SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE IN STIRLING

[2019] FAI 9

STI-B108-18

DETERMINATION

BY

SHERIFF WILLIAM GILCHRIST

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

into the death of

DIONNE KENNEDY

Stirling, 21 February 2019

The Sheriff, having considered the cause determines:

[1] In terms of section 26(2)(a) of the Fatal Accidents and Sudden Deaths Inquiries Etc. (Scotland) Act 2016 Dionne Kennedy, born 13 March 1995, and while detained in lawful custody at HMP Cornton Vale, died within cell 1:1, Skye House, Cornton Vale Prison, Stirling at a time between 2200 hours on 1 November 2014 and 0800 hours on 2 November 2014. Her life was pronounced extinct at 0850 on 2 November 2014.

[2] In terms of section 26(2)(c) of the said 2016 Act, the cause of death was "1a Hanging" and that by suspension by her neck with a ligature formed from her bed sheet secured to the frame of her bunk bed within her cell.

[3] Given the circumstances of Dionne Kennedy's death, no issues in relation to sections 26(2)(b) or (2)(d) arise. In addition I make no findings in terms of

section 26(2)(e) of the said 2016 Act as I have been unable to identify any precautions which could reasonably have been taken and which, if they had been taken, might realistically have resulted in the death being avoided. Similarly, I have been unable to identify any defects in any system of working which contributed to the death.

NOTE

Introduction

[4] The inquiry was held under the Inquiries into Fatal Accidents and Sudden Deaths Etc. (Scotland) Act 2016 into the death of Dionne Kennedy. By interlocutor dated 11 June 2018 the court ordered that an inquiry be held on 9 and 10 August 2018 with a preliminary hearing to be held on 24 July 2018. On 9 August 2018 the mother of the deceased was represented for the first time and at her request the inquiry was adjourned until 12 December 2018. A further preliminary hearing was held on 11 October 2018 by which stage the solicitor representing the deceased's mother had obtained legal aid but had not had the opportunity to fully consider the disclosure bundle and take instructions thereon. Accordingly, a further preliminary hearing was assigned for 15 November 2018. The inquiry then heard from four witnesses on 12 and 13 December 2018.

[5] During the course of the inquiry it became apparent that certain documentation relating to the deceased's reception at the prison on 28 and/or 29 October 2014 had not been recovered. The Scottish Prison Service was instructed to investigate the location of said documentation and submit the outcome of such enquiries to the court on or before

21 December 2018. In the event, it did not prove possible to recover the documentation. Parties to the inquiry were then given an opportunity to indicate whether they wished to examine any further witnesses. As no party wished to do so, by interlocutor dated 15 January 2019, the court directed parties to lodge written submissions.

[6] The Crown were represented at the enquiry by Ms Cook, procurator fiscal depute. The Scottish Prison Service was represented by Ms Thornton, the National Health Service by Ms Jardine, the Scottish Prison Officers' Association by Ms Merchant and the family of the deceased by Mr Forbes. On 12-13 December 2018 the inquiry heard from Margaret Dryden, the mother of the deceased; Catherine McGregor, a prison officer; Carol-Anne Murray, a prison officer; and Dr Duncan Alcock, a consultant forensic psychiatrist who had been instructed by the Crown to provide an independent expert report. The inquiry also had the benefit of an extensive joint minute of agreement to which were attached the statements of a number of police officers, prison officers and persons who were detained at Cornton Vale at the time of the death.

The legal framework

[7] The inquiry was a mandatory inquiry under section 2(4)(a) of the Inquiries into Fatal Accidents and Sudden Deaths Etc. (Scotland) Act 2016 as Dionne Kennedy was in legal custody at HMP Cornton Vale at the time of her death. The inquiry was governed by the Act of Seredunt (Fatal Accident Inquiry Rules) 2017. In terms of section 1(3) of the 2016 Act the purpose of the inquiry was to establish the circumstances of the death and consider what steps (if any) might be taken to prevent other deaths in similar

circumstances. In terms of section 26 of the Act the court is required to make findings as to the following circumstances –

(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.

