SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT FALKIRK

[2025] FAI 6

FAL-B118-23

DETERMINATION

BY

SHERIFF SG COLLINS KC

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

into the deaths of

KATIE ALLAN and WILLIAM BROWN

Falkirk, 13 January 2025

The sheriff, having considered the information presented at the Inquiry, determines as follows[1]:

(A) STATUTORY FINDINGS

In terms of section 26(1)(a) of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the 2016 Act"), the following findings are made in relation to the circumstances mentioned in section 26(2):

1. In terms of section 26(2)(a) (when and where the deaths occurred):

    a. Katie Allan, date of birth 25 April 1997 ("Katie"), died in in cell 1/33, Blair House, HM Prison and Young Offenders Institution Polmont, Redding

[1] Given the length of this determination a table of contents and summary are appended.

Road, Brightons, Falkirk ("Polmont") sometime between 2010 hours on 3 June 2018 and 0550 hours on 4 June 2018, her life being pronounced extinct at 0610 hours on 4 June 2018;

b. William Brown (also known as William Lindsay), date of birth 20 October 2001 ("William"), died in cell 2/45, Monro Hall, Polmont, sometime between 2055 hours on 6 October 2018 and 0740 hours on 7 October 2018, his life being pronounced extinct at 0755 hours on 7 October 2018.

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

a. Katie's death was self-inflicted, and not the result of any accident.

b. William's death was self-inflicted, and not the result of any accident.

3. In terms of section 26(2)(c) (the cause or causes of the deaths):

a. The cause of Katie's death was hanging.

b. The cause of William's death was hanging.

4. In terms of section 26(2)(d) (the cause or causes of any accident resulting in the deaths):

a. Katie's death was self-inflicted, and not the result of any accident.

b. William's death was self-inflicted, and not the result of any accident.

5. In terms of section 26(2)(e) (any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the deaths, or any accident resulting in the deaths, being avoided):

a. As regards Katie:

(i) Katie could reasonably have been accommodated in a cell without a rectangular metal toilet cubicle door stop, located at more than 1.7m above floor level, which was readily capable of being used as a ligature anchor point without ingenuity or adaptation.

b. As regards William:

(i) William could reasonably have continued to be subject to contact/observations in accordance with the Scottish Prison Service ("SPS") Talk To Me suicide prevention strategy ("TTM")[2] following the case conference held at around 0945 hours on 5 October 2018.

(ii) William could reasonably have been reassessed under TTM after the said case conference, and contact/observations reinstated, in the light of information received by prison, healthcare, and social work staff in Polmont during the morning of 5 October 2018, being information received from William himself, his external social worker, and his Includem support worker.

[2] A table of abbreviations is appended.

(iii) William could reasonably not have been accommodated alone in a cell with a double bunk bed, which was readily capable of being used as a ligature anchor point without ingenuity or adaptation.

6. In terms of section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the deaths or the accident resulting in the deaths):

a. As regards Katie, the following defects in a system of working contributed to her death:

(i) There was no system in place within SPS to (i) regularly audit the physical environment of Katie's cell for the presence of ligature anchor points, and (ii) to remove such ligature anchor points as had been identified by the audit.

b. As regards William, the following defects in a system of working contributed to his death:

(i) There was no system in place within SPS to (i) regularly audit the physical environment of William's cell for the presence of ligature anchor points, and (ii) to remove such ligature anchor points as had been identified by the audit.

(ii) The system for sharing information with SPS by external agencies relevant to a risk of suicide in respect of young prisoners remanded or sentenced straight from court (rather than transferred from secure accommodation) was defective, such that available information relevant to William's risk of suicide did not accompany him to

Polmont, and was not otherwise readily available to prison staff following his admission.

(iii) The system within SPS at Polmont for sharing information received from external agencies relevant to a risk of suicide in respect of young prisoners was defective, such that information communicated to SPS officers in Polmont which was relevant to William's risk of suicide was not effectively shared or acted upon.

(iv) The system for actioning mental health referrals to the Forth Valley Health Board ("FVHB") mental health team at Polmont was defective, in that the emailed referral made in respect of William by social worker Andrew Doyle at around 1130 hours on 5 October 2018 was printed out and placed in a filing tray by an administrator, but not actioned by healthcare staff until 8 October 2018, by which time William was dead.

(v) The system for assessing the risk of suicide under TTM was defective in that it failed to require that William continue to be subject to TTM observations on 5 October 2018 in the absence of, and pending receipt of, information relevant to his risk of suicide from other parties who might have been involved in his care, in particular his family, social work services, mental health services, and/or third sector agencies.

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

a. As regards Katie, other facts relevant to her death are as follows:

(i) The documentation relative to the TTM reception risk assessment ("RRA") carried out at HM Prison Cornton Vale ("Cornton Vale") on 5 March 2018 was lost. In any event it would not have been accessible by SPS staff at Polmont following Katie's transfer there on 7 March 2018. Accordingly the information contained in this RRA documentation was not available to SPS staff (and in particular Katie's personal officers) to inform ongoing suicide risk assessment of Katie while she was in Polmont.

(ii) Katie's history of self-harm was not recorded on the RRA documentation completed by Alan Macfarlane, the mental health nurse who assessed her following transfer to Polmont on 7 March 2018. Nor was it brought to the attention of SPS staff by FVHB staff while she was in Polmont. Accordingly this information was not available to SPS staff (and in particular Katie's personal officers) to inform ongoing suicide risk assessment of Katie while she was in Polmont.

(iii) Entries recorded on the VISION healthcare system by Nurse Joanne Brogan on 27 April 2018, 23 May 2018, 26 May 2019 and 29 May 2018 were factually inaccurate insofar as they suggested that

Katie was being formally assessed and reviewed by the FVHB mental health team at Polmont. These inaccuracies were due in part to the need to select drop down options when inserting entries. They led Dr Fiona Collier, in particular, to assume that Katie was receiving formal assessment and ongoing support for her mental health by FVHB when in fact Nurse Brogan was not providing support on this basis.

(iv) There was a systemic failure by SPS staff in Polmont to use concern forms in accordance with TTM. Accordingly no concern forms were completed in respect of Katie while she was in Polmont, notwithstanding multiple occasions when they could or should have been completed. In particular such forms could or should have been completed (a) on 21 March 2018, following Katie's distress at being body (strip) searched; (b) on 8 April 2018 relative to her observed distress on that day; (c) on 12 April 2018, relative to the report of bullying recorded in the intelligence log; (d) on 27 April 2018, 1 May 2018, 4 May 2018 and 22 May 2018 relative to her observed distress due to her alopecia; (e) on 21 May 2018 relative to her reporting another prisoner's plans for suicide; (f) on 29 May 2018 following the hearing at which Katie's appeal was abandoned; and (g) on 3 June 2018 relative to reports of bullying. Accordingly the information giving rise to these concerns was not recorded as required by TTM,

and was not available to SPS staff (and in particular Katie's personal officers) to inform ongoing suicide risk assessment of Katie.

(v) As a result of all of the foregoing matters, there was no single, readily accessible source of all the information relevant to Katie's risk of suicide which was available to SPS staff in Polmont. There was therefore no system by which a proper, ongoing/dynamic assessment of her risk of suicide could be carried out, standing that such a system must enable the assessor to take account of all relevant history in relation to a prisoner, and assess changes in their risk and protective factors, as well as their self-report and non-verbal presentation.

(vi) The Death In Prison Learning Audit Review ("DIPLAR") conducted in relation to Katie's death failed to consider or make recommendations in relation to the ligature anchor point, and the ligature, which she had used to die by suicide.

b. As regards William:

(i) Brian Leitch, the mental health nurse carrying out the pre-case conference assessment of William on 5 October 2018, did not attempt to contact his social worker, even though his name and telephone number was known to him from a vulnerable prisoner report ("VPR") produced by Glasgow Health and Social Care Partnership ("HSCP") and which had accompanied William to Polmont.

(ii) Even assuming that the repeated, dangerous and spontaneous nature of William's previous suicidal and/or self-harming behaviour was discussed and disclosed to Nurse Leitch at the pre-case conference on 5 October 2018, this information was not recorded in the pre-case conference documentation, and so not available in writing for the other members of the case conference itself.

(iii) The case conference carried out on 5 October 2018 was not carried out properly in accordance with TTM: (i) not all the members of the case conference had read all the available paperwork; (ii) the prison officers in attendance, John Dowell and Natalie Cameron, overly deferred to Brian Leitch's views as mental health nurse, even though each of them was individually responsible for the decision; (iii) undue weight was placed on William's self-report and presentation in the absence of background information; (iv) no consideration was given to inviting William's social worker to participate; and (v) the case conference lasted only around 5 minutes, which was not long enough to properly explore the suicide risk which William presented.

(iv) The DIPLAR conducted in relation to William's death failed to consider or make recommendations in relation to the ligature anchor point, and the ligature, used by him to die by suicide.

(B) RECOMMENDATIONS

In terms of section 26(1)(b) 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, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances), the following recommendations are made:

1. Double bunk beds should be removed from all cells in any wing or hall within Polmont in which young prisoners are accommodated. SPS must take all necessary measures to ensure that no young prisoner is in future accommodated on a single occupancy basis in a cell in which there is a double bunk bed.

2. All door stops of the type identified in the book of photographs which forms Crown Production 92 (photographs 95 - 112), and which are of the same or equivalent design as the door stop used as a ligature anchor point by Katie, should be removed from all cells in Polmont and replaced with sloping door stops (such as that identified in the photograph in SPS Production 22/2), or an equivalent anti-ligature design.

3. SPS should take steps to make standard cells at Polmont safer by identifying and removing, as far as reasonably practicable, ligature anchor points present in such cells. In that regard it should:

    a. Develop a standardised toolkit for auditing cells for the presence of ligature anchor points. This toolkit should, in particular, (i) identify both obvious and potential ligature anchor points; (ii) specify whether such points are

inherent to the design of fixtures or fittings within the cell, or due to modification of, or damage to, such fixtures and fittings; (iii) provide a system of grading the level of risk in relation to each identified ligature anchor point (for example, by reference to the ease/level of ingenuity required to use it for self-ligature), and so provide a system of grading the level of ligature anchor point risk in relation to the cell as a whole;

b. Use the foregoing toolkit to conduct an audit of potential anchor ligature points within all standard cells. This should result in the production of a report detailing all obvious and potential ligature anchor points within each cell, identifying whether they are inherent to the fixtures and fittings within the cell or are due to modification or disrepair, and provide a grading of the risk for each identified ligature anchor point and for the cell as a whole;

c. In the light of the foregoing audit:

    i. As regards any ligature anchor points arising from damage to or modification of fixtures or fittings, (a) repair or replace same so as to remove or at least reduce the risk of ligature arising therefrom as soon as practicable; and thereafter (b) institute a policy of regular ongoing cell audit using the said toolkit so as to promptly identify and repair

or replace any further damage or modifications which have created further ligature anchor points;

ii. As regards any ligature anchor points arising from the inherent nature of fixtures or fittings, (a) develop and publish a plan for their phased removal, replacement or modification, again so as to remove or at least reduce the risk of ligature arising therefrom; (b) specify a timeframe over which this plan is to be implemented having due regard to available resources; (c) commence implementation, for example, beginning with removal, replacement or modification of those fixtures and fittings graded as presenting the highest level of risk pursuant to the said toolkit; and (d) publish annual reports of progress in implementation of the said plan;

d. Ensure that proposed fittings and fixtures in any new build or refurbished cells are audited using the said toolkit at the planning stage, and that any fittings or fixtures graded as presenting an inherent and significant risk of being used as ligature anchor points are not included within such cells when built or refurbished.

4. SPS should actively pilot and review use of in cell "signs of life" suicide prevention/monitoring technology in Polmont. SPS should not confine this pilot and review to Safer Cells but should also consider its use in standard cells. SPS should report the findings of this pilot and review, and any recommendations

arising therefrom, to Scottish Ministers, within 12 months of the date of publication of this determination.

5. SPS should review and revise its policy regarding permitting young prisoners to routinely have possession of items which are readily capable of being used as ligatures without ingenuity or adaptation, in particular belts and dressing gown cords. The new policy should contain a presumption, as regards young prisoners in Polmont, that they are not permitted to have possession of such items. That presumption should only be overcome in limited circumstances, for example where a healthcare professional has certified in writing that the prisoner is not at risk of suicide and that there is therapeutic reason for permitting them to have use of such items. The Prisons and Young Offenders Institution (Scotland) Rules 2011, SSI 2011/331 (as amended) ("the Prison Rules") should be amended accordingly.

