SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2019] FAI 5

EDI-B1160-18

DETERMINATION

BY

SHERIFF NORMAN MCFADYEN

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

into the death of

ALAN SMITH

Edinburgh, 31 January 2019

DETERMINATION

The Sheriff having considered the information presented at the inquiry, determines in terms of section 26 of the Act that:–

Alan Smith who was born on 6 February 1968 and was a serving prisoner in HM Prison, Edinburgh, 33 Stenhouse Road, Edinburgh died at said prison at 0850 hours on 16 April 2014.

In terms of section 26(2)(a) the death occurred at HM Prison, Edinburgh, 33 Stenhouse Road, Edinburgh at 0850 hours on 16 April 2014.

In terms of section 26(2)(c) the cause of death was

1a hanging

RECOMMENDATIONS

In terms of section 26(1)(b) I have no recommendations to make.

NOTE

Introduction

The Inquiry was held under the Fatal Accidents and Sudden Deaths Etc. (Scotland) Act 2016 into the death of Alan Smith. The death of Mr Smith was reported to COPFS on 16 April 2014. There were preliminary hearings on 21 November and 6 December 2018 and the inquiry took place on 9 and 10 January 2019.

The participants and their representatives were:

The Procurator Fiscal - Ms K Rollo, procurator fiscal depute

The Scottish Prison Service (SPS) - Mr D Scullion, solicitor, Anderson Strathern, Solicitors, Edinburgh

National Health Service Lothian (NHS) - Mr S Holmes, solicitor, Central Legal Office, Edinburgh

The State Hospital Board – Ms L Jardine, solicitor, Central Legal Office, Edinburgh

The Prison Officers Association Scotland – Ms J Merchant, solicitor, Thompsons Solicitors, Glasgow.

The following witnesses gave evidence:

1. Karen Weir, former partner of Mr Smith
2. Bernard Young, prisoner, HM Prison Perth
3. Kevin Torley, Residential Officer, HM Prison, Edinburgh

4. Stephen McDougall, Prison Officer, HM Prison, Edinburgh

5. Dr Craig Revill, General Practitioner

6. Kimberley Powell, Mental Health Nurse, HM Prison, Edinburgh

7. Professor Lindsey Thomson, Consultant Psychiatrist and Director, the State Hospital

8. Elaine Worsford, retired Mental Health Nurse, formerly HM Prison, Edinburgh

9. Lesley McDowall, Health Strategy and Suicide Prevention Manager, SPS

10. Dr Alexander Quinn, Consultant Forensic Psychiatrist, Orchard Clinic, Royal Edinburgh Hospital, Edinburgh

11. Dr Nick Hughes, Consultant Psychiatrist, Murray Royal Hospital, Perth

It was agreed by joint minute that the statement of the following witness should be considered equivalent to parole evidence and it was read into the record of proceedings:

Grant Hook, Prison Officer, HM Prison, Edinburgh

The Legal Framework

The Inquiry is one held under section 1 of the Fatal Accidents and Sudden Deaths Etc. (Scotland) Act 2016 and is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. The purpose of such an Inquiry is set out in section 1(3) of the Act and is to—

(a) establish the circumstances of the death, and

(b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

Section 26 of the Act states, among other things, that

> "(1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out—
> (a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and
> (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.
> (2) The circumstances referred to in subsection (1)(a) are—
> (a) when and where the death occurred,
> (b) when and where any accident resulting in the death occurred,
> (c) the cause or causes of the death,
> (d) the cause or causes of any accident resulting in the death,
> (e) any precautions which—
> (i) could reasonably have been taken, and
> (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided,
> (f) any defects in any system of working which contributed to the death or any accident resulting in the death,
> (g) any other facts which are relevant to the circumstances of the death.
> (3) For the purposes of subsection (2)(e) and (f), it does not matter whether it was foreseeable before the death or accident that the death or accident might occur—
> (a) if the precautions were not taken, or
> (b) as the case may be, as a result of the defects.
> (4) The matters referred to in subsection (1)(b) are—
> (a) the taking of reasonable precautions,
> (b) the making of improvements to any system of working,
> (c) the introduction of a system of working,
> (d) the taking of any other steps,
> which might realistically prevent other deaths in similar circumstances."