The court is also empowered to make such recommendations (if any) in relation to the taking of reasonable precautions, the making of improvements to any system of working, the introduction of the system of working, or the taking of any other steps which might realistically prevent other deaths in similar circumstances. At the inquiry the procurator fiscal depute represented the public interest. The inquiry was an inquisitorial process but it was not the purpose of the enquiry to establish civil or criminal liability.

Summary

[8] The evidence established that Dionne Kennedy was sentenced to 300 days in custody on 13 March 2014 for charges of assault to injury and behaving in a threatening or abusive manner. She was released on license on 2 July 2014. Her license conditions were breached and she was recalled to custody on 16 August 2014. She was apprehended by police officers on 22 August 2014 and sent to HMP Cornton Vale. She was later released from this sentence on 20 October 2014 but was then apprehended on an outstanding warrant for contraventions of section 38 of the Criminal Justice and Licensing (Scotland) Act 2010 and section 49(1) of the Criminal Law (Consolidation) (Scotland) Act 1995. She was apprehended at about 0050 hours on 21 October 2014. Later that day she appeared from custody at Kilmarnock Sheriff Court and was committed for further examination and remanded in custody. She appeared for full committal at Kilmarnock Sheriff Court on 28 and/or 29 October 2014 and was again remanded in custody. (There was some confusion as to the date of her full committal and whether she had been taken to Kilmarnock Sheriff Court on both dates.) She was lawfully detained in custody within HMP Cornton Vale at the time of her death.

[9] At the time of her detention the SPS Suicide Risk Management Strategy was known as ACT2Care (hereinafter referred to as "ACT"). A revised prevention of suicide in prison strategy known as "Talk to Me" was subsequently introduced in December 2016.

[10] The evidence established that any individual working within a prison could raise an ACT or Talk to Me document at any time should they have concerns about a

prisoner. The assessment of the prisoner was not restricted to when a prisoner entered or re-entered an establishment. Under the ACT regime, if a prisoner was assessed as being at "high risk" or "low risk" a decision had to be made on how to safeguard the prisoner. Measures available to the establishment ranged from allowing the prisoner to remain in their cell but with certain items removed, or placing the prisoner in an anti-ligature cell with a "high risk" status which would involve the prisoner being observed every 15 minutes.

[11] The inquiry had available to it the ACT paperwork for the deceased's reception at the prison on 21 October 2014. Regrettably, no such paperwork was available for the deceased's reception at the prison on 28 and/or 29 October 2014. Given the deceased's background, she was clearly someone who required to be assessed as she had an extensive history of self-harm. Her background history is summarised in Dr Alcock's report, dated 16 May 2018. In his report he refers to a previous psychiatric report prepared by Dr Jacqueline Scott, consultant psychiatrist, NHS Ayrshire and Arran. That report was prepared on 26 February 2014 at the request of Kilmarnock Sheriff Court. In her report Dr Scott documents that at the time of the assessment Ms Kennedy was an 18 year old woman currently held at HMP Cornton Vale. She advised Dr Scott that she had previously had contact with a consultant psychiatrist Dr Brian Hart. She described to Dr Scott that she had a history of deliberate self-harm which she felt had worsened in the last year. She also described having had contact with child and adolescent mental health services. Ms Kennedy advised Dr Scott that she had a history of "severe mood swings" and that she was unsure and unclear why she self-harmed. She informed

Dr Scott that her self-harming had been severe including cutting herself and recurrent overdoses. She described to Dr Scott that it was in her second year of high school that she was expelled and was subsequently transferred to a secure unit. Ms Kennedy advised Dr Scott that she was unsure of the trigger of the deterioration in her behaviour and she denied any history of trauma. She admitted to Dr Scott having had contact with the police from approximately the age of 12 or 13. She advised that this had arisen after a fight she had with her brother when she took a knife to him. Thereafter it would appear that she had a number of offences. She described how at the age of 16 years she was transferred from a secure unit to HMP Cornton Vale. Ms Kennedy admitted to Dr Scott that her self-harming followed a typical pattern which tended to be impulsive.