6. SPS should undertake or commission a research project in relation to the availability and cost of alternative bedding materials for use in cells by young prisoners in Polmont. This should determine whether there are bedding materials available which, even if not certified as anti-ligature and inappropriate for use in standard cells (such as Crown Production 38) are nevertheless rip-resistant, to the extent that they are significantly less amenable to being cut or torn by a prisoner so as to form a ligature than are the bedding materials currently in use. SPS should publish the findings of this research project, and

review its choice of bedding materials in standard cells at Polmont in the light of it.

7. The Scottish Ministers ("SM") should put in place a system to ensure that all written information and documentation available to a court at time of remanding a young person, or sentencing them to custody, is passed to SPS with that young person on admission, whether physically or electronically, such that it can be considered when carrying out the RRA on that person. This should include, in particular, any written information or documents provided to the court by the young person or their representative, by social work or third sector agencies (including any criminal justice social work report ("CJSWR")), and by health care services (including any mental health assessments carried out relative to the person's fitness to appear in court).

8. SPS should introduce a secure electronic portal whereby social work, medical staff and third sector organisations can provide information relevant to a prisoner's suicide risk directly to Polmont, and a system whereby any such information received will be immediately drawn to the attention of the first line manager ("FLM") or nightshift manager of the hall where the prisoner is located, and recorded in a form which is readily accessible by SPS staff having contact with the prisoner.

9. SPS should provide a dedicated 24 hour telephone number by which family members can call into Polmont in order to notify a concern relevant to suicide risk which they may have in relation to a prisoner. This phone number should

be readily accessible on the SPS website, along with guidance as to its purpose and use. Where such a concern is received, an electronic concern form should be completed immediately, sent to the FLM or nightshift manager of the hall where the prisoner is located, and recorded in a form which is readily accessible by SPS staff having contact with the prisoner.

10. SPS should introduce a system so as to ensure, except where there is an over-riding requirement in relation to prison security in a particular case, that where intelligence information is received suggesting that a young prisoner has been or is being bullied it (or at least the gist of it) is promptly and proactively shared with the FLM of the hall in which the prisoner is located, and with SPS staff having contact with them.

11. SPS and the FVHB should review their guidance in relation to sharing of information in relation to young prisoners in Polmont, and training in relation thereto, so as to ensure that both prison officers and health care staff are aware of all relevant issues which may affect a prisoner's risk of suicide when assessing or reviewing his or her case.

12. FVHB should implement a system for ensuring that referrals received by the mental health team in Polmont are immediately passed to and reviewed by a mental health nurse and, where necessary, acted on without delay. Written instruction and guidance for relevant staff should be produced, and if necessary, training given thereon.

13. FVHB should provide further training to staff working within Polmont on the importance of accurate record keeping, with particular reference to the VISION system.

14. TTM should be revised as follows:

    i. TTM guidance should be amended to emphasise the increased risk of suicide (a) within a prisoner's first 72 hours in custody and (b) during the more restrictive regime in operation at weekends. TTM should provide as a default, and in the absence of exceptional circumstances to the contrary, that all young prisoners should be made subject to TTM for a minimum of 72 hours after admission to Polmont, and not removed from TTM thereafter until and unless a case conference has so decided.

    ii. All TTM risk assessment forms should be amended so as to contain a guided process for the assessor. This should include specific prompts, checklists, and questions to be answered and recorded, so as to better enable (i) the identification, assessment and recording of the prisoner's suicide risk and protective factors at the time of assessment; and (ii) ongoing assessment in the light of any changes in any of those factors thereafter.

    iii. Where a prisoner is assessed to be at risk of suicide, TTM initiation forms should be amended as to contain a guided process for the assessor in relation to care planning for a prisoner being made subject to TTM. This should include specific prompts, checklists, and questions to be answered

and recorded, so as to better enable the initiating member of staff to grade the level of risk presented and so put in place protective measures for the prisoner which are sufficient and proportionate to it.

iv. TTM should contain specific guidance to prison staff in relation to obtaining background information relative to a prisoner's suicide risk on admission, with express reference to the particular types of information which should be sought, when it is appropriate to obtain them, the process to be followed, and the person or persons who are responsible for doing so. In particular TTM should require staff to try to obtain background information relevant to suicide risk from the prisoner's family, and from relevant health and social care agencies, (i) where the prisoner is young, (ii) it is their first time in prison, and/or (iii) there is evidence which may suggest a history of self-harm or suicide attempts. In such circumstances, and pending receipt of such information, the default position should be that the prisoner is made - or should continue to be - subject to TTM.

v. TTM guidance as regards risk assessment should be amended so as to better emphasise the importance of reduction of the risk of self-ligature in the context of suicide prevention. All risk assessment forms should be amended to require the assessor to consider the cell environment in which the prisoner is (or is to be) accommodated, and to assess the ligature anchor point risk within that particular cell as part of the overall risk assessment.

vi. TTM guidance as regards ongoing risk assessment should be amended so as to better emphasise (i) the importance of obtaining background information in relation to a prisoner, (ii) identifying dynamic risk and protective factors in relation to the particular prisoner, and (iii) that a prisoner's self-report and non-verbal presentation in relation to a risk of suicide should not be taken as determinative, but must be considered in the light of such information. Where a prisoner is observed to be in distress such as should trigger the completion of a concern form, guidance should place a requirement on the officer concerned to review all TTM documentation in relation to the prisoner.

vii. In addition to the present system of suicide risk assessment based on RRAs and reactive day to day assessment by prison officers, TTM should include periodic proactive reviews and evaluations of a prisoner's suicide risk and protective factors in the light of all available information. This should include review of prisoners who are not currently subject to TTM, and be at such frequency as may be determined on a case by case basis.

viii. SPS should develop a new system of recording issues of concern which relate to a prisoner's suicide risk under TTM, so as to ensure that all relevant information in relation to such a risk is recorded in writing, collated in a single place, and is available to be periodically reviewed and assessed. Pending development of a new system of recording issues of concern, SPS should issue further guidance and provide specific training

so as to clarify when a concern form should be completed by prison staff and its importance and purpose for TTM. This should emphasise: (i) that concern forms should be used where prison staff have witnessed a prisoner in distress, and are not only for use by external agencies or staff without regular access to prisoners; (ii) that a concern form should be completed even where it is not thought that the prisoner is at risk of suicide; and (iii) the importance of accurate and timeous record keeping in relation to concerns relevant to ongoing assessment of suicide risk.

ix. SPS should develop a system of electronic recording for all TTM documentation, that is, relating to a prisoner's suicide risk assessment, recorded concerns and reviews, so as to ensure that all such documentation is not lost or mislaid, and is in any event readily accessible to frontline SPS staff.

x. A transitional care plan should continue to be mandatory for all young people removed from TTM, so as to ensure appropriate supports and follow-up checks are in place, and that their cell environment is appropriate in relation to potential ligature anchor points. Specific guidance and training should be provided on the options available to staff when compiling a transitional care plan for a young prisoner, including referrals to the FVHB mental health team, other agency referrals, counselling/other supports, or chaplaincy visits. This guidance and training should

emphasise the prevalence of suicide by persons who have previously been subject to TTM.

xi. TTM refresher training should be provided to all staff at a significantly greater frequency and/or duration than 2 hours every 3 years, the precise amount to be determined by the current TTM review. Training should place particular focus on ligature anchor point and ligature item risks, the importance of accurate record keeping, the importance of obtaining information from external agencies, how to properly conduct a case conference, the use of concern forms, and any changes implemented as a result of the ongoing TTM review and this inquiry.

15. Where a prisoner has died by suicide, the DIPLAR process must consider, and if so advised make recommendations, in relation to the safety of their physical environment with Polmont and the means by which they were able to complete suicide. Where suicide has been by self-ligature, the DIPLAR process must consider the ligature anchor point risk of the cell or other place in which the death by suicide took place, and the nature and availability of the item used as a ligature.

(C) THE INQUIRY - PROCEDURE AND EVIDENCE

[1] This Fatal Accident Inquiry ("FAI") concerned the deaths of Katie and William. They both died while in lawful custody at Polmont and, therefore, inquiries into their deaths were mandatory in terms of section 2(4)(a) of the 2016 Act. Although their deaths

were not directly connected a single inquiry was held, it appearing to the Lord Advocate that their deaths occurred in similar circumstances: 2016 Act, section 14. The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017, SSI 2017/103 ("the 2017 Rules").

[2] The First Notice of the inquiry was lodged on 23 May 2023. Why this was not done until almost 5 years after the deaths was not explained to me, and I was not invited to make any findings or recommendations in relation to this. However it is too long a delay, even allowing for the scale of the inquiry which has resulted. It is a matter of public record that several more young prisoners have died by suicide at Polmont since the deaths of Katie and William, and the recommendations made in this determination will be too late to try to prevent these deaths.

[3] A preliminary hearing under rule 3.8 of the 2017 Rules was held on 11 July 2023, at which time an evidential hearing was fixed to start on 8 January 2024. In preparation for this, further preliminary hearings were held on 15 September, 31 October and 18 December 2023.

[4] The evidential hearing, originally set down for 6 weeks, was concluded within 19 court days between 8 January and 1 February 2024. At this hearing I heard oral evidence from the following witnesses:

1) Linda Allan, mother of Katie
2) Stuart Allan, father of Katie
3) Alan Macfarlane, mental health nurse, who carried out the RRA of Katie on her admission to Polmont on 7 March 2018

4) Heather Morrison, prison officer, who was Katie's secondary personal officer

5) Joanne Brogan, mental health nurse, who provided support to Katie in April and May 2018

6) Dr Fiona Collier, who treated Katie for alopecia

7) Jennifer Wilson, prison officer, who was involved in supervising visits to Katie by friends and family

8) Megan Sandeman, a former prisoner, who was detained with Katie in Blair House between March and June 2018

9) Marie Doherty, prison officer, who was on duty in the visiting room on 3 June 2018, observed Katie's visit with Linda Allan that day, and subsequently took Katie back to Blair House

10) Scott Wilson, prison officer, who was Katie's primary personal officer

11) Donald Scott, prison chaplain, who met with and provided support to Katie while she was in Polmont

12) Caroline Tart, former prison officer, who was on duty in Blair House on the afternoon of 3 June 2018 and had contact with Katie following her return from the visiting room on that day

13) Thomas Coffey, prison officer, who worked as a residential officer in Blair House, Polmont, and had contact with Katie between March and May 2018

14) Stephen Cain, former project worker with Includem, who had provided regular support to William from 2016 onwards, and who provided

information about his suicide risk to Officer Ross Cormack on 5 October 2018

15) Lynne Watson, former prison officer, who was the last person to see Katie alive, following a check on her in her cell at around 2010 hours on 3 June 2018

16) Jane Goodsir, prison officer, who carried out the RRA of Katie following the abandonment of her appeal against sentence on 29 May 2018

17) Christopher McAinsh, prison officer, who carried out the RRA of William on 4 October 2018

18) Natalie Cameron, prison officer, who had contact with William in Monro Hall on the morning of 5 October 2018 and participated in his case conference

19) John Dowell, prison officer and FLM in Monro Hall, who participated in William's case conference on the morning of 5 October 2018

20) Tara Duthie, prison health care addiction worker employed by Signpost Recovery, a charity operating within Polmont, who carried out a routine addictions assessment of William on the morning of 5 October 2018

21) Nick Cameron, former prison Governor, who spoke to his reports on the adequacy of the suicide prevention systems in place in relation to both Katie (Crown Production 26) and William (Crown Production 52)

22) Mark MacDonald, William's social worker from October 2017, who provided information about him to Andrew Doyle on 5 October 2018

23) Andrew Doyle, a social worker based in Polmont, who spoke to Mark MacDonald on 5 October 2018 and then emailed a referral in relation to William to the FVHB mental health team

24) Robert Baird, former prison officer, who had contact with William in Monro Hall on 5 October 2018

25) Jill Morrison, prison officer, who was the last person to see William alive, having checked on him in his cell in Monro Hall at around 2055 hours on 6 October 2018