The procurator fiscal represents the public interest. An Inquiry is an inquisitorial process and it is not the purpose of an Inquiry to establish civil or criminal liability.

Summary

[1] Alan Smith, born 6 February 1968, died at 08.50 hours on 16 April 2014 at Saughton Prison, 33 Stenhouse Road, Edinburgh, otherwise known as HM Prison

Edinburgh ("the prison"). At the date and time of his death, Mr Smith was lawfully detained in custody there, serving a sentence of imprisonment in respect of a breach of licence in 2009 in respect of a charge of culpable homicide arising from a sentence imposed in 2004.

[2] At approximately 20.30 hours on 15 April 2014 Mr Smith was locked up within cell 4/31 within Ingliston Hall at the prison. At about 07.15 hours on 16 April 2014, Steven McDougall and Tracy Scott, Prison Officers, found Mr Smith suspended from a window frame by a belt. He was cut down and chest compressions were commenced.

[3] At about 07.20 hours on 16 April 2014, practitioner nurse, Inger McGowan or Goos attended at Mr Smith's cell in response to an emergency call. She observed that he was cold to the touch, had no pulse and rigor mortis had set in. She concluded that Mr Smith was dead and there was no need for further medical intervention. Dr Craig Revill, prison doctor attended at the cell and pronounced life extinct at 08.50 hours on 16 April 2014.

[4] The body of Mr Smith was examined post mortem on 22 April 2014 at the City Mortuary, Cowgate, Edinburgh by Dr Robert Ainsworth, consultant forensic pathologist. The cause of death was certified as

1a hanging

An examination of the head and brain revealed no injuries. The brain showed no evidence of abnormalities or injury on dissection.

[5] Mr Smith had a long history of mental illness. He had a difficult life, having been abused as a child and, although he had a long term relationship which had produced

two children and he clearly had some happy times, he had much unhappiness in his life. He had longstanding problems with substance abuse, including solvent abuse, dating back to his teens and this impacted on his mental health. By the time he was about 30 he was using drugs and drinking as well. There were times when he was sleeping on the street. He spent periods in prison, often in connection with theft by housebreaking where he would be looking for solvents. In recent years he was not able to look after himself when at liberty.

[6] He had been diagnosed at various times with drug or substance induced psychosis and had spent three periods in the State Hospital, Carstairs. He had severely mutilated himself in December 2000, over four years before the circumstances giving rise to the culpable homicide, but apparently during a psychotic episode. He did not have any history of attempting to take his own life and there was no history of self-harm in recent years. Because he got well and had remained well in a drug free environment without medication while at the State Hospital, the conclusion there was that he was suffering from drug induced psychosis and not schizophrenia.

[7] Although he had committed a very serious crime and was at times obviously mentally disturbed, Mr Smith was a popular prisoner, who was regarded with genuine affection and sympathy by prison officers and staff, prison nursing staff and other medical professionals, as well as by many other prisoners. He was described as quiet and respectful, generally withdrawn and, although he did not mix greatly with other prisoners, he was friendly with a few prisoners and other prisoners and some prison

officers would look out for him. He was kind to those around him and thoughtful and could be jovial, but he was very vulnerable and lacking in social skills.

[8] He also continued to be friendly with his former partner, Karen Weir, who gave evidence at the Inquiry, including about his long-standing problems, as already described. When he was at liberty she looked out for him and stayed in touch with him when he was in prison. She knew he was unwell in the time leading up to his death and was not sure what would happen to him, although she did not have specific concerns about him taking his own life.

[9] Mr Smith was known to have mood swings in particular when he was engaging in substance abuse. While he did not have money and could not afford to buy illicit substances, other prisoners would sometimes give him such substances and he would take what he could get.

[10] He could have good and bad days, but there were also extended periods when he was of low mood and might be withdrawn for weeks on end, but equally there were long periods when he would engage. There were periods when he might miss meals or even not eat for a few days. Most of the time he was pleasant to be around. If his mood was low his presentation would be a problem and he had less motivation.

[11] Dr Alex Quinn, the consultant psychiatrist responsible for treating Mr Smith in prison was concerned, in 2012, about his poor motivation and wondered if he was showing negative symptoms of a schizophrenic illness and therefore requested that he be assessed by Dr Andrew Wells with a view to admission to the State Hospital. Dr Wells concluded that he did not meet the criteria for detention under the Mental Health

legislation and, accordingly, a transfer for treatment direction was not appropriate. Between then until his death there were no other episodes of acute psychosis.