[12] Dr Scott conducted a mental state examination and concluded that at the time of seeing Ms Kennedy there was no evidence of her suffering from psychotic type symptoms, nor did she appear to be suffering from any form of mood disorder.

Dr Alcock noted from Dr Scott's report that Ms Kennedy's contact with NHS Ayrshire and Arran began in August 2010. It would appear that she was discharged from child and adolescent mental health services in January 2012 due to her non-engagement and due to currently being remanded in HMP Cornton Vale. It was noted that she missed several appointments with Dr Hart. It was noted that she was reviewed at the outpatient clinic on 4 December 2013 where she was given the diagnosis of incipient borderline personality disorder (otherwise known as emotionally unstable personality disorder borderline type). It would appear that she was reviewed at an outpatient clinic during an episode of self-harming while intoxicated and it is described that this was the

third time that such behaviours had occurred within a week. She was admitted to hospital from an outpatient clinic on 31 December 2013. Various conditions were placed upon her in relation to this admission. Unfortunately Ms Kennedy broke the terms of those conditions by inflicting superficial cuts to her face and both legs, although she denied any suicidal ideation, plans or intent at that time. She was also noted to be intoxicated with alcohol. Her diagnosis on discharge at that time was of alcohol misuse and personality disorder.

[13] In his report, Dr Alcock records that on 2 January 2014 Ms Kennedy was seen at the A&E department having engaged in self-harming by cutting her face and legs. She was noted to have been consuming alcohol. At this time it was noted that Ms Kennedy's self-harming, although provocative, alarming and disfiguring, was not a means to end her life. On 25 January 2014 care workers noted that Ms Kennedy continued self-harming as well as using alcohol and drugs and being arrested by the police. It was felt she might benefit from some psycho-educational work regarding self-harming and borderline personality disorder. On 5 February 2014 the procurator fiscal at Kilmarnock contacted health services to express concern about Ms Kennedy's self-harming behaviours and her historic behaviours whilst in custody. On 10 February 2014 a referral was made to the forensic mental health team court liaison service. This resulted from Ms Kennedy having self-harmed while in police custody.

[14] In his report, Dr Alcock notes that Ms Kennedy was well known to prison officers and nursing staff at Cornton Vale. Her first admission to Cornton Vale occurred in November 2011. It was noted that during her two more recent admissions to prison

Ms Kennedy had repeated contact with members of the health care team based in the prison. When admitted on 22 August 2014 she was placed on ACT with 15 minute observations. She was removed from ACT on 26 August 2014 having been subject to an ACT case conference and she was described as being more settled and happy in the Skye House accommodation block. Following this on 25 September 2014 she was placed on ACT with 30 minute observations although these were removed the subsequent day following a case conference. At the point of her release on 21 October 2014 a note was made by the nursing staff member who recorded that there was no apparent risk of suicide and that Ms Kennedy denied any thoughts of deliberate harm or suicide. The nursing staff member recorded that Ms Kennedy was relaxed and chatty.

[15] When Ms Kennedy was returned to Cornton Vale on 21 October 2014 she was reviewed at that time through ACT by a prison officer in reception and subsequently by a member of the nursing staff. Both the prison officer and the nurse recorded that Ms Kennedy expressed no active thoughts of self-harm or suicide. The nurse noted that there were "no concerns raised at this moment in time". When Ms Kennedy was fully committed at Kilmarnock Sheriff Court on 28 or 29 October 2014 she should have been reviewed again on her return to Cornton Vale. Unfortunately the documentation relating to her reception on those dates could not be traced. The enquiry did have the benefit, however, of the evidence of two prison officers who had dealings with Ms Kennedy in the days prior to her death. Officer Catherine McGregor gave evidence to the effect that she had known Ms Kennedy for a couple of years. She described a Halloween party on 31 October 2014 which Ms Kennedy attended and participated in.