26) Lynsey Bland, prison officer, who was on nightshift duty in Monro Hall on the night of 6 to 7 October 2018

27) Anthony Martin, Head of Operations and Public Protection, Scottish Prison Service, and former Deputy Governor of Polmont between December 2021 and October 2023, who spoke to SPS operational and policy issues bearing on suicide prevention

28) Siobhan Taylor, National Suicide Prevention Manager ("NSPM") in the SPS headquarters health team, who spoke to policy and operational issues in relation to TTM;

29) Ross Cormack, former prison officer, who was on duty in Monro Hall on 5 and 6 October 2018 when William was accommodated there

30) Dr Mayura Deshpande, consultant forensic psychiatrist, Southern Health Foundation NHS Trust, who spoke to her reports on the risk assessment of Katie (Crown Production 23) and William (Crown Production 49)

31) Dr Martin Culshaw, consultant forensic psychiatrist, NHS Greater Glasgow, who spoke to his report regarding the risk assessment and treatment of Katie (Crown Production 21)

32) Rosemary Duffy, FVHB health care manager in respect of Polmont in 2018, who spoke to health care systems, processes and records in respect of Katie and William, and her involvement in the DIPLARs into their deaths

33) Professor Graham Towl, forensic psychologist, Durham University, an expert on suicide in prisons, who spoke to his reports on the adequacy and application of SPS suicide prevention policy to Katie (Crown Production 24) and William (Crown Production 50)

34) Natalie Beale, Governor of HM Prison Glenochil, and formerly Deputy Governor of Polmont between 2017 and 2020, who spoke to SPS policies and processes in Polmont during this time, and to her participation in the DIPLARs into the deaths of Katie and William, and

35) Dr Helen Smith, consultant child and adolescent psychiatrist, who spoke to her reports on the adequacy of the assessment and management of William whilst in Polmont (Crown Productions 47 and 48), and her involvement in the 2019 HM Inspector of Prisons in Scotland ("HMIPS") Expert Review Report into Mental Health services for young prisoners in Polmont ("ERoMH").

[5] An affidavit from the following witness was read into the record of the inquiry, and by agreement was taken to comprise his evidence in chief, cross examination being then taken by live CCTV link pursuant to a vulnerable witness application:

1) Brian Leitch, mental health nurse, who carried out a risk assessment of William on 4 October 2018, and who participated in his case conference the following day.

[6] Affidavits from the following witnesses were read into the record, and by agreement were taken to comprise their whole evidence:

1) John Reilly, half-brother of William, and
2) William Brown, senior, father of William.

[7] Statements taken from the following witnesses, by agreement, were read into the record and taken to comprise their whole evidence:

1) Stuart McQuarrie, deceased, former Glasgow University Chaplain, who visited Katie several times in Polmont
2) Lesley McDowell, former Head of Health Strategy, SPS, who until 2021 was policy manager for SPS suicide prevention strategy and for reviewing deaths in custody, and
3) Kirsty McIntyre, prison officer, relative to an entry made by her on the SPS computerised prisoner record ("PR2") in relation to Katie on 8 April 2018.

[8] Three lengthy joint minutes were agreed by the parties and read into the record:

1) Joint minute number one, dated 8 January 2024, which agreed matters relating to Katie and William's personal details and medical history, their

time in Polmont, their deaths, post-mortems, and the DIPLARs which followed. Parties also agreed that all productions were what they bore to be and that documentary evidence should be admitted to evidence without the need for it to be spoken to by its author

2) Joint Minute number two, dated 1 February 2024, which agreed general information about Polmont, TTM policy and guidance, RRAs, initiation of TTM, case conferences, prison officer training, developments in TTM since 2018, SPS and FVHB records systems, Polmont Standard Operating Procedures, and certain marks found on Katie's body post-mortem, and

3) Joint Minute number three, dated 8 January 2024, which agreed information in relation to William 's arrest and charge, his assessment by social workers, the involvement of the Scottish Children's Reporter Administration ("SCRA"), investigation into the (non) availability of secure accommodation, his court appearance and remand, and his transport to Polmont.

[9] The Crown helpfully produced a joint bundle of documentary productions for the inquiry (referred to in this determination as Crown Productions), but further inventories of productions were lodged by other participants, prior to and in the course of the hearing, in particular by SPS. In total, the documentary productions ultimately ran to around 5000 pages.

[10] At the conclusion of the evidential hearing on 1 February 2024, I gave directions to the Crown and SPS to identify and produce certain further evidence. A procedural

hearing was then held on 21 February 2024, and further evidence was led at a hearing on 17 April 2024. On this latter date I heard oral evidence from the following witness:

1) William McKean, an architect employed by SPS in its estates department, who spoke in particular to the ligature anchor point review report ("the LAP Review") which he and his colleagues had produced after conducting an audit at Polmont at the end of 2018.

[11] A fourth Joint Minute, dated 15 April 2024, was also produced. In this Minute parties agreed that the statements of the following witnesses, all lodged since the previous hearing, should be taken as their whole evidence to the inquiry:

1) Edward Hanna, Director of The Lava Group, a company which for 10 years has been developing contactless "signs of life" monitoring technology for use in medical, care and custodial settings
2) Detective Constable Gary Mackie, who attended at cell inspections carried out at Polmont on 8 March 2024
3) Gregg Pearson, Head of Professional and Technical Services within SPS, who assisted William McKean with the 2018 ligature anchor point audit at Polmont
4) Graeme Mitchel, Estates and Technical Services Project Sponsor within SPS, who is currently involved in investigating the potential use by SPS of "signs of life" technology being developed by a company called Safehinge Primera

5) Stephen Joseph Coyle, Head of Justice for SPS, who spoke to his involvement with the National Suicide Prevention Management Group ("NSPMG") and its awareness of issues relating to ligature anchor points, and

6) Michael Stoney, Governor of HMP Barlinnie, who spoke to the investigations being made for installation of new technology, including "signs of life" technology, in the proposed new HM Prison Glasgow.

Further productions lodged by SPS were also agreed, including certain photographs taken in Polmont since the previous hearing (in particular, photographs of a rectangular metal door stop identical to that used as a ligature anchor point by Katie).

[12] Following the hearing on 17 April 2024 a timetable was agreed for lodging and exchanging written submissions. These submissions ran to a total of around 300 pages. An oral hearing in relation to them took place on 25 June 2024, being the earliest date on which all leading counsel and solicitors were available. Thereafter I reserved my determination.

[13] In the inquiry the Crown was represented by Ms Cross, Senior Advocate Depute, assisted by Mr Halliday, Advocate. Katie's mother Linda Allan, her father Stuart Allan, her brother Scott Allan, and William's half-brother, John Reilly, were all represented by Ms McMenamin, KC, assisted by Mr Miller, Advocate. Mr Stewart, KC, assisted by Ms Smith, Advocate, represented William's father, William Brown Senior. Ms Davie, KC, assisted by Mr Dundas, Advocate, represented FVHB. Mr Reid, KC, assisted by Ms Arnott, Advocate, appeared for Scottish Ministers ("SM") as representing SPS.

Mr Rogers, solicitor, represented the Scottish Prison Officers Association and Officers John Dowell and Natalie Cameron ("SPOA"). Mr Pollock, solicitor, represented Mr Brian Leitch, mental health nurse.

[14] I would wish to repeat my thanks to all solicitors and counsel for their contributions to the inquiry, and also to all court staff involved for their work in managing the many administrative and practical difficulties which arose.

(D) LEGAL FRAMEWORK

[15] This is a FAI under the 2016 Act. It is inquisitorial in nature, not adversarial: 2017 Rules, paragraph 2.2. The Crown represents the public interest in such inquiries. The purpose of the inquiry is defined and circumscribed by sections 1(3) and 1(4) of the 2016 Act. It is to (a) establish the circumstances of the deaths, and (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It is not the purpose of an inquiry to establish civil or criminal liability.

[16] Although the scale and breadth of the issues covered might suggest otherwise, therefore, this is not a public inquiry initiated (or converted) under the Inquiries Act 2005, where the terms of reference might have been more broadly stated. It is not an inquiry into whether, for example, children or young adults should in principle be subject to detention in a young offenders' institution. It is not an inquiry into whether the courts were right to order that Katie and William be so detained. Nor is it an inquiry into the incidence and causes of suicide in Scottish prisons generally, or what might be done to prevent or reduce it. Its task is firstly a fact finding one, that is, to look back

and determine why and how Katie and William died. Thereafter it must attempt to look forward, and consider whether anything can be learned from their deaths which might prevent other young persons like them from dying in similar circumstances, that is, by suicide, while detained in Polmont. Insofar as any findings or recommendations may have wider application as regards SPS, FVHB, SPOA or the prison estate in Scotland generally, that is strictly speaking incidental, given the restrictions placed on the scope of the inquiry by the 2016 Act.

[17] That said, this was an unusual FAI. Since 2010 more than ten children and young persons have died by suicide[3] in Polmont, and more than a hundred prisoners have died by suicide across the whole Scottish prison estate. Each of these deaths will have generated a FAI under the 2016 Act and its predecessor, and hence a hearing of evidence followed by a determination from a sheriff. Yet seldom have such inquiries made significant findings in relation to precautions or defective systems of work, nor have they made substantial recommendations for a change of approach to suicide prevention[4]. Meantime deaths by suicide continue to occur in Scottish prisons, and at a rate which appears, as detailed below, to be markedly in excess both of the suicide rate in the Scottish population generally, and the suicide rate to be found in almost all other

[3] The expressions "committed suicide" or "completed suicide" are now recognised as inappropriate, and so have been avoided throughout this determination.

[4] I am conscious of the criticism that has been made by the Scottish Centre for Crime and Justice Research of both the process and outcomes of FAIs in relation to deaths in custody - and to which both of Katie's parents have contributed: see for example *A Defective System: Case Analysis of 15 years of FAIs in Scotland* (October 2021), and most recently *Nothing to See Here? Deaths in Custody and FAIs in Scotland* - 2023 (February 2024). These are thought provoking reports, but this is not the time or place to try to address all the criticisms made in them.

prison populations in Europe. Moreover, again as detailed below, the number of such deaths may be increasing.

[18] Notwithstanding all this, previous FAIs into the deaths of young prisoners like William have in the past not shone much light on suicides in Polmont, in the sense of attracting much national media attention to them, or leading to calls for a change of approach by SPS in relation to its suicide prevention policies. Katie's death, however, and the subsequent campaigning work by her parents Linda and Stuart Allan, has prompted a more fundamental examination of the issues. Hence the substantial public resource and effort that has been put into this FAI. There was an acceptance by the participants, in the light of this, that I should therefore take a relatively expansive approach to consideration of the issues. That approach was supported by SPS, and was reflected in the helpful and constructive approach to the issues taken by its counsel throughout the inquiry.

[19] It remains necessary to remember that a FAI is not for the purpose of attributing fault, whether to individuals or institutions. It is not about seeking to hold any person or institution "to account" for the deaths, nor to "hold them responsible". That is simply not its function. But if the evidence presented does establish that the deaths arose due to fault, whether because an individual did not do what they should have done under an existing system, or because the system was defective in requiring them to do what they did, then the determination of the inquiry should say so. Although such a finding cannot amount to a finding of civil or criminal liability, the inquiry is not to be inhibited

in the discharge of its functions by any likelihood of liability being inferred from facts that it determines or recommendations that it makes: cf Inquiries Act 2005, section 2(2).

[20] A related issue was raised by Katie's next of kin in their submissions to the inquiry. That is the question of whether SPS or its employees could or should be subject to criminal proceedings in relation to deaths such as those in the present case, or whether they enjoyed Crown immunity therefrom.

[21] As I understand it - I was not given detailed submissions on the relevant law - there is no such immunity in relation to the Corporate Manslaughter and Corporate Homicide Act 2007 - see section 11. But in practical terms the offence created by the 2007 Act is difficult to prove (see in particular sections 1(1)(b) and 1(3)), and so is seldom prosecuted. Nor, in principle, does SPS have Crown immunity from the onerous requirements of the Health and Safety at Work Act 1974, but it cannot be prosecuted for breaching its duties under this Act, merely censured by the Health and Safety Executive[5]. This might appear anomalous, particularly given that NHS Trusts no longer have such protection, and indeed have been successfully prosecuted and fined in relation to in-patient suicides arising from a failure to adequately manage ligature anchor points in secure mental health wards: see *R (HSE)* v *Essex Partnership University NHS Foundation Trust*[6].