[12] At the time of his death Mr Smith received depot injections of anti-psychotic medication fortnightly.

[13] On 2 April 2014 Mr Smith was seen by a mental health nurse, Elaine Worsfold (who is now retired), who found him looking and feeling well, enthusiastic and pleased to say that he was not using illicit drugs.

[14] On 9 April 2014, however, Mr Smith was noted by a nurse not to have attended for supervised medications for two days and was visited in his cell. He reported that he had hurt his hip and was in severe pain with very limited movement. It was also reported that day by another prisoner that Mr Smith had said he was doing "kung fu" in his cell when he hurt himself and was sleeping on the toilet floor. He had said he was hearing voices again. Prison officers confirmed he had been behaving oddly for a couple of days.

[15] Mr Smith was seen on 11 April in his cell by Dr Craig Revill, the prison doctor, because he refused to attend the GP clinic, saying he was too unwell. He said he had fallen and banged his left hip, possibly the previous weekend and said he had also banged his head. He had a slight headache, was drowsy and his right pupil was significantly dilated. There was no sign of any hip injury. Dr Revill was concerned there might be a change in his mental health due to psychosis or head injury or concussion and arranged for a scan at the Royal Infirmary of Edinburgh and for mental health assessment if that was normal. The scan was carried out that day and was normal.

[16] Mr Smith was seen later that day for assessment by a mental health nurse, Kimberley Powell. She saw him in his cell, which was unkempt, although that was not unusual. He was lying on top of his bed, with the covers pulled up over his head and continued to face the wall and away from staff while he was spoken to. He said "I'm just tired" and said he had a sore hip or leg. He said he was eating fine, although there were uneaten cereal and snacks in the cell. Asked if he was experiencing any auditory hallucinations, he said "a little bit" and would not elaborate, but asked if the voices were nice or not nice replied "not nice". He denied taking illicit substances recently. He would not make eye contact and had no spontaneous conversation, offering minimal responses to direct questions. He agreed to have his depot injection brought to him. It was noted that a prisoner with whom he was friendly had reported that he was his usual self on 4 April but had been presenting as he now was since the previous Saturday (5 April).

[17] The following day, Saturday 12 April Kimberley Powell attended again to administer the depot injection and review his mental health state, Mr Smith having refused to attend the treatment room. He was lying the same way, but able to express a preference as to administration of the drug. He denied illicit substance abuse but indicated low mood, saying "I've just had enough, nothing is going to change". She took that as an indication of hopelessness. He described having "racing" thoughts. He denied there being any significant events or news which might affect how he was feeling. He acknowledged he had not eaten for several days, saying he was not hungry. Asked if there was anything Ms Powell could do, he said "not really". She noted that

there had been a significant deterioration over the previous seven days and she asked Dr Quinn, the consultant psychiatrist, to carry out an urgent review. He was due to attend on Monday 14 April, which she thought was sufficient. She did not think there was a risk of self-harm and she was not aware of any history of self-harm in custody.

[18] Dr Alexander Quinn, who has been a consultant since 2011 and provides psychiatric services to Saughton and Addiewell Prisons, was asked to see Mr Smith when he attended the prison on Monday 14 April and spoke to prison officers who confirmed the recent history of being in the cell and refusing to engage with prison officers or prisoners, including a particular individual he had known for many years, over a period of ten days. He had had previous contact with Mr Smith. He understood from nursing staff that they were concerned that he had relapsed into psychosis.

[19] Dr Quinn visited him in his cell and attempted to engage with him for approximately ten minutes. He lay in his bed rolling cigarettes, at times covering his face with his hands. He intimated that he did not want to talk to Dr Quinn and said only a few words during the consultation. He observed his cell to be particularly barren, with little evidence of any personal belongings other than uneaten food, smoking paraphernalia and a television which he denied using. There were numerous smoked cigarette butts on the mattress where he lay. Dr Quinn wondered if he was suffering from a relapse of psychotic symptoms. At one point during the consultation he appeared to tell someone to "shut the fuck up" but he did not appear to be talking to Dr Quinn. Mr Smith described his head as being a mess and that everything was disgusting.