On 1 November 2014 Officer McGregor spoke to Ms Kennedy. They were joking and Ms Kennedy seemed in good spirits. Later that day, Officer McGregor carried out a final check of Ms Kennedy's cell during lock up. Officer McGregor recalled having a conversation with Ms Kennedy who had thanked her for leaving a newspaper for her. At no point over these two days did Ms Kennedy give Officer McGregor any cause for concern. It was Officer McGregor's evidence that she had placed prisoners on ACT, and now Talk to Me, on many occasions. She confirmed that if a prisoner requested to share a cell with another prisoner, then consideration would be given to this. However, it was Officer McGregor's position that if she had any concerns about a prisoner the more appropriate action would be to initiate the ACT process. Officer McGregor's position was that there were a number of prolific self-harmers in Cornton Vale but that this did not necessarily indicate that the prisoner was suicidal.

[16] The second prison officer to give evidence was Carol-Anne Murray. In her evidence she outlined the differences between Ross House and Skye House. If a prisoner is deemed to be at risk of self-harm or suicide, they will be located in Ross House. She described the environment in Ross House as being louder and the safer cells within Ross House being very bare. She indicated that this could be detrimental to those who did not require being in such an environment. In addition to the evidence of Officers Murray and McGregor, the inquiry had the benefit of statements from other prisoners who were friendly with Ms Kennedy. It is clear from those statements that her fellow prisoners did not have any concerns about her behaviour on the evening of 1 November 2014. There is a reference in Dr Alcock's report to his having reviewed

witness statements from prison office staff, health care staff and fellow inmates. Dr Alcock had noted that there was a great degree of uniformity in the accounts given, in particular the views expressed appeared to indicate that none of the witnesses suspected that Ms Kennedy would have committed suicide. Dr Alcock noted that the witness statements given by prisoners who had contact with Ms Kennedy in the hours prior to her death indicate that Ms Kennedy presented to them in no different fashion from previously. Dr Alcock's conclusion was that it would appear that there was no indication in Ms Kennedy's demeanour or conversations with others to suggest the action that she would then take.

[17] Ms Kennedy left two notes. The first note was addressed to the prison staff and the second to her mother. In the note to staff there is the following passage:

> "I know by the choice I've made it's going to raise loads of questions. I am sorry about that. But they must know that there was absolutely nothing yous could have done differently to prevent this from happening…for the upcoming days I really did manage to bluff my way into having everyone to believe there was no reason to have any concerns about me or my safety;…I might be one of the first to go in the prison's defence by saying this…but this place has improved a lot in almost every aspect I guess…the staff, the managers, the governors, the opportunities they've all made with this place way easier to live in, it's not even in the list of the reasons why I've done what I did. I'm just sorry it had to be in here that it's happened."

[18] On the morning of 2 November 2014, shortly after 0830 hours, staff undertaking their morning checks opened Ms Kennedy's cell and discovered her suspended by a bedsheet around her neck, the sheet having been twisted into a ligature and tied in a loop through the top of the bed frame, approximately 5 feet above the floor. She was noted to be slumped forwards away from the bed with her feet resting slightly on the

floor. The ligature was subsequently cut from around her neck, and she was placed on her back and resuscitation initiated, a paramedic in attendance soon after declared her dead there at 0850 hours that day. A post-mortem examination was carried out on 6 November 2014 by Dr Robert Ainsworth. At autopsy, she was found to have a somewhat ill-defined band of partmented abrasion (ligature mark) extending across the front of her neck, the mark rising towards an apparent suspension point at the back of her head. There was also a further patterned bruise on her right lower neck, and periorbital and conjunctival petechiae. Internally within the neck, there were no further injuries. Dr Ainsworth concluded that these findings would be consistent with Ms Kennedy's death being due to ligature suspension-hanging, with the comparatively ill-defined nature of the ligature mark being consistent with the use of a soft ligature such as a twisted sheet, as reported. Dr Ainsworth found no other significant fresh injuries although he noted that there were numerous scars on her face, trunk and limbs in keeping with the history of previous self-harm. Post-mortem toxicology identified only therapeutic levels of two medications – mirtazapine and propranolol. Dr Ainsworth certified the medical cause of death as being 1a hanging.