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[5] The inquiry was not provided with any information as to whether such a censure was considered or made in relation to Katie or William's deaths.

[6] https://www.judiciary.uk/wp-content/uploads/2022/07/R-v-Essex-Partnership-NHS-Trust-sentencing-remarks-16Jun21.pdf; and see generally McNeill, *Prisoner Suicides: why is the Prison Service immune from failure?* BCL News, 23 November 2023.

[22] The potential relevance of this issue in the inquiry might perhaps have lain in whether the failure of SPS to take steps by which the deaths of Katie and William might have been avoided was contributed to in some part by its immunity from prosecution under the 1974 Act. For example, it might have been argued that SPS had to some extent an institutional culture resulting from such immunity in which there were insufficiently robust systems for attributing responsibility for individual failures and attaching sanctions thereto. It might perhaps have been suggested that the removal of Crown immunity from SPS under the 1974 Act could serve, as it may have done in the health sector, as a potentially important tool in driving up health and safety standards, particularly in relation to provision and maintenance of a safer prison environment in which the possibility of a prisoner dying by suicide might be reduced. But this was not formally raised as an issue for the inquiry. And although touched on in the submissions on behalf of Katie's next of kin, I was ultimately not asked to make any findings or recommendations in relation to it. Accordingly I do not do so. It is a complex issue which might bear consideration on another occasion. I express no view on it.

[23] The manner in which evidence is presented to an inquiry such as this is not restricted. Information may be presented in any manner, and the court is entitled to reach conclusions based on that information: see rule 4.1 of the 2017 Rules. Accordingly, and as noted above, I had extensive oral evidence, including evidence taken via live links, affidavit evidence, witness statements accepted in lieu of oral evidence, and numerous productions whose provenance and contents were agreed without the need for them to be spoken to by witnesses. I also, ultimately, had

four detailed joint minutes pursuant to rule 4.10. While helpful in cutting down the length of the evidential hearing, and representing the agreed position of the participants on the matters contained therein, these minutes were not formally binding on me, in the sense of requiring me to accept some or all of the facts contained therein without qualification. An FAI which uncritically accepts a set of facts agreed by participants, some or all of whom may have an interest in avoiding judicial criticism in relation to a death, is likely to be no proper inquiry at all.

[24] Section 26 of the 2016 Act sets out what must be determined by a FAI, as follows:

> "26 The sheriff's determination
>
> (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.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to—
(a) a participant in the inquiry,
(b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature."

[25] In considering what did or did not happen in relation to the circumstances of the deaths, as matters of fact - for example, the time, place and direct cause of death in terms of sections 26(2)(a) to (c) - the court will simply exercise its traditional fact finding function. It will decide what evidence to accept, what to reject, and make findings in fact accordingly. The standard of proof is on balance of probabilities. However in considering section 26(2)(e) of the 2016 Act the court must decide whether there were any precautions which "could reasonably have been taken" and which, "had they been taken, might realistically have resulted in the death… being avoided". This requires not only an exercise in fact finding, but also a judicial assessment of - in effect - a conditional counterfactual: if x had been done, might y not have occurred? Reference to an evidential standard of proof is not appropriate in relation to this assessment.

[26] The wording of section 26(2)(e) of the 2016 Act can be contrasted with that used in the preceding legislation, that is, section 6(1)(c) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("the 1976 Act"). This required there to be a finding

made as to "the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided". Reasonableness, in the 2016 Act, now qualifies the taking of the precautions rather than the precautions themselves. It is now sufficient that precautions "could" reasonably have been taken. "Might" has become "might realistically". But ultimately, and after some consideration, it seems to me that these changes are largely either distinctions without substantive differences, or seek to clarify in statutory form the substance of the way in which most (but not all) sheriffs had interpreted section 6(1)(c) of the 1976 Act[7]. Therefore observations made in determinations under that Act can continue, with caution, to guide the correct approach to section 26(2)(e) of the 2016 Act.

[27] In particular, it remains true, as has long been recognised, that a FAI is very much an exercise in applying the wisdom of hindsight[8]. The court proceeds on the basis of the evidence and information adduced as to what is now known, not the state of knowledge at the time of the death. The statutory provisions are concerned with the precautions which could reasonably have been taken at the time of the death, and not with whether they were, or ought to have been, recognised and acted upon. It does not matter whether it was or was not reasonably foreseeable at the time that if the identified precautions were not taken, that death would result, reasonable foreseeability being a concept relevant to a fault finding exercise, not a FAI.

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[7] This is confirmed by the Policy Memorandum which preceded the introduction of the 2016 Act, which notes (at paragraphs 178 - 179) that Lord Cullen's 2009 Report "*Review of Fatal Accident Inquiry Legislation*" had specifically recommended changing the wording of section 6 of the 1976 Act to clarify its meaning, not to change it.

[8] *Determination into the death of Sharman Weir*, 23 January 2003, Sheriff FL Reith, QC, Glasgow Sheriff Court.

[28] However it is not every precaution which might conceivably have been taken that justifies a finding under section 26(2)(e). First, it must be a precaution which arises from and is supported by the evidence adduced at the inquiry and reasonable inferences drawn therefrom, not from the use of speculation or creative imagination on the part of the sheriff. Second, it must be a precaution that could reasonably have been taken, that is, it must have been available, suitable and practicable, even if not one that was required or indicated by guidance or practice at the time[9]. Third, the precaution must be one which if taken might realistically have resulted in the death being avoided. Accordingly it is not necessary for the court to be satisfied that the precaution would necessarily have had this result, or even that it would probably have done so. What is required is rather a realistic possibility that the death might have been avoided, or put in other ways, an actual rather than a fanciful possibility, a real rather than a remote chance[10].

[29] Fourth, what has to be considered is whether the precaution might have avoided "the" death, that is, the death which actually occurred. Accordingly, if otherwise justified, a finding under section 26(2)(e) should still be made even if the evidence indicates that had the deceased not died when and how they did, that they would or

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[9] *Determination into the death of George Bartlett* 11 April 2022, Sheriff Miller, Aberdeen Sheriff Court.

[10] Sheriff Kearney used the oft quoted expression "lively possibility" as signifying something less than a probability in the context of section 6(1)(c) of the 1976 Act: *Determination into the death of James McAlpine,* 17 January 1986, Glasgow Sheriff Court, referred to in Carmichael, *Sudden Deaths and Fatal Accident Inquiries*, 3rd edition, paragraph 8-99. This expression was described as "entirely apt and … consistent with the language of section 6(1)(c)" in *Sutherland* v *Lord Advocate* 2017 SLT 333, at paragraph 31 (a judicial review of a sheriff's determination in a FAI under the 1976 Act). "Realistic possibility" appears to me to be an expression more in keeping with the language of section 26(2)(e) of the 2016 Act, but I doubt that there is any real difference.

might well have died in another way in any event. If, for example, an employee dies because of a fault in a piece of factory machinery, it is no answer to a submission that a finding under section 26(2)(e) should be made in relation to a failure to fix that fault, to point out that there was another, separate fault in the machine which would have been fatal to the employee anyway. To hold otherwise would, in effect, to make no finding in relation to an actually lethal fault for which the employer was responsible because it was also responsible for another potentially lethal fault. It would be to ignore a failure to take one reasonable precaution because of a failure to take another. For reasons I will come on to, this point has particular relevance in the present inquiry as regards the availability of ligature anchor points and ligature items in Polmont.

[30] In relation to section 26(2)(f), the question of whether "any defects in any system of working… contributed to the death…" is a matter of fact. The evidence relating to this issue should be assessed and findings made on a balance of probabilities. A defect may consist in the absence of a proper system of working, not merely a defect in a system which already exists. A system may also be classified as defective not because of what it stipulates as a matter of form, but because those charged with operating it routinely fail to do so without effective correction or sanction.

[31] The use of the word "contributed" points toward a causal relationship between an identified defect and the death. However a defect may "contribute" to a death without being the only or main cause of it. Nor is it necessary to conclude that "but for" the defect the death would not have occurred. It is sufficient that it was at least a

significant or material cause, whether alone or in combination with other factors, but not so remote from the death as to have played no real part in it.

[32] Under section 26(2)(g) the court is required to record "any other facts which are relevant to the circumstances of the death." This invites, in particular, the formal recording of matters which have been shown to be relevant to the death in relation to reasonable precautions or defective systems of work, but where the necessary causative connection for a finding under sections 26(2)(e) or (f) is absent. In other words, it enables the court to highlight a precaution which it would have been reasonable to take, even it has not been established that there was a realistic possibility that the death might have been avoided if it had been. Similarly, it enables the court to identify a defect in a system of work, even if it has not been established that this defect contributed to the particular death. Accordingly section 26(2)(g) provides another way in which the inquiry can enable lessons for the future to be learned from the circumstances of the death.

[33] Sections 26(1)(b) and 26(4) of the 2016 Act empower the court to make forward facing recommendations as regards reasonable precautions, improvements to, or introduction of, a system of work, or the taking of any other steps. Such recommendations can be made if the sheriff considers them "appropriate", indicating that what is called for is an exercise of judicial discretion and judgment. Recommendations under section 26(4) can be made even no findings are made under section 26(2)(e) or (f). However I agree with the submission by SPS in this inquiry that any recommendations must be reasonable, grounded in the evidence, and made on

the basis that they might realistically prevent other deaths occurring in the future in similar circumstances to the deaths under consideration in the inquiry. This means recommendations must be limited to those which might realistically prevent the deaths, by suicide, of young prisoners[11] in Polmont.

(E) FINDINGS IN FACT

[34] In the light of the evidence led at the inquiry, I found the following facts admitted, agreed or proved. While there were many areas of factual agreement, there were also a number of sharp factual disputes. It can be taken that in relation to those areas there was a conflict in the evidence of witnesses, I accepted the evidence which is consistent with following findings, and rejected that which is not. Where further comment on contentious evidence is appropriate it will be made later in this determination.

Polmont

General

[35] Polmont is Scotland's national detention facility for young male offenders and remand prisoners. In 2018 this meant those aged between 16 and 20 years of age inclusive. In 2018 Polmont also accommodated a female population. Both young females and adult females were held there.

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[11] By use of the expression "young prisoners" in this determination I mean in particular prisoners of 20 years of age and under. I am conscious of course that Katie had just turned 21 years of age a few weeks before she died.

[36] Typically, young male offenders leave Polmont when they turn 21 years of age and are transferred to the adult prison estate. However some can continue to be detained there until the age of 23, for example if they are deemed to be benefitting from the regime.

[37] Brenda Stewart was the Governor in charge of Polmont between April 2017 and November 2021. Gerry Michie became acting Governor in August 2021 and interim Governor in September 2021. He has been Governor in charge since January 2022.

[38] In July 2023, young female prisoners were moved to HM Prison and Young Offenders Institution Stirling. HM Prison Stirling is now Scotland's national detention facility for young women offenders and remand prisoners. As of January 2024, Polmont also began accommodating low supervision short-term adult male offenders. Accordingly, Polmont now accommodates a population comprising of young males as well as adult males and adult females.

[39] On 4 June 2024 the Children (Care and Justice) (Scotland) Act 2024 received the Royal Assent ("the 2024 Act"). Sections 18 and 19 of this Act were brought into force on 28 August 2024. As a result, children are no longer to be remanded or sentenced to detention in a young offenders' institution. Therefore Polmont has ceased to accommodate 16 and 17 year old males. Polmont continues to accommodate young male prisoners of 18 to 20 years of age.

[40] Polmont has a design capacity of 758 places but only 607 places are in fact available. In 2018, and since, Polmont has operated at under capacity. In 2018 there were around 500 prisoners in Polmont, of whom around 25% to 30% were held on

remand. Between 30 to 50 of the total number were 16 or 17 year olds. Between 2021 and 2023 there were never more than around 350 prisoners in total, and the number of 16 and 17 years had decreased. Inevitably, prisoner numbers fluctuate from day to day.

[41] There was one female prison hall within Polmont in 2018, called Blair House. This hall could accommodate approximately 130 women. It is split into three levels. In 2018, level 1 accommodated young females aged 16 to 21. Levels 2 and 3 accommodated adult females aged 21 and over.