[20] Dr Quinn did not think it necessary to manage Mr Smith on ACT 2 Care, the then prison protocol for prisoners considered to be a high risk of suicide. He did not have a recent history of self-harm and had not expressed suicidality to Dr Quinn or other professionals. His past serious self-mutilation was not committed in a manner which was rooted in depression or a wish to harm himself, but was done to challenge others while he was psychotic.

[21] Dr Quinn was of the view that Mr Smith could only be cared for in conditions of high security and he telephoned Professor Lindsay Thomson at the State Hospital, who had been his previous responsible medical officer, and she agreed to review him with the intention to possibly admit him. She asked if he wished Mr Smith to be reviewed that week but he declined; he had seen numerous dips in his presentation similar to the current episode and these were usually related to consuming illicit substances. He asked Professor Thomson to leave her review to the following week.

[22] The State Hospital, Carstairs is part of the NHS and cares for individuals with mental illness who have offended or are alleged to have offended or are at high risk to themselves or others. There is a formal referral process, but in general referrals are made by doctors, psychiatrists and sometimes legal professionals or the courts. There is an assessment process and generally there will be discussion between professionals as to whether the case is urgent or routine; if the latter, the case is considered at a patient pathway meeting at 9.30am every Monday when the relevant professionals will assess the suitability of patients and availability of beds, etc. A patient will then be assessed by a consultant psychiatrist who will lead the assessment, but may involve social work,

nurses, psychologists, etc. If the case is urgent an early assessment can be carried out, even the same day if that is required.

[23] A routine assessment is usually carried out in one to two weeks after allocation, but as often as not within days. If the patient is assessed as suitable the timescale for admission is usually very short. There is no issue about having sufficient beds. They admit about 30 patients a year from 60 to 80 referrals and probably about ten of these are urgent: urgent referrals are more likely to be admitted.

[24] Dr Quinn offered medication, which Mr Smith declined. He completed a referral letter which was sent on 15 April 2014, by which time Mr Smith had died. In his letter he indicated that Mr Smith's "long deteriorating manner in prison has pushed my view of his diagnosis from drug-induced psychosis to one of schizophrenia". He did not note asking Mr Smith particularly about suicidal intentions, although it was likely that he would have done so, approaching it in a gentle way.

[25] Mr Smith hanged himself with a belt. He did not apparently use a belt, but it was easy to obtain or exchange items of clothing from or with other prisoners and, except where a prisoner was placed in safe cell conditions, it was not feasible to restrict access to particular types of clothing.

[26] Although Mr Smith's mental health had deteriorated in the 10 days before his death and his mood was very low, he had long been subject of mood swings, including long periods of low mood, and there was nothing exceptional about his presentation during this period and in particular there was nothing to indicate that he was at risk of self-harm or indeed taking his own life. In addition to nursing and medical staff he was

seen during this period by prison staff and indeed his fellow-prisoner friend Bernard Young, who similarly had no concerns that he might harm himself.

[27] There were different levels of control under ACT 2 Care, depending on the risk assessment, varying from, at the lightest level, hourly observations of a prisoner in his own cell, to quarter hourly (or even shorter periodic) observations of a prisoner in a safe cell with anti-ligature furniture and clothing. If Mr Smith had been placed on the ACT 2 Care regime he would probably have been removed to a completely barren safe cell, with a thin plastic mattress, cross-hatched shorts and t-shirt and a thin cross-hatched blanket. He would likely have been placed on 15 minute observations through a hatch.

[28] Staff and medical professionals were familiar with ACT 2 Care and it is clear that a number of them who dealt with him in the period leading up to his death would have implemented the necessary procedures if they thought he was at risk of self-harm. There was, however, no basis for placing him on the ACT 2 Care regime, which itself could have been stressful to and felt like a punishment for a prisoner who did not present a risk of self-harm. If he had been placed in a safe cell he would have been unable to come out and socialise if he so chose.

[29] An Operational Learning Review following Self-Inflicted Death (now known as DIPLAR - Death in Prison Learning and Audit Review) was held on 18 August 2014 and, while it did not identify any actions or omissions that would have changed the outcome for Mr Smith, it did identify that Rule 41 of the Prison and Young Offenders Institutions (Scotland) Rules 2011 could be used more often at the prison and, had he been managed under Rule 41, that would have ensured effective communication

between operational and health care staff and alerted SPS Headquarters to issues regarding transferring him to hospital.