Mother's evidence

[19] Ms Kennedy's mother, Margaret Dryden gave evidence on the first day of the inquiry. She described how her daughter changed after going to secondary school; she became withdrawn and also became volatile. She would fight with her brother and when she was aged 13 she had stabbed him in the shoulder. This had led to her being in

and out of care. Ms Dryden described how her daughter did not have a normal teenage life. She indicated that her daughter had started self-harming when she was about 13. This had resulted in her being in and out of hospital. She confirmed that until her death there had been no previous attempts at suicide.

[20] Ms Dryden said that her daughter's focus after being returned to prison in August 2014 was on being released. When she was arrested on the day of her release and returned to prison this made her angry and upset.

[21] Ms Dryden explained that she was concerned when she heard that her daughter was in a cell on her own. She was aware that her daughter had on previous occasions been in what she described as a non-ligature cell where you could not harm yourself with anything. She also understood that her daughter had been sharing a cell in the past which Ms Dryden thought was safer for her daughter as she thought that cell mates would look after each other and provide mutual support. She was also concerned that her daughter was in the cell with a bunkbed. This provided her with the means by which she managed to hang herself. Given that it was known that her daughter was someone who could act impulsively, Ms Dryden questioned the appropriateness of putting her in a cell on her own.

Submissions

[22] On behalf of the Crown it was submitted that the court should make a formal determination as to the place, time and cause of death but that there were no grounds for making any recommendations or for identifying any precautions which could

reasonably have been taken which, had they been taken, might realistically have resulted in the death being avoided. With regard to the missing ACT paperwork from 28 and/or 29 October, it was accepted that this was regrettable. However it was submitted on behalf of the Crown that there was no evidence to suggest that Ms Kennedy should have been on ACT at the time of her death. The evidence established that ACT is a continuing process and any staff member can put a prisoner on ACT at any time and it did not have to happen purely at the point of reception. It was submitted that the evidence pointed to there being no reason for prison or medical staff to suspect that Ms Kennedy was about to take her own life.

[23] With regard to the issue of cell sharing, it was pointed out that Ms Kennedy had not requested to share a cell and that if she had, and another prisoner was willing to share with her, then this would have been considered. However, it was submitted that the sharing of cells is not a reasonable precaution which should have been taken nor could it be said that there was a real or likely possibility that Ms Kennedy's death would have been avoided if she had shared a cell.

[24] With regard to the standard of psychiatric care that Ms Kennedy received whilst in Cornton Vale, the Crown submitted that the evidence clearly pointed to staff within Cornton Vale being aware of Ms Kennedy's past medical history and of her diagnosis of emotionally unstable personality disorder borderline type. There was a clear consensus amongst medical professionals that Ms Kennedy was not suffering from an active mental illness. Accordingly, as there was no evidence to suggest that Ms Kennedy was

likely to take her own life, it would have been extremely difficult, if not impossible, for those around her to have been able to act in order to prevent this tragic event.

[25] On behalf of the Scottish Prison Officers Association it was submitted that there were no "cues or clues" – which prison officers are trained to identify – that Ms Kennedy was planning to commit suicide. Had staff thought there was a concern or risk, they would have initiated the ACT policy. With regard to cell sharing, it was submitted that it would have been entirely inappropriate for another prisoner to be given the responsibility of looking after a fellow prisoner. It was further submitted that there were no defects in any system of working used by prison officers which contributed to Ms Kennedy's death. The court was invited to accept the evidence that all prisoners – regardless of why they had been out of the prison – were subject to a risk assessment carried out by a reception officer and then by a nurse. It was admitted that all available evidence was that on each occasion that Ms Kennedy returned to Cornton Vale in October 2014 she was deemed low risk. Being deemed low risk, she was allocated to Skye House, where she was allocated a specific cell. At that time all cells within Skye House had bunkbeds and all cells could hold two prisoners. Ms Kennedy was allocated a double cell on her own but raised no concerns about being in a cell on her own. It was submitted that it would be entirely unworkable for every prisoner with a history of self-harm, suicide, or mental health problems to be subject to special observations or measures. In addition, there was evidence to the effect that there can be severe negative consequences to placing a prisoner on ACT and moving them to a non-ligature cell which would be a bare cell, with little or no items in it and anti-ligature

clothing and bedding which is very different to normal clothing and bedding. In addition, placing a prisoner in Ross House could be distressing due to the nature of the women housed there. It was submitted that prisoners should not be placed in such an environment unless there was a risk identified at that time and there was a need for measures to be taken for their own safety.