[42] There are two main accommodation blocks for young males: Iona and Monro Halls. Monro Hall is split into four levels. In 2018, level 1 accommodated convicted young males across all sentence lengths; level 2 accommodated male children between the ages of 16 and 18; level 3 west accommodated offence and non-offence protection males aged over 21 (that is, prisoners who required protection from other prisoners either due to the nature of their offence or for some other reason). Level 3 east accommodated young males in the Positive Futures Unit. Level 4 accommodated offence and non-offence protection young males, aged 18 to 20.

[43] The other residential unit in Polmont is a Separation and Reintegration Unit ("SRU") named Dunedin. This is for young males. There are 14 cells in this unit, one of which is a Safer Cell and one of which is a Silent Cell (now disused).

[44] As at 2018 all young prisoners detained in Polmont were accommodated in single cells. Although double bunk beds were still located in some cells, in practice there were never two occupants.

[45] All young persons entering Polmont are vulnerable, in the sense of being at a higher statistical risk of suicide than young persons in the general population, but some will present with more vulnerabilities than others.

Staff shift patterns

[46] Between Monday and Friday there are three residential shifts at Polmont. These are (a) the early shift from 0630 to 1230 hours; (b) the late shift from 1200 to 2130 hours; and (c) the night shift from 2100 to 0645 hours.

[47] At the weekends, the day shift is from 0800 to 1800 hours. A short patrol shift is then in place until night shift commences at 2100 hours. During the patrol and night shifts prisoners are locked in their cells and their doors would only normally be opened for an emergency or welfare issue.

[48] Between the hours of 0630 and 2130 hours Monday to Friday, and between 0800 and 1800 hours Saturday and Sunday, one FLM is responsible for managing Blair House, together with seven residential officers.

[49] One FLM is responsible for managing Monro Hall, together with 16 residential officers between the hours of 0630 and 2130 hours Monday to Friday, and between the hours of 0800 and 1800 hours Saturday and Sunday. Four residential officers work on each floor, two to each wing on the floor.

[50] The above shift patterns, and the number of staff in each Hall, has not changed since 2018, other than temporarily during the Covid pandemic. These shift patterns are historic, and are based on accommodation of staffing needs, not prisoner needs.

[51] In 2018 the total SPS staffing complement at Polmont was just under 400. Staff shortages were common at this time, with maybe 20 to 30 staff off sick at any given point. The Deputy Governor was authorised to backfill absences with overtime, in particular so as to maintain activities for young prisoners. Nevertheless it would not be unusual for there to be one fewer member of staff on a floor than the full complement. In any event staff shortages meant that staff might have to be moved around from another part of the prison. Such relief staff would be unlikely to know the prisoners on the hall as well as those staff who normally worked there.

[52] There was a particularly low number of young female prisoners in Blair level 1 throughout 2018 - between around 6 and 15 prisoners. Given this, and as there was a complement of three officers in this hall, it was the first target for the transfer of an officer to other parts of the prison in the event of a staff shortage. Accordingly there was a particular risk of a loss of consistency of staff within Blair level 1 at this time.

Regime

[53] Two prison officers are assigned as personal officers to each prisoner. Personal officers are in particular responsible for a prisoner's paperwork, for example their case management and updating prisoner narratives. The second personal officer is assigned to provide cover when the first personal officer is on leave or off sick. Given the nature of the role, officers will generally have greater contact with, and familiarity with, the prisoners to whom they are assigned as personal officers.

[54] Significant effort and resources have been invested in seeking to provide a range of positive regime activities for young prisoners at Polmont. In 2018, more activities are available for prisoners than in any other Scottish prison. These included activity spaces, youth work, education, vocational training, a gym, and access to open-air areas on a daily basis. Such activities were available for both convicted and remand prisoners. Typically, more activity places were available than there were prisoners who wished to attend.

[55] A prisoner is entitled to at least 30 minutes per day for the purpose of receiving visits in any period of 7 consecutive days. Visit sessions at Polmont are ordinarily 45 minutes long.

[56] Convicted young prisoners are required to attend work and activities, but un-convicted prisoners are not. Opportunities to attend work and activities are more limited for un-convicted prisoners.

Standard Operating Procedures

[57] Certain SPS Standard Operating Procedures ("SOPs") were operational within Polmont in 2018.

[58] SOP 41 outlined the procedure for admission to Polmont of young people under the age of 18. It is produced as Crown Production 53. The purpose of this procedure was to apply the SM Whole Systems Approach policy for young offenders ("WSA") in circumstances where a person under 18 was admitted direct from court. WSA required, in particular, that the relevant local authority should have been notified within 24 hours,

unless the prisoner was admitted over the weekend. An initial custody review was to be convened within 10 working days, attended by the prisoner, SPS staff, and social work. This review was to be organised by the local authority. For young persons who were looked after by the local authority, reviews were to be held within 72 hours, as a matter of best practice.

[59] SOP 54 outlines the detailed processes and procedures for young people who are transferred from secure residential care to Polmont. A copy (as reviewed in January 2020) is lodged as Crown Production 74. It recognises that a transfer to Polmont from secure care may be a planned transfer, for example, on the young person's eighteenth birthday. In this event SOP 54 envisages a process which should begin 6 months prior to the transfer, and involve a multi-agency exchange of information in relation to the young person, familiarisation visits, application of the WSA, and post transition reviews.

[60] SOP 54 also makes provision for exchange of information following an unplanned transfer of a young person to Polmont from secure care, for example, by order of the court. In this event Scottish Government Children's and Families Directorate ("SGCFD") should notify the Duty Governor at the earliest opportunity - by email and phone call - that a young person is attending court and that there is a possibility that they may be sent to Polmont. SGCFD should then forward any relevant information to the Duty Governor, to include any immediate concerns or risks in relation to the young person, and also in particular a copy of any criminal justice social work report, any risk assessments undertaken by social work pre-sentence, the Child's

Plan, and copies of relevant minutes and education reports. All this information should be shared with all relevant stakeholders at Polmont, including reception, healthcare, social work, psychology, and the hall manager, so as to inform decision-making in the immediate period following transfer. Telephone numbers, including an out of hours number, are provided.

[61] SOP 54 did not cover the situation where a young person was sent to Polmont directly from court in circumstances where they were not at the time in secure residential care. There was no standard operating procedure in relation to such admissions.

Body (strip) searches

[62] In 2018, following every visit, one in five prisoners were chosen at random and body searched. The purpose was to prevent prisoners bringing items into the prison which were unauthorised, prohibited or considered to be a threat to good order or discipline. Such random body searches were distinct from intelligence led searches, that is, searches carried out pursuant to information suggesting that a particular prisoner might be in possession of such items. A body search (otherwise called a strip search) involves removing all of a prisoner's clothing, although not necessarily all at the same time. Bodily cavities are not searched.

[63] Crown Productions 16, 17, and 18 contain guidance and training documents issued by SPS regarding the procedure for carrying out body searches of female prisoners in 2018.

[64] On 6 May 2021 SPS issued a Governors and Managers: Action ("GMA") directing that all routine body searching for young prisoners aged 16 to 17 should cease. In terms of the GMA, there were certain exclusions. These were (a) searches for intelligence led purposes, (b) searches on admission to Polmont, or upon leaving on escort/licence or liberation, (c) searches deemed necessary for preservation of life or personal safety in respect of the TTM process; and (d) searches carried out at the conclusion of a control and restraint intervention.

[65] In the reception area at Polmont, since around 2021, there has been an airport style body scanner. This reduces the need to undertake body searches, and in particular random body searches. Intelligence led searches continue to be carried out when required. It is unclear on the evidence available to the inquiry whether random body searches have been discontinued entirely in relation to young prisoners between 18 and 20 years of age.

"Window warriors"

[66] At night, it was and is common for some prisoners at Polmont to shout from the windows of their cells. This behaviour is sufficiently regular to cause prisoners who engage in it to be known as "window warriors". Sometimes the shouting may be done in an attempt to communicate with prisoners in other cells or halls. On occasions it can involve abuse and attempts to intimidate or threaten other prisoners. In any event, as a result of the noise of the shouting other prisoners' sleep can be disturbed. The relatively

small numbers of prison officers on duty at night are often either unable or unwilling to effectively prevent such behaviour.

Safer Cells

[67] SPS has designated certain cells in all prisons as "Safer Cells". A Safer Cell is a cell designed in such a way as to limit and, where possible, remove all fixtures, fittings and furniture which may be used to cause self-harm, including those from which it may be possible to attach a ligature in order to effect death by suicide ('ligature anchor points').

[68] The furniture and fittings used in a Safer Cell are designed to be as tamper proof as possible and more resilient to being damaged than those in standard cells. They may be sealed to the walls with anti-pick mastic, in such a way that they cannot be used to inflict self-harm. The cell windows are non-opening, with natural ventilation provided through a grill. There are no exposed services or pipework. The sinks, toilets, showers and heating systems are of an anti-ligature design. Shower and toilet cubicles do not have doors. However even Safer Cells are not a wholly ligature free environment. Rather they are, as the name suggests, generally "safer" than standard cells in this respect.

[69] While Safer Cells are less likely to contain items that could be used by the prisoner to harm themselves, they have historically been more austere and unpleasant to be accommodated in. Accordingly such cells have been recognised as potentially adverse to mental and emotional wellbeing, and therefore inappropriate for use as

accommodation for prisoners other than for short periods. Accordingly as a matter of policy SPS has decided that a prisoner should only be accommodated in a Safer Cell in exceptional circumstances, and for as short a time as possible.

[70] But SPS thinking in relation to Safer Cells has been developing over the last 10 years. Safer Cells do not necessarily have to be more austere and unpleasant to reside in than a standard cell. And standard cells do not necessarily have to contain obvious ligature points. It is a matter of design and construction. For example, Safer Cells and standard cells in HMP Grampian, opened in 2014, are more similar as regards safety and amenity. Standard cells in this new build prison typically contain anti-ligature measures such as a sloping toilet door with sloping top bracket, a continuous piano hinge on the toilet door, and angled shelf design. The sinks in standard cells have also been configured so that they have no visible pipework, radiators have been removed from cells and replaced with underfloor heating, and windows have ventilators with mesh so there is no opening element which could form a ligature point. The furniture inside the cells is also designed to be anti-ligature.

[71] Accordingly the marked historical difference between the safety and amenity of Safer Cells on the one hand and standard cells on the other has, as a matter of policy and design, been significantly reduced in Scottish prisons built in recent years. Modern standard cells are safer than before, while modern Safer Cells are significantly less austere. Indeed they can appear to the untrained eye almost indistinguishable from standard cells - see the comparison photographs of Safer and standard cells in HMP Grampian at SPS Production 22/1.

[72] But the historical disparity between the safety and amenity of Safer Cells and standard cells continued to be present at Polmont in 2018: see the comparison photographs at SPS Production 22/2. At that time there were nine Safer Cells: one in Dunedin SRU, two in Iona Hall; two in Blair House (one on level 1 and one on level 2); and four on Monro Hall (two on level 2 and two on level 4). Since 2018, seven cells within Blair House have been converted to Safer Cells. As of January 2024, Blair House contains a total of nine Safer Cells.

Health care services in Polmont

[73] Since 2011 health care services for Scottish prisoners have no longer been provided by health care staff employed by SPS, but by the NHS. This change necessitated the creation of a framework for responsibilities as between SPS and health boards. This framework is set out in a 2012 Memorandum of Understanding, now lodged as Crown Production 56. This Memorandum is supplemented by a 2013 Information Sharing Protocol ("ISP"). The purpose of the ISP is, in particular, to regulate and facilitate sharing of personal health information by health boards in relation to prisoners, including that relevant for the purpose of suicide risk management, while respecting prisoners' rights to medical confidentiality: see in particular Crown Production 55, page 2388, paragraph5.2.

[74] The ISP stipulates that only the minimum necessary personal information consistent with the purposes set out therein will be shared. However staff are directed that they should not hesitate to share personal information in order to prevent abuse or

serious harm, in an emergency, or in life-or-death situations. Disclosure of information is to be conducted within the legal framework of the Data Protection Act 1998, the Human Rights Act 1998 and in compliance with the common law duty of confidence. But it is recognised that compliance with the duty of care towards a prisoner may require sharing of personal health information without the prisoner's consent. The Caldicott Principles should be applied.