[30] Rule 41 provides:

> "41.—(1) The Governor must order that a prisoner be accommodated in specified conditions where a healthcare professional –
> (a) advises the Governor that it is appropriate to do so in order to protect the health or welfare of the prisoner or any other prisoners; and
> (b) informs the Governor of the care and treatment planned for the prisoner while the prisoner is accommodated in specified conditions."

[31] Operational SPS staff felt that they did not have enough information about Mr Smith and that NHS staff had been dealing with him but not communicating what they were doing; SPS staff were not aware that things were being done. Rule 41 involves a multi-agency care plan and staff would have had access to that; if there was difficulty getting the prisoner to hospital they could have escalated that.

[32] The Operational Learning Review also noted as a learning point that there seemed to be some reluctance from mental health facilities in Edinburgh to take prisoners under the Mental Health (Care and Treatment) (Scotland) Act 2003.

[33] While the use of Rule 41 may have improved communication between SPS and NHS staff it would not have affected the outcome for Mr Smith and the question of admission to mental health facilities in Edinburgh was not one which arose in this case given his situation and the nature of the index offence (culpable homicide), from which it was clear that if he did require hospital treatment it would have been in the State Hospital, as was being explored at the time of his death.

[34] ACT 2 Care was replaced in 2016 by Talk to Me, a multi-agency policy which provides a more flexible response to self-harm and assessment of risk. Neither policy or regime was relevant to the circumstances of Mr Smith's death, since no risk of self-harm had been identified by the many professionals and others with whom he was in contact in the period leading up to his death; all staff with unescorted access to prisoners were trained in ACT 2 Care and in particular to look out for "cues and clues" and possible triggers to self-harm.

Submissions

[35] All of the participants offered their sympathy and condolences to the family of Mr Smith.

[36] The procurator fiscal depute noted that Mr Smith appeared to have been well thought of and liked by people he had contact with, both on a personal and professional level, and as a consequence of this it appears that people went that little bit extra to try to assist him, but that his condition was not one which was easily manageable. There were no cues or clues which would have indicated a need to invoke ACT 2 Care, or indeed, in the more current environment, Talk to Me. She submitted that Mr Smith's decision to take his own life came as a shock to all concerned and that he gave no indications to anyone of his intention. She did not suggest any findings other than in relation to section 26(2)(a) and (c) – place and time and cause of death.

[37] The solicitor for SPS addressed in particular section 26(2)(e) – reasonable precautions – and submitted that there was no evidence which would justify such a

finding. Implementation of ACT 2 Care and use of an anti-ligature cell might have prevented the death, but the court would need to be satisfied that such a measure was reasonable in the sense that it ought to have been taken and that would be to ignore the evidence of witnesses, including the fellow prisoner Mr Young, that nobody formed the opinion that he was at risk of self-harm and would also be to ignore the evidence that placing him in ACT 2 Care detention could itself be harmful, particularly when he was psychotic and paranoid. It was important to take account of the evidence of staff and their knowledge of him and of his history of low mood. There was equally no evidence of any defect in a system of working and no basis for a finding under section 26(2)(f).

[38] As far as concerns section 26(2)(g) – any other facts which are relevant to the circumstances of the death – it was accepted that this was wider in scope, but they must be so relevant. There had been evidence about Rule 41 and that it was now used more frequently in the management of prisoners with mental health issues, but no-one who gave evidence was of the opinion that it would have prevented the death and I was invited to make no finding or recommendation under section 26(1)(b).

[39] The solicitor for the NHS similarly invited me to make formal findings. There was no evidence of reasonable precautions which could have been taken. He had been seen by nursing staff and Dr Quinn as well as prison officers and prisoners and no-one anticipated that he would self-harm in any way. Dr Quinn had stated that it was likely that he would have asked him in a gentle way about suicidal intentions. It was clear from Dr Hughes' report that ACT 2 Care had been used in a flexible way while Mr Smith was in prison and "its omission on this occasion was not inconsistent with

previous episodes of care that had not been associated with acts of self-harm" (report, page 18). There was no evidence he would have been placed at the higher level of ACT 2 Care or transferred to a safe cell even if ACT 2 Care had been activated. As Dr Hughes had made clear in page 22, para 8 of his report, there were no serious errors or omissions that would have been likely to significantly change the outcome.