[26] On behalf of Forth Valley Health Board it was submitted that formal findings only should be made. It was submitted that no evidence was led to challenge the decisions of any staff members following Ms Kennedy's admission to Cornton Vale on 21 October 2014 (and then her return on 28 and/or 29 October) not to place Ms Kennedy on ACT. Reference was made to the evidence to the effect that all operational staff were trained in ACT and had they had any concerns they would have placed Ms Kennedy on ACT.

[27] The submissions on behalf of the Scottish Prison Service were to the effect that the evidence supported the conclusion that Ms Kennedy did not present as suicidal or at risk of self-harm from the day of her admission on 21 October 2014 to the day of her death. It was submitted that Ms Kennedy was familiar with the prison environment and had built a rapport with staff and prisoners in her hall. She had not been placed on ACT during this period because she did not give anybody any cause for concern.

[28] With regard to the failure to locate the ACT risk assessment from 28 and/or 29 October 2014, it was submitted that the absence of this documentation could not be found to have a causal link to Ms Kennedy's death. It was submitted that the evidence detailed the dynamic nature of the ACT policy which could be initiated by any member

of staff at any time. It was submitted that Ms Kennedy gave no indication to anyone that she would take her own life. Similarly, it was submitted that Ms Kennedy being placed in a cell with a bunkbed on her own could not be causally linked to her death. The evidence pointed to the fact that it could be dangerous to "buddy up" two prisoners. The more appropriate option was to initiate the ACT process. This was due to prisoners having a potentially negative effect on each other and, in addition, to it being inappropriate to place such a heavy burden on a fellow prisoner.

[29] In his written submissions on behalf of Ms Kennedy's mother, Mr Forbes raised his concern about the delay in holding an inquiry. Ms Kennedy had died on 2 November 2014 and there was then a period of over four years before the matter fell to be considered at an inquiry. It was submitted that a delay in matters being brought to an inquiry can be problematic for a number of reasons. Firstly, it could prove prejudicial to certain aspects of the inquiry itself if, for example, potential witnesses leave their positions, or, as occurred in this case, paperwork which may have had a bearing on the inquiry could not be traced. Secondly, this can result in a delay in relation to the implementation of any recommendations felt necessary in light of the conclusions of the inquiry. Thirdly, there is the issue of the interests of the family who can find that they require to revisit clearly traumatic events a number of years after they occurred.

[30] Mr Forbes accepted that, to a limited degree, one of the delays in this matter was attributable to the fact that he did not receive instructions to represent Ms Dryden until July 2018 with the result that the hearing originally arranged for August 2018 fell to be adjourned.

[31] Mr Forbes then directed his submission to two points in particular. The first concerned the arrangements in the cell within Cornton Vale which Ms Kennedy was occupying at the time of her death. She had hanged herself by tying a ligature made from her bed sheet to the metal frame of the top bunk of a two bed bunk-bed situated within her cell. Given that Ms Kennedy was a young woman with a considerable number of difficulties including a lengthy history of self-harm and given that she had in the past been identified as a possible suicide risk and had in the past been made subject to ACT restrictions, it was submitted that the court should consider whether it was appropriate for Ms Kennedy to be allocated a cell containing what appeared to have been a means to affect her eventual suicide, that is to say the double bunkbed and accompanying bedding from which a ligature had been constructed.

[32] The second point which Mr Forbes raised concerned the absence of documentation in relation to Ms Kennedy's reception at Cornton Vale on 28 and/or 29 October 2014. He submitted that if the normal procedure had been followed then it was to be expected that there would have been a record of same by way of two duly completed ACT forms. It was submitted that the absence of the ACT forms for 28 and/or 29 October 2014 represented a major omission in the case as "if same had been available they would have been indicative of any position reflected by the deceased together with the observations of those carrying out the assessment only a few days prior to her taking her life". It was submitted that there may be three explanations for the non-appearance of those forms: the procedure was not carried out at all; that the procedure was carried

out but no written record completed; or that the forms were completed in the course of the procedure but were subsequently lost.