[75] In practice, communication and information sharing between SPS and NHS staff in Polmont was and is generally good. Patient confidentiality is respected by NHS staff in relation to prisoners, but significant health care information is usually effectively passed to SPS staff as and when required to secure prisoner health and safety. In particular information indicating suicidality or significant self-harm can and generally is passed to SPS staff. In any event all NHS staff working in Polmont who may have direct contact with prisoners are themselves trained in TTM. They are able to initiate this policy themselves, without reference to SPS staff, if they consider that a prisoner may be at risk of suicide.

[76] FVHB maintained a number of teams of clinical staff at Polmont in 2018: the primary care team, addictions team, and a mental health team, supported by four administrative staff. On reception, a prisoner would be subject to a clinical health check in addition to the assessment by a mental health nurse for the purposes of suicide prevention.

[77] Prior to the transfer of prison health services from SPS to the NHS, all prisoners would be assessed by a doctor within 24 hours of admission. This practice continued

after 2011 only in relation to women prisoners entering Cornton Vale, and was still in place there in 2018.

Prisoner information recording systems

[78] The PR2 prisoner records system is SPS's live prisoner electronic management system. It is a repository which holds records relating to each prisoner, including the prisoner's personal details, appearance, location history, sentence, case management, risk and conditions, finance, visits, suicide prevention history etc. It does not hold a prisoner's medical records.

[79] All SPS staff and managers have access to some parts of PR2, but access to other parts is graded by an individual staff member's role and security clearance. For example, residential officers would not necessarily have access to a prisoner's financial information.

[80] There are PR2 terminals in all residential areas in Polmont. Subject to workload on any given day, prison officers have the opportunity to check PR2 for information about a prisoner, and do so when they consider that they need to. The management expectation in Polmont is that personal officers should interrogate PR2 to find out as much information as they can about their personal prisoners.

[81] PR2 contains a section known as "narrative", where prison officers can enter updates on a prisoner's progress. Where such narrative entries have been made, they can be used by prison officers to check for background information on a prisoner within their care. In 2018 use of the narrative section of PR2 by prison officers within Polmont

was inconsistent and unstructured. It still is. Some officers look at PR2 entries when a new prisoner arrives in their Hall. Others might use the narrative section of PR2 to record a noteworthy event in relation to a prisoner. Others do not.

[82] In Cornton Vale there was at one time what was effectively a mandatory instruction to personal officers to update the PR2 narrative every week in relation to each prisoner allocated to them. This resulted in a readily accessible running written commentary on each prisoner, recording issues in relation to their management and/or well-being. It could be accessed by any prison officers who came into contact with the prisoner - for example, officers not previously familiar with them. There was no similar instruction at Polmont, nor was there any general guidance to prison officers on what should be recorded in the narrative section of PR2, or when.

[83] In 2018 and now, all prisoners at Polmont also have personal files, held in paper form in an office in the reception area of the prison. This file should contain, in particular, the warrant from the court, any paperwork accompanying the prisoner on arrival, the Prisoner Escort Record ("PER"), any report by the sentencing judge, and/or any CJSWR.

[84] SharePoint is a document repository for electronic files which can be shared and accessed by prison staff, indeed anyone who has access to Microsoft Outlook within the prison. It does not link in with PR2, but can be accessed through the same terminals within the halls. Minutes of meetings might be held on SharePoint, as might lists of prisoners involved in activities on a given day, or with appointments in the health

centre. All GMAs are held on SharePoint, and when a new GMA is received in the prison it is uploaded to SharePoint and staff are emailed to advise them of this.

[85] Prison officers can submit intelligence reports to the Intelligence Management Unit ("IMU") at Polmont. This intelligence is collated into an intelligence log for each prisoner to which it relates, directly or indirectly. FLMs have access to this intelligence log, but residential officers do not. Accordingly such officers cannot themselves access intelligence log entries for those prisoners to whom they are assigned as personal officers.

[86] Intelligence is graded by SPS. The source of the information is graded from A to E, where A is "always reliable" and E is "untested and should be treated with caution". Intelligence is also given an evaluation grade number, from 1 to 4. The number "2" means that the information is known to the source but not to the reporting officer. The number "4" means that the information is known to the source but cannot be corroborated in any way. The intelligence also is given a handling code. A handling code of "1" means that there is no risk to any individual and that the information is of common knowledge within the prison.

[87] The intelligence log record for Katie is produced within Crown Production 14. The intelligence log record for William is produced within Crown Production 39.

[88] The electronic healthcare recording system within Scottish prisons is known as "VISION". It is administered by the NHS. This only contains health records relative to a prisoner which have been created whilst they are in prison. Accordingly a person

entering prison for the first time will not have a VISION record, and one will be created for them. SPS staff do not have access to VISION.

[89] NHS staff working within prisons do not have ready access to a prisoner's GP or other community-based medical records. These must be specifically requested, and may take many weeks to be provided. A GP working within the prison will become a prisoner's registered GP, and so obtain their community GP records, only if the prisoner is to be in custody for more than 6 months.

[90] FVHB also operates the "DOCMAN" system. Any external medical records (such as community-based medical records) that a patient enters prison with, or which are requested and received whilst a patient is in prison, are scanned and stored on DOCMAN. The documents scanned and stored on DOCMAN can be accessed from VISION.

[91] FVHB staff within Polmont do have ready access to a prisoner's emergency care summary ("ECS") from their community medical records. ECS shows information regarding prescriptions and medication for patients. Such staff also have access to a clinical portal. This is FVHB wide, and gives staff access to secondary care records, such as hospital appointments, but not GP records.

[92] Care Partner is a mental health recording system within Forth Valley prison healthcare ("Care Partner"). It was introduced after 2018. Care Partner is only used where a mental health referral is received. Only mental health disciplines and supporting staff can input information into Care Partner. Other health professionals have read only access to Care Partner. This includes administration staff, pharmacy

staff, primary care nurses, sexual health nurses, general practitioners and advanced nurse practitioners. Progress notes recorded in Care Partner are copied to VISION. Care plans and assessments are uploaded as a document onto Care Partner.

[93] Where a mental health referral is now received in respect of a prisoner at Polmont, a triage assessment will be completed and discussed at the weekly clinical team meeting which includes a range of professionals, including the mental health team, psychiatrists, addictions workers, occupational therapy and social work. The triage template is available on Care Partner and is lodged as Production 4 for FVHB. If the outcome of that meeting is that the prisoner is added to the mental health caseload, the allocated nurse will complete a full mental health assessment and a risk assessment document. The assessment and risk assessment templates are held on Care Partner and are lodged as Productions 5 and 6 for FVHB.

Talk To Me suicide prevention strategy

Talk To Me and Act 2 Care

[94] TTM is a multi-agency suicide prevention strategy. It is operated in all prisons in Scotland. TTM was introduced in December 2016 following a 2-year multi-agency review of the previous suicide prevention strategy, Act 2 Care ("A2C"). Its principal aspects, as it existed in 2018, were as follows.

[95] The key aims of TTM are stated to be (i) to assume a shared responsibility for the care of those at risk of suicide; (ii) to work together to provide a person-centred care pathway based on an individual's needs, strengths and assets; and (iii) to promote

a supportive environment where people in custody can ask for help. That said, it is a suicide prevention policy, not a policy to promote mental health or well-being more generally.

[96] A copy of the TTM strategy published in 2016 is produced as Crown Production 57. SPS staff were advised of TTM by GMA 068A/16, now Crown Production 82. TTM is set out in three documents, all of which were uploaded by SPS to SharePoint, and so were readily available to prison staff:

1) TTM Prevention of Suicide in Prison Strategy - this sets out the strategy (14 pages);

2) The TTM Prevention of Suicide in Prison Strategy Guidance, Part 1 - this supplements the strategy and contains guidance on how to respond to someone in distress while in custody. The guidance includes sections on the TTM process, risk assessments, individualised care plans, provision of a supportive environment and regime, adoption of a multidisciplinary and multi-agency approach, provision of support on release from custody, training requirements, incident response, the process following a suicide, bereavement support, document retention, and governance over the policy (20 pages);

3) The TTM Prevention of Suicide in Prison Strategy Guidance, Part 2 - this provides guidance on the procedure to be followed on receipt of information that indicates an individual in custody may be distressed. It also contains guidance relating to forms to be used under the strategy,

including the concern form, the RRA form, the TTM initiation form, the pre-case conference healthcare assessment form, the case conference form, and the closure form (including the transitional care plan) (40 pages).

The guidance was arranged in two different parts because SPS management thought that the previous A2C guidance had become too unwieldy. The intention was that Part 2 of the TTM guidance would contain more of the practical day to day information which staff would need to refer to in order to operate the strategy.

[97] Key changes made when transitioning from A2C to TTM included changes to the categorisation of a prisoner when carrying out a risk assessment. Under TTM a prisoner can be categorised as either "At Risk" or "No Apparent Risk". Under A2C a prisoner could have been categorised as "high risk" or "low risk". The change was made because staff found it difficult to determine whether a risk of suicide was low or high. In any event, it was perceived as leading to default care plans being implemented in practice. A prisoner assessed as being at high risk would be placed in a Safer Cell with 15 minute observations; one assessed as being at low risk would remain in a standard cell with observations every 30 or 60 minutes.

[98] Accordingly the risk categories were changed in TTM to try to encourage more individualised care plans, intended to take into account the personal needs of the particular prisoner. The risk categories appear to be binary, but are not. That is because TTM moves the difficulties of grading the level of risk into the process of considering what protective measures should be put in place for a prisoner once the threshold of their being "at risk" is met. For example, at what minimum frequency an at risk

prisoner should be subject to observations will depend on an assessment of their level of risk.

[99] TTM also sought to formalise and standardise the process for recording concerns relative to a prisoner's risk of suicide. In 2013 SPS had instructed all prison governors that a process for recording concerns relative to suicide risk was required see GMA072A/13. The intention was to ensure that any concerns raised from an external source in relation to a prisoner's risk of self-harm or suicide were accurately recorded and actioned. This followed an FAI determination where a concern from a family member was not actioned within a prison. However there was no template for recording and actioning concerns under A2C. TTM therefore introduced a template and guidance with a view to trying to ensure a consistent approach throughout SPS. It sought to provide a mechanism to record a concern in relation to someone currently assessed as "no apparent risk", where that concern did not of itself indicate that the prisoner should now be assessed as being "at risk". The intention was to share information where a concern had been raised, ensure appropriate action was taken, and to provide feedback if it was an individual in the community who had raised the concern.

[100] TTM also sought to reduce use of Safer Cells. There was a concern that safer cells were being overused under the A2C policy in circumstances where these cells were traditionally more austere and potentially adverse to a prisoner's well-being than standard cells. TTM included a direction that Safer Cells should now only be used in exceptional circumstances. Additional safeguards were also introduced in the TTM

guidance, including review by a SPS Unit Manager within 72 hours of placing a prisoner in a Safer Cell.

[101] These instructions failed to take account of the development of less austere Safer Cells in new build prisons, and of making standard cells in such prisons safer, as detailed above. They also reflected the failure of SPS to improve the amenity of Safer Cells, and the safety of standard cells, in the existing prison estate.

Key elements of TTM policy

[102] TTM correctly acknowledges that assessing risk of suicide is a dynamic process, where levels of risk often change, sometimes very quickly. It suggests that assessment should be evidence-based, and should balance protective and risk factors. It is recognised as important that an assessment includes appropriate information from the individual, and also from other relevant parties who may have been involved in their care previously.

[103] TTM can be initiated at any time by any member of staff who is trained in the TTM Strategy. In practice this means all members of staff who have unescorted access to prisoners, including NHS staff. If a member of staff considers that a prisoner is "at risk" of suicide, they should complete an initiation form. The completion of the initiation form results in the prisoner being placed on TTM immediately.

[104] TTM identifies the following "key indicators" that a prisoner may be at risk of suicide. These are that they (a) are experiencing their first time in custody; (b) are newly sentenced; (c) have a history of mental illness; (d) have a history of self-harm,

especially when repeated; (e) are the subject of bullying; and (f) are suffering from withdrawal from drugs or alcohol. TTM does not therefore recognise and highlight that prisoners in the early days following admission to a prison are known to be at a statistically higher risk of suicide, nor whether that admission has been from court, or by way of transfer.