[40] The solicitor for the State Hospital Board also submitted that only formal findings were necessary. There was no reasonable precaution which could have been taken nor any defect in system of working and there was no basis for a finding under section 26(2)(g). She referred in particular to the evidence of Professor Thomson and Dr Quinn; they had a clear discussion about Mr Smith's presentation and the question of transfer to the State Hospital. Nothing else could have been done to avoid his death.

[41] The solicitor for the Prison Officers Association Scotland also invited me to make only formal findings. She referred to the evidence of Mr McDougall who had worked with Mr Smith for five years; periods of being up and down were not unusual for him. The request for review by the mental health team was appropriate. Prison officers were aware of his deteriorating mental health and had taken the reasonable precaution of involving mental health services.

Discussion and Conclusions

[42] The facts narrated at paras [1] to [4] of the summary were the subject of joint minutes between participants. It was also agreed that the report of the examination and dissection of the body of Mr Smith was contained in Crown production number 1 – post

mortem and toxicology report, that Crown production numbers 2 – computerised records, 3-5 inclusive – medical records, 6 – physical and mental health records and 7 & 8 – prison files were reordered and replicated within Crown production number 16 – reordered copy medical notes. It was also agreed that Crown production number 9 – SPS Operational & Learning Review following Self-Inflicted Death was produced by the Scottish Prison Service following a review of the circumstances surrounding the death of Mr Smith. Witnesses Bernard Young, Kevin Torley, Stephen McDougall, Dr Craig Revill, Kimberley Powell, Elaine Worsford and Dr Alexander Quinn all knew Mr Smith relatively well and interacted with him during the days leading up to his death. Their observations of him during this period were consistent and have enabled me to set out a generally chronological summary of events.

[43] Professor Lesley Thomson, as already noted, also knew Mr Smith well and, although she did not see him during this period, she did discuss him and his presentation with Dr Quinn with a view to assessment for the State Hospital shortly before his death.

[44] Lesley McDowall was able to describe the Operational Learning Review following Mr Smith's death as well as the ACT 2 Care and Talk to Me regimes and the use of Rule 41.

[45] Dr Nick Hughes was instructed by the Procurator Fiscal as an independent expert and spoke to his report (Crown production number 14). He was asked to review the relevant prison and medical records and report on the appropriateness of Mr Smith's care, particularly in the lead-up to his death and in particular whether he should have

been moved or treated differently, whether he was in the right place and the actions of staff were correct and whether there was anything that would have alerted staff that he was in danger of taking his own life. Dr Hughes was satisfied that he was treated appropriately, including in respect of the assessment that he required transfer to hospital and the timeframe which had been arranged in that regard. He did not identify

> "any serious errors or omissions that would have been likely to significantly change the outcome on balance",

but he considered that the professionals

> "should perhaps have examined more carefully for and *documented* [his emphasis] the presence of thoughts of self-harm or suicide, alongside any interim measures put in place to manage any risks"

while awaiting transfer (report, page 22, para 8).

[46] His own practice was to have an extremely low threshold for invoking ACT 2 Care to reduce the risk of self-harm, for example involving a degree of observation. It was not clear that was necessary in this case, but he would have documented it – saying yes or no and why. He also commented that it might have been prudent to re-evaluate the approach to risk management in light of changes which were observed in the days leading up to his death, which he described as a significant change

> "in comparison to previous episodes of mental ill health …….[which] may have triggered the development of a more robust immediate risk management plan. This may have included using ACT [ACT 2 Care] as a means by which to reduce the risk" (page 21, para 5).

Nonetheless, he concluded that there was

> "nothing other than a retrospective knowledge of Mr Smith's suicide to clearly indicate that Dr Quinn's balancing of the relevant risks was inappropriate at the time" (page 22, para 8).

I do note that the evidence of health-care professionals who dealt with Mr Smith was that his presentation was consistent with previous episodes and Dr Hughes himself noted in his report that the omission of ACT 2 Care

> "on this occasion was not inconsistent with previous episodes of care that had not been associated with acts of self-harm" (page 18).

[47] Dr Hughes did observe (at page 21, para 7) that there was

> "no standardised structured approach to the *assessment* [his emphasis] of risk of self-harm in Scottish prisons".

