resources of the Mental Health Team may be deployed in dealing with prisoners who are not in fact at risk of suicide, possibly to the detriment of others, given the limited resources within that prison. However, no evidence was led as to whether the automatic referrals process proposed here would require additional resources of the Mental Health Team. No evidence was led as to the existing MHT resources, or the likely impact upon them, either in HMP Edinburgh or across the prison estate in Scotland.

[64] Again, SPS is best qualified to assess the feasibility of a system of automatic referral to the Mental Health Team, by reference to the statistical information held as to the number of prisoners suffering from mental health issues and the number of prison suicides, the learning outcomes from DIPLARs across the prison estate, and psychiatric and other advice as to the criteria which should be applied.

My recommendations

[65] There are critical questions raised by this Inquiry around whether there should be any changes to the current Reception Risk Assessment process. That process has been criticised by Dr Palin as too generic, and insufficiently person-centred. That criticism is met by SPS, and others, who contend that the process is person-centred, by reason that the reception staff take the RRA Form as no more than a starting point, and go beyond it in particular cases, using their judgment, which is based on considerable experience. There is the issue of whether the form itself should ask more specific questions, such as whether the new prisoner is a first time offender, or include offence-

related questions, on the basis that the answers to such questions taken together might flag up a greater likelihood of self-harm or suicide. There is the issue of whether, if certain questions taken together flag up that risk, there should be an automatic placing on the Talk to Me Programme, and whether it is possible to establish criteria which would trigger an automatic referral to the Mental Health Review Team. All of that requires to be measured against the resources available. In HMP Edinburgh the number of prisoners passing through reception is high, the number of trained staff is limited, and the time available to conduct an assessment with each is therefore constrained. The number of secure cells available within HMP Edinburgh is again limited such that a system of automatic referrals to Talk to Me might create problems. Moreover, other prisons within the SPS estate might have greater demands upon them, relative to prisoner reception, or less. They may have greater resources available, or less. Against that background, one should be wary of making general recommendations for change which would affect the whole of the prison estate.

[66] Taking all this together, I am satisfied that there is value in considering, in terms of Crown Recommendation 1, whether the reception risk process should be modified, such that if the three factors identified above – a first custodial sentence, conviction for a sexual offence and a previous suicide attempt – are present, there should be an automatic referral to the Talk to Me process. In my view that is a decision which should properly be made by SPS, as part of their current review of the prevention of suicide process, for the reasons outlined above. I will make a recommendation to that effect.

[67] Turning to Crown Recommendation 2, I am also satisfied that there may well be value in reviewing the RRA Form, firstly, to emphasise more explicitly the risk factors mentioned above; a first time sentence, a sentence for a sexual offence, and a medical history which involves at least one previous suicide attempt. I consider also that it would be worthwhile reworking the form to introduce the specific considerations of risk proposed by the Crown, as noted above, and a requirement to list clearly the relevant risk factors, and record the action taken, or the decision not to take action. This would necessarily make the form a more detailed document, but if carefully drafted it ought not undermine the individualised and person-centred approach which is followed in HMP Edinburgh, and hopefully elsewhere.

[68] I am of the view that this exercise should be carried out by SPS, as part of their current review of the prevention of suicide process, for the reasons outlined above. I will make a recommendation to that effect.

[69] On Crown Recommendation 3, I am not persuaded that it is feasible for the reception process to include a review of the prisoner's medical records, for the reasons set out above.

[70] On Crown Recommendation 4, I am of the view that SPS and NHS Lothian are best qualified to assess the feasibility of a system of automatic referral to the Mental Health Team, for the reasons set out above. SPS should do so as part of their development of a new suicide prevention policy. I will make a recommendation to that effect.

[71] Accordingly, I formulate recommendations in the following terms:

(i) The reception process should be reviewed by SPS at the earliest convenient opportunity (and if possible within the scope of the current review of prevention of suicide policy) with a view to considering whether there should be an automatic referral to the Talk to Me process where a new prisoner is a first time offender, an offender convicted of a sexual offence (or other offences which carry an increased risk of suicide) and an individual with a history of one or more suicide attempts;

(ii) The Reception Risk Assessment Form should be reviewed by SPS, at the earliest convenient opportunity (and if possible within the scope of the current review of prevention of suicide policy) with a view to considering whether the following should be added:

(a) a specific record of whether a new prisoner is a first time offender, an offender convicted of a sexual offence (or other offences which carry an increased risk of suicide) and/or an individual with a history of one or more suicide attempts;

(b) a note for the guidance of SPS staff within the from that these factors, taken together, may indicate a higher risk of suicide than the norm;

(c) provision for the recording of factors relating to the specific consideration of risk in relation to gender, age, evidence of chronic and disabling physical illness, evidence of drug or alcohol misuse, evidence of social isolation, evidence of assessment of the prisoner's mental

state, evidence of hopelessness, worthlessness, and feelings of guilt and/or unworthiness;

(d) a requirement for SPS staff to document the actions taken by staff following identification of such risk factors, or the rationale for not taking any action.

(iii) The reception process should be reviewed by SPS and Lothian Health Board at the earliest convenient opportunity (and if possible within the scope of the current review of prevention of suicide policy) with a view to considering whether it is feasible to establish a system for automatic referral to the prion's Mental Health Team, based on an established set of criteria.

[72] I have no other recommendations to make.

Postscript

[73] I am grateful to all those who assisted the Inquiry, and in particular to Mr Gregor for the fair and balanced way in which he presented the Crown case.

[74] At the conclusion of the Inquiry I extended my condolences to Mr Lothian's family, who were present in court. All parties to the Inquiry extended their own condolences to Mr Lothian's family during the course of the submissions. I offer my sincere condolences once again to Mr Lothian's family and to all those affected by his death.