[105] TTM training materials indicate that staff should be trained on these key indicators and on how to look for signs that may indicate that an individual is at risk of suicide. The guidance states that: "Most people thinking about suicide in prison will try to let someone know." This approach underlines the choice of name for the policy, and the resulting emphasis on looking for, and in any event recognising, common verbal and non-verbal warning signs - "cues and clues" - suggesting that a prisoner may be at risk of suicide, and encouraging them to disclose suicidal thoughts prior to acting on them. It also acknowledges, by implication, that at least some people thinking about suicide in prison will *not* try to let others know. The challenge for TTM is therefore not only to be sufficiently sensitive to pick up and act on the verbal and visual messages that most suicidal prisoners will send, but also to protect those who send few or no messages at all.

[106] The verbal cues and clues outlined within the TTM guidance and training materials are that a prisoner (a) states that they are going to die by suicide; (b) expresses feelings of guilt, anger, depression, hopelessness; (c) talks about suicide or self-harm; (d) states that they find prison difficult to handle; (e) expresses low self-esteem; and (f) talks about bullying or vulnerability. The non-verbal cues and clues are that the prisoner exhibits (a) a change in behaviour/acting out of character; (b) a lack of

motivation; (c) self-neglect or not eating; (d) withdrawal from company of others, social isolation; (e) irrational behaviour; (f) anger and aggression (especially young people); or (g) self-harm behaviour.

[107] The following events are also identified in the training materials, being events that may trigger a risk of suicide. These are (a) bullying and intimidation; (b) all court appearances/outcomes, including appeals and tribunals; (c) relationship or family problems; (d) the anniversary of sentence or crime; (e) a suicide attempt by others; (f) immediate, or near, completion of drug detoxification; or (g) that the prisoner is still in withdrawal. "Court appearances" include appearances conducted remotely, that is, by CCTV link to the court from within the prison.

[108] Although, as noted, TTM does acknowledge the need to obtain background information from other relevant parties, overall there is an over emphasis and over reliance in the TTM guidance and training materials on encouraging staff to look for verbal and presentational cues and clues from the prisoner themselves. This tends to reduce the relative importance of investigating and assessing evidence of historical and dynamic risk factors, and so tends to distract from the need to place evidence of self-report and presentation firmly in the context of such factors in carrying out suicide risk assessment.

Reception risk assessments

[109] Each prisoner arriving at a prison from court should receive an RRA under TTM. Guidance on RRAs is set out in Part 2 of the TTM strategy guidance. An RRA should

also take place when a prisoner is transferred from another prison, or returns to prison from a court appearance, from hospital, a home visit, a children's panel, or a parole hearing. A RRA should also be carried out before the prisoner is returned to their cell after attending a court hearing that has been conducted remotely, that is, via CCTV from within the prison. All RRAs should be completed and recorded in the same way, regardless of the prisoner movement which triggered it.

[110] When a person enters prison, they should be accompanied by a PER. The PER is completed by the escorting service and should contain information on healthcare conditions, disabilities, risk of violence and risk of suicide. There may also be additional information available at the point of entry such as information received from the court or the police, or from an external organisation such as social work. All available information should be considered in the initial RRA. There is however no system which requires that copies of all written information or documentation which was before the court which sentenced or remanded the prisoner accompanies them to the prison.

[111] A RRA is not intended to be a formal, detailed, mental health assessment. Such assessments do take place within prisons. They may take 1 to 2 hours, and will address a person's mental health generally and not only whether they present an apparent risk of suicide. The RRA is, and is intended to be, more akin to a screening assessment, focused on suicide risk rather than the prisoner's mental health or well-being more generally.

[112] There are two stages to an RRA: an assessment by a prison officer; and an assessment by a healthcare professional. A RRA by a healthcare professional should be

carried out where there is a new admission to a prison, a transfer from another prison, or where the prisoner has returned from court as a convicted prisoner after a period on remand. In all other circumstances where an RRA must be carried out, a healthcare risk assessment is not required, but can be requested by SPS staff if they think that it would be appropriate to do so.

[113] TTM policy requires that following a RRA the prisoner must be designated as being either "at risk" or "no apparent risk" of suicide. If the outcome of the prison officer's assessment is "at risk", the officer should complete a TTM initiation form. If the outcome of the officer's assessment is "no apparent risk", but a healthcare assessment is necessary or considered appropriate, the prisoner will be passed to a nurse for this purpose. If the nurse assesses the prisoner as being "at risk", they should complete a TTM initiation form, even if one has not already been completed by the officer.

[114] TTM includes forms for completion when a prisoner is assessed as being at risk of suicide. When introduced, the TTM documentation was loose leaf paperwork, the intention being that once completed it could be scanned and uploaded to PR2. Subsequently, however, SPS found that PR2 did not have sufficient capacity to do this. Accordingly from 12 September 2018 it replaced the TTM loose leaf documentation with a booklet: see GMA056A/18, now Crown Production 84. These booklets contain guidance on the process and paperwork, sufficient space for three case conferences to be recorded, as well as for daily reports, a transitional care plan and case conference minutes. The RRA and concern forms remained in loose leaf format.

[115] When a TTM case is live the booklet should be kept in the TTM case file. If an individual is transferred to another prison while on TTM their live TTM booklet must transfer to the receiving establishment. Where an individual is placed on TTM at reception the information contained in the RRA form should be summarised in the initiation form.

[116] If the prison officer has assessed the prisoner as being "at risk", a nurse could in theory then assess the prisoner as being at "no apparent risk". However the TTM strategy would still be engaged as a result of the officer's "at risk" assessment. If "no apparent risk" is the outcome following the officer's assessment and, where applicable, is also the outcome of the nurse's assessment, no further action under TTM will be taken at that time. A copy of the RRA should be filed in the prison where the assessment was undertaken.

[117] RRA forms were not kept electronically in 2018. Rather they were supposed to be kept in paper form in an office in the reception area of the prison. If an officer wished to have sight of any previous RRAs, then they would have to go to the office and physically find them. This might take several minutes, depending on where within the prison, and thus how far from reception, the officer was then on duty. Officers were unlikely to go and look at previous RRA forms, given the time it would take and the number of such forms that they might be required to complete in a given day. In any event, paper RRA forms are sometimes mislaid, and if so would not be accessible. In principal there is no technological barrier to RRA forms being stored and accessed electronically.

[118] The documentation in relation to a prisoner who is being managed on TTM is held in paper form. There is no technological barrier to such documentation being stored and accessed electronically. Although TTM documentation is not stored on PR2, there is a visible tab on this system which gives notice to prison officers that the prisoner is or has previously been subject to TTM.

[119] TTM documentation such as RRA forms and TTM initiation booklets, although completed in part by health care staff, is considered to be SPS property, and so is not stored on VISION.

Case conferences

[120] Once TTM is initiated, the policy requires that a case conference must take place within 24 hours. In the event that it cannot take place immediately, however, a care plan should be put in place for the purpose of keeping the prisoner safe pending a fuller assessment of their risk at the case conference. Guidance in relation to case conferences is set out in Part 1 of the TTM strategy guidance. Guidance in relation to immediate care planning is set out in Part 2 of the TTM strategy guidance.

[121] A healthcare assessment must be carried out prior to the case conference. This must be carried out by a healthcare professional (where possible a mental health nurse). Guidance in relation to this is set out at Part 2 of the TTM strategy guidance.

[122] A minimum of three staff must take part in the case conference: the FLM responsible for the hall where the prisoner is accommodated; a residential officer who works in this same area; and a healthcare professional (where possible a mental health

nurse). Any decision by a case conference to remove a prisoner from TTM must be unanimous; if any one of the three members of staff considers that the prisoner may still be at risk of suicide, the prisoner will remain subject to TTM.

[123] Consideration should be given to including others who might add value to the case conference due to their knowledge of the individual or the role they carry out. This might include the prisoner's social worker, chaplain or, if the individual requests it, a friend or family member who may provide support. There is no good reason why such persons could not attend the case conference by remote means, that is, by video or audio call.

[124] If the prisoner has previously been engaged with other services in the community, contact may be made with those services if the case conference thinks it appropriate. This might include contact with the prisoner's GP, with mental health or addictions services, and/or with social work. Where additional information is required from a community healthcare services, this should be obtained by the healthcare professional. Where the information is required from a service such as secure unit, this should be carried out by the FLM or through prison based social work. Healthcare staff in case conferences regularly make contact with external community services to obtain additional information. Gathering additional information from external sources is part of the duties of a FLM or residential officer.

[125] As part of TTM training, staff are told about the importance of ensuring they have all relevant information available so they can make an informed decisions regarding an individual's risk of suicide. Ample time should be made available at the

case conference to fully discuss the issue. If insufficient time or resources are available, staff are trained that they should adopt the safest option until more information and time is available.

[126] What is sufficient information to properly assess suicide risk should be determined by the members of the case conference on a case by case basis. Where a prisoner has previously engaged with other services in the community, TTM provides that it is for the case conference to decide if they need to make contact with those services. Case conferences can be adjourned if necessary for the purpose of obtaining further information.

[127] If following a case conference it is determined that the prisoner remains "at risk" of suicide, a person-centred care plan should be prepared. If it is determined that there is "no apparent risk", the TTM file will be closed. When closing the file, consideration should be given to whether a "transitional care plan" is necessary, and if it is, arrangements should be made and implemented in this regard. A transitional care plan might include ongoing supports for the prisoner - a referral to the mental health team, facilitating contacts with outside agencies, etc, - or gradual removal from existing protective measures.

[128] SPS may receive additional information regarding a prisoner's suicide risk, for example, from a source outwith the prison. This may be at any time after the prisoner first entered custody. Regardless of whether they are currently on TTM, policy requires that staff must act on any information that is received from an external source. On

receiving information regarding a prisoner's mental health or risk of suicide, a further assessment of the prisoner must be carried out.

Care planning options

[129] Where a prisoner is put on TTM, whether at RRA or otherwise, the member of staff initiating TTM should liaise with the FLM of the area where the prisoner is accommodated or is to be accommodated. There should be discussion and agreement as to care planning. This should include the cell in which the prisoner should be accommodated (that is, whether a Safer Cell or standard cell), whether they should be allowed to wear their own clothing or be required to wear anti-ligature clothing, whether they are permitted or prevented from having any particular personal items to use in their cell, whether there are any regime aspects which they should or should not participate in, and the frequency of contact with the prisoner by prison staff. If the decision is to accommodate the prisoner in a standard cell, the officer carrying out the risk assessment has no control over which cell that will be. This is a matter for the hall FLM to decide.

[130] A care plan for a prisoner placed on TTM should record the decisions in relation to all these matters. In particular it should detail the maximum interval between contact with the prisoner by prison staff. This can range from continuous contact, to contact at no more than 60 minute intervals. There should also be "details regarding the nature of the contact". These may vary according to regime. Although "contact" is often also

referred to as "observation", TTM states that it is "not only about observing someone; time should be taken to interact in a meaningful way". It is acknowledged that it is

> "important to record and communicate the expectations of the nature of the contact for all staff who may be responsible for the care of the individual during day time, lock up periods and during the night".

The TTM training materials require participants to consider the "type of observation at night (visual, verbal or both - and why!)" and to understand the importance of recording the rationale of this decision on the care plan: see Crown Production 60, page 2603.

[131] Accordingly it is not sufficient in terms of TTM policy to simply write on a care plan, for example, "30 minute observations", and to then leave it to individual officers to decide whether, for example, to require both a verbal and visual response from the prisoner during the night - which may involve regularly waking them up and so depriving them of sleep. The nature as well as the frequency of the contact at night should be specified in the care plan. Nor does it follow from TTM that the prisoner must necessarily be placed in a Safer Cell if a maximum of 15 minute contact is stipulated following a RRA. Some staff at Polmont in 2018 were mistaken in relation to this.

[132] In practice, there is a lack of clarity among prison officers about the way in which night-time contact should be carried out - and in particular whether it is necessary to wake the prisoner up. The standing orders for staff within Polmont in relation to conducting checks are teleological: the stated purpose is to ensure that the prisoner is "safe and well", but how this is done is left to individual staff. Some turn on the cell

light and observe the prisoner. Some try to get a reaction or response, albeit that this might be by listening to ensure that the prisoner is breathing. Regularly waking a prisoner up through the night is however likely to be detrimental to their well-being.

Concern forms

[133] As noted above, TTM requires that if a member of staff has a concern in relation to the prisoner, but it is not thought that the prisoner is "at risk" of suicide, a standardised concern form should be completed. In particular a concern form "must" be completed when information is received that indicates that a prisoner may be "distressed": Crown Production 57, Bundle page 2485. Importantly, TTM requires that a concern form should be completed both when an external party (such as a relative of the prisoner, or an outside agency such as social work) contacts the prison to raise a concern about a prisoner (an "external concern"), and also where a member of staff is concerned as a result of something they have personally witnessed in relation to a prisoner (an "internal concern").

[134] The concern form system provides a structure by which staff should respond to a prisoner who may be in distress. It also requires the recording in writing of the source of the information, the nature of the concerns, and the actions taken following discussion with the prisoner. Therefore if operated in accordance with TTM policy, it enables SPS to build up an accessible picture of issues and events relative to a prisoner's risk of suicide over time, notwithstanding that the particular issue or event giving rise to the completion of the concern from may not in itself indicate that the prisoner is presently at

risk of suicide such as to justify initiation of TTM. Accordingly it enables - and in terms of TTM it is central to - the carrying out of properly informed, dynamic risk assessment of the prisoner, throughout the period of their detention, by those entrusted with their day to day care.

[135] In accordance with the guidance in force in 2018, a prison officer receiving information giving rise to concern should pass this to the residential area where the individual is located. An officer in the residential area should then complete the concern form. Then, in conjunction with a FLM (or in cases of urgency with another officer), the residential officer should meet with the prisoner and consider whether TTM should be initiated. If, following this meeting, the prisoner is thought to be "at risk" of suicide an initiation form should be completed, the prisoner placed on TTM.

[136] Where information is received about a prisoner currently on TTM, this should be recorded in the narratives of the TTM documentation. The officer should then consider if this information means the person is at a greater risk of suicide, and if so whether their current care plan is sufficient. Where there are concerns regarding an individual's safety, following information received, an additional case conference may be held. Where a case conference is not possible, a FLM can change the care in place by completing an immediate care plan.

[137] As at 2018 concern forms were paper forms, which when completed were filed centrally with the prisoner's personal paper file. They were therefore not immediately available to prison staff for the same reasons already noted in relation to RRA forms. Should such staff wish to see any previous concern forms in relation to a prisoner they

would require to physically go to the office and consult the prisoner's file. In practice staff might not have sufficient time to do this given their other duties, but in any event they were at least dis-incentivised to do so. In principle there was no technological barrier to concern forms being stored and accessed electronically so as to make them more readily accessible to residential staff.

[138] The concern form system was and is a central aspect of the TTM strategy. It was intended to be the means by which the perceived overuse of suicide prevention intervention measures as defaults under A2C could be avoided. It was the safety net which was put in place to enable, in effect, the bar for such intervention to be raised. It was the means to enable proper ongoing dynamic risk assessment of at least some of those who might previously have been placed on A2C as "low risk". In circumstances where, for example, an allegation of bullying might be recorded in an informal handover note, via a suspected bullying report ("SBR") under the Think Twice anti-bullying strategy ("TT") , or as a narrative entry on PR2, the concern form was intended to be a way of recording all information relevant to a risk of suicide in the same place and in the same way.

[139] In practice however, in 2018, prison officers at Polmont who were directly involved with a prisoner did not use TTM concern forms for internal concerns in relation to that prisoner. They regarded them as unnecessary paperwork. They saw them as effectively sending forms to themselves. Rather than complete concern forms they would go and speak to the prisoner directly, which is what would be required in any event if a concern form were completed. If in the light of this the officer had concerns

that a prisoner might be at risk of suicide, they would simply initiate TTM. If not, no record of the event would generally be made.

[140] Accordingly residential prison officers at Polmont regarded the TTM concern forms as being only for use by external agencies - that is, for external concerns - or at best for use by prison officers who did not have direct contact with the prisoner concerned. The residential officers themselves captured information in relation to significant incidents affecting the well-being of a prisoner in their hall in other, informal, ways. Typically they would discuss incidents verbally with other officers, write them down in informal handover notes for the next shift, report them to the intelligence unit if need be, and occasionally - and if time permitted - make a narrative entry on PR2. But in any event the standardised concern form system central to TTM was not operated at Polmont, contrary to the terms of the policy.

[141] This systemic failure of residential officers at Polmont to give full effect to TTM policy in relation to use of concern forms was known to and in effect tolerated by FLMs and SPS senior management. The Deputy Governor of Polmont in 2018 was, for example, not aware that in terms of TTM it was mandatory for officers to complete concern forms, and not merely advisory. FLMs generally shared the view of residential officers in relation to perceived unnecessary form filling. Sanctions for failure to complete concern forms were not imposed. The failure to use concern forms was also known to at least some of those who trained prison officers in TTM. Audits were conducted of the content of those concern forms which were in fact completed in Polmont, but the relative absence of concern forms from residential officers was not

recognised nor acted upon. Those within SPS senior management responsible for implementation and oversight of the TTM policy were unaware of the extent to which this aspect of it was not being implemented.

TTM training

[142] As noted, all members of staff who have unescorted access to prisoners (including NHS staff) must be trained on TTM. Four separate training packages were developed to accompany TTM:

a. TTM conversion training for staff who had completed core A2C training. The training material for this course is produced as Crown Production 61.

b. TTM core training delivered to all new staff. The training material for this course is produced as Crown Production 60. The core training is classroom based and lasts 1 day, from 9.00am to 5.00pm.

c. TTM awareness training for those who do not have unescorted access to prisoners. The training material for this course is produced as Crown Production 58.

d. TTM refresher training which must be completed by staff at least once every 3 years. The training material for this course is produced as Crown Production 59. The refresher training is classroom based and lasts for 2 hours: see GMA054/18, Crown Production 83.

[143] Prison Officer Scott Wilson received the Core Training in July 2016, and the refresher training in February 2019 and April 2022. A copy of his training record is

contained in Crown Production 76. Prison Officer Marie Clare Doherty received the Core Training in September 2016, and the refresher training in February 2019.

[144] Prison Officer John Dowell received the Core Training in July 2016, and the refresher training in April 2019 and April 2022. A copy of his training record is contained at Crown Production 42. Prison Officer Natalie Cameron received the Core Training in November 2016, and the refresher training in March 2019 and August 2022. A copy of her training record is contained at Crown Production 43. Prison Officer Robert Baird received the Core Training in May 2017. A copy of his training record is contained at Crown Production 77.

[145] The training records for Nurse Joanne Brogan show that, before moving from a mental health nursing role in Polmont to a mental health nursing role within a community team in 2019, she received the A2C Core Training in June 2015, and the Conversion Training in October 2016. The training records for Nurse Brian Leitch do not show the dates on which he underwent TTM training.

Prisoner attitudes to TTM

[146] It is not uncommon for prisoners not to disclose thoughts of suicide, and as noted, an important policy aim behind TTM is to encourage them to do so. But prisoners often do not want to be subject to TTM, even if they do have thoughts of suicide. If a prisoner is subject to TTM, and in particular is subject to regular observations, this will likely soon become known to the other prisoners in the hall. Prisoners on TTM may be perceived as weak by other prisoners. They may therefore

become targets for bullying from other prisoners. They may be the target of verbal abuse at night, for example from the Polmont "window warriors". Further, the carrying out of contact by staff during the night may lead to sleep disturbance for a prisoner on TTM, as the prison officer may choose to wake them up each time they carry out their observations.

[147] Accordingly prisoners have incentives to want to not be on TTM, and so to seek to maintain - for example at RRA or a case conference - that they are not suicidal and do not need or want to be subject to observations. These incentives are increased at weekends, given the restricted nature of the prison regime at this time, during which a prisoner is liable to be in their cell for prolonged periods. These incentives are well known. Accordingly staff considering whether to put a prisoner on TTM or remove them from TTM should not place undue reliance on a prisoner's self-report or presentation, particularly where that prisoner is unknown to them and there is no independent background information available in relation to their risk of suicide. A prisoner's self-report and presentation must therefore be assessed critically, and weighed in the balance in the light of historic and dynamic factors bearing on suicide risk.

Think Twice anti-bullying strategy

[148] TT is SPS anti-bullying strategy. A copy of the policy as it existed from April 2018 is lodged as Crown Production 71, this being a revision of an earlier anti-bullying policy from 2008: see GMA 029A/18, Crown Production 72. It was

intended to achieve consistency in anti-bullying policy and practice across the SPS estate, while allowing for variations in relation to issues arising in particular prisoner populations.

[149] TT has as its stated aims, in particular, reducing the level of bullying within prisons to a minimum and reducing its severity, ensuring that incidents of bullying are discussed and investigated and action taken if necessary, and managing and recording proven incidents of bullying effectively. TT recognises that bullying may involve a range of behaviours by one person towards another falling short of physical assault. It is defined not just by the behaviour concerned but by its adverse impact on a person's agency, that is, their capacity to feel in control of themselves, by engendering a feeling of helplessness and inability to act. The bullying behaviour need not always be repeated, but at least the threat of it must be sustained over a period of time.

[150] Prison staff are required to act under TT if approached by someone experiencing bullying, if they witness it, or if it is disclosed by others. They are also expected to be proactive in detecting it. A SBR should be made, to prompt a decision whether to intervene, and for recording and monitoring purposes. However it is not uncommon for prisoners to make false complaints in relation to bullying, and a prison officer receiving a complaint will therefore investigate, and look for other information to corroborate it, before taking action. Information in relation to risks and conditions arising from bullying should be recorded on PR2: see GMA 049A/18, lodged as Crown Production 73.

[151] In practice, there was - and is - a lot of low-level bullying behaviour in prisons. In Polmont, in particular, there are frequent verbal arguments between young male

prisoners, name calling (for example by the "window warriors"), and episodes of low level violence. Given the daily frequency of such behaviours, prison officers often attempt to deal with it in an informal manner, for example by talking directly to those concerned, rather than invoking the TT policy. In practice prison officers are trusted by management to decide whether a particular incident or behaviour merits invoking the policy and completing an SBR. Different officers have different thresholds in relation to this.

[152] The use of such informal processes was criticised by HMIPS in its 2018 report on Polmont, and were reviewed in its 2023 report, now Production 3 for FVHB. HMIPS had recommended, in particular, that incidents of bullying were recorded on PR2, regardless of whether they were managed formally or informally, or reported to the intelligence unit. By 2023 HMIPS was satisfied that all reported incidents of bullying were being captured by the intelligence unit, who in turn notified the residential FLM of the area concerned. However it was not clear that all incidents were being recorded and reported appropriately. Negligible numbers of reports were made under TT, and while staff were aware of the policy, HMIPS considered that it was not being followed at Polmont. HMIPS recommended that a senior manager lead a review and maintain oversight of implementation.

[153] Accordingly in 2018 not every low-level bullying incident was recorded or dealt with in terms of the TT policy. By not taking formal action, there might therefore be no record of a bullying incident. An entry might be made on an intelligence log without triggering an SBR under TT. But in that event, although the information would be

communicated by the intelligence unit to the FLM of the hall concerned, it would not be accessible by residential officers, including personal officers. Accordingly such officers might be unaware of intelligence in relation to low-level bullying of a prisoner when considering ongoing suicide risk assessment under TTM, particularly if such bullying had not separately been recorded on a concern form.

[154] In its 2023 report, HMIPS also considered that the level of support and assistance offered to the victims of bullying in Polmont remained poor. SPS responded by designating certain residential officers as community safety officers, tasked with weekly checks on PR2 for those marked as victims of bullying. This was to be followed by a referral and a meeting with the prisoner concerned at which support could be offered. Such a system is however reliant on there being a marker on PR2, which is in turn reliant on the recording of bullying incidents under TT.

Death in Prison, Learning, Audit and Review

[155] A DIPLAR is process for reviewing deaths in prison custody in Scotland, including but not confined to suicides. It provides a system for SPS and NHS to record any learning points and identify actions following such a death. The aim of a DIPLAR is to learn from the incident and consider the circumstances and the immediate actions taken. It is designed in particular to examine management processes and practice and how the person was being managed in prison. The process also focuses on how the incident impacted on staff involved, other prisoners, the person's family, and the establishment as a whole.

[156] In 2018 a DIPLAR would be co-chaired by the Governor or Deputy