Lesley McDowall, who gave evidence prior to Dr Hughes, took issue with that suggestion, stating that there was an assessment when prisoners first came in and staff knew how to interview someone who was at risk, look for clues, etc. However, in his evidence, Dr Hughes elaborated upon his comments by saying, as I understood it, that there was a lack of a standard tool for risk assessment adapted to the prison context.

[48] All of the witnesses who gave evidence appeared to do so in an honest and constructive way and I accept their evidence to the extent that it proceeds upon reliable observation. In the case of Mr Bernard Young, I considered that he was, like all of the witnesses, endeavouring to assist the court, although his evidence was in part based on assumptions which were not justified. That is not a criticism of him, because, for reasons no doubt in part of patient confidentiality, he could not have been made aware that, far from not being given help, Mr Smith was being seen regularly by psychiatric nurses, had been seen by Dr Quinn and had been referred to the State Hospital. Equally, although Mr Smith was not co-operating with medication to the extent of refusing to

attend for that purpose, he was being visited in his cell and allowed medication to be administered.

[49] Mr Young drafted a petition (Crown production number 18) among prisoners, because he believed the death could have been avoided if Mr Smith had been given the help he deserved. He could have been put on observations and other measures taken. Another prisoner had contact details for Ms Weir and he got her address and wrote to her with the petition, which was signed by a number of prisoners, many of whom had added their own comments. He had signed as Ben Young. Those signing (118 individuals, although it was said that others unable to sign it agreed with the sentiments) apparently agreed that the treatment Mr Smith received was unprofessional, unethical and unacceptable, that he was subject to medical negligence and his tragic death could and should have been avoided if the mental health team and NHS staff had given a due care to his wellbeing and mental health. They considered this was not an isolated incident, referring to this being the third death of this nature in the prison in a few months and there also having been a number of suicide attempts.

[50] I have concluded, as set out in the summary, in particular at paras [26] and [28], that there was nothing to indicate that Mr Smith was at risk of self-harm or indeed taking his own life at that time and that there was no basis for placing him on the ACT 2 Care regime. It is a sad truth that, had he been placed on that regime, he may not have been successful in taking his own life, but that is to take undue advantage of hindsight, because all the evidence was that there was no basis for doing so and, indeed, the effect of doing so could have been harmful to his mental health.

[51] It is appropriate that I make the formal findings required by section 26(2)(a) and (c) of the 2016 Act. Section 26(2)(b) and (d) are not applicable, relating as they do to accidents. Given the clear consistency of evidence about the lack of any indication of risk of self-harm there are no precautions that I can properly find could reasonably have been taken, which might realistically have resulted in the death being avoided and there are no defects in any system of working which contributed to the death.

[52] As already noted, the court has a broad power to make recommendations under section 26(1)(b) as to

> "(a) the taking of reasonable precautions,
> (b) the making of improvements to any system of working,
> (c) the introduction of a system of working,
> (d) the taking of any other steps,
> which might realistically prevent other deaths in similar circumstances."

[53] It is good that there were learning points from the Operational Learning Review, but these do not, in my opinion, come within the scope of section 26(1)(b) and they have, in any event, already been taken on board.

Any Other Information, Observation or Comment

[54] It is open to the court to make other less formal observations or comments. Although I understand the point which Dr Hughes was making about a risk assessment tool, I do not think I had sufficient information to form any view as to whether and how that might be achieved and I think that is a matter properly to be discussed further by the relevant professionals.

[55] Dr Hughes also indicated that he would have documented that the question of intention to self-harm had been raised with the prisoner. This was a case where the health-care professionals knew the prisoner well and where he was only prepared to communicate to a very limited extent. It is not clear to me that in that situation it would be helpful to suggest that a specific question should be put to such a prisoner and I do not think it is appropriate to offer any particular observation or comment in that regard.

[56] It is customary to thank the procurator fiscal depute and legal representatives for their conduct of the inquiry, but my thanks in this case are fully merited. The bulk of the work in this regard normally falls on the Crown, but the solicitors for the various participants also approached the inquiry in a wholly professional, constructive and sensitive manner and they all have my gratitude.

[57] Finally, while I expressed my sympathy and condolences to the family and friends of Mr Alan Smith at the outset of the inquiry, it is appropriate that I record that again at this stage.