[33] In so far as any recommendations in terms of section 26(1)(b) in relation to the assessment issue, Mr Forbes noted that this would appear to be a situation where the circumstances surrounding the incident had been superseded by events given the delay in the matter coming before the court. This was a reference to the fact that a new assessment procedure was being introduced by the Scottish Prison Service and therefore Mr Forbes submitted that any recommendations relative to any perceived deficiencies in relation to the form of procedure might have little effect. Nonetheless, he felt it right to raise his concerns in relation to the question of record keeping.

Discussion and conclusions

[34] The absence of the ACT documentation from 28/29 October is unfortunate. However, I have no reason to suppose that the correct procedures were not applied on those dates. In any event, I am satisfied from the evidence of staff and fellow inmates that in the days leading up to her death Ms Kennedy was not presenting as someone who required to be made subject to the ACT process. I am also satisfied that if Ms Kennedy had been assessed as being at risk the only appropriate course of action would have been to place her under observation in a non-ligature cell. It would not have been appropriate to place her in a cell with another prisoner solely for the purpose of having that prisoner support Ms Kennedy and prevent her, should the circumstances arise, from taking her own life.

[35] I cannot make a finding that if Ms Kennedy had been placed in a cell with another prisoner this would have prevented her from committing suicide and, in any event, I am satisfied that this would not have been a reasonable precaution which should have been taken.

[36] That then leaves the question whether it would have been a reasonable precaution not to place Ms Kennedy in a cell with a bunkbed. As it appears that all cells within Skye House contained bunkbeds, the only alternative to placing her in a cell in Skye House would have been to place her in a cell in Ross House. However, I do not consider that that would have been a reasonable precaution. I am satisfied that Ms Kennedy should only have been placed in Ross House if she had been assessed as being at risk of suicide or self-harm. As she was not assessed as being at risk, I am satisfied that it was reasonable to place her in Skye House.

[37] The only remaining question then is whether the mere fact of having bunkbeds in Skye House was in some way a defect in the system of working. The argument being that if someone wishes to commit suicide by hanging, the existence of a bunkbed and bedding provide the means to do so. I am not persuaded however, that the evidence allows me to identify this as a defect in the system. The evidence presented to the inquiry did not address the alternative means by which someone could hang themselves. Equally it did not address the other methods by which someone could commit suicide. It is clear from the notes left by Ms Kennedy that she had resolved to commit suicide. In the circumstances, I am not satisfied that the mere fact of there being

bunkbeds in cells represents a defect in the system of working which contributed to her death.

[38] As I am satisfied that (1) there were no grounds for initiating the ACT procedures and (2) it would not have been appropriate to place Ms Kennedy in a cell with another prisoner as an alternative to initiating the ACT procedures, I have not been able to identify any precautions that could reasonably have been taken, and had they been taken, might realistically have resulted in the death being avoided. Equally, I have not identified any defects in the system of working that contributed to the death. The only possible defect drawn to the inquiry's attention related to the use of bunkbeds which, as in this case, could be used to facilitate hanging. However, I am not persuaded that this was a defect as such. Regrettably, there are many ways in which a person intent on committing suicide can do so, and many everyday objects that can be utilised. I understand that the new facilities planned for Cornton Vale will result in all cells being for single occupancy. Accordingly, even if I had considered the use of bunkbeds to be a potential hazard, that would not have resulted in my recommending any improvements to the system of working that are not already in contemplation.

[39] In conclusion, I would wish to offer my condolences to Ms Kennedy's family for their tragic loss. I should also record that I share their concern over the delay in the holding of the inquiry, although I accept that this was partly due to the need to obtain a second independent expert report from Dr Alcock after the expertise of the first expert instructed by the Crown was questioned in an inquiry in 2017 into another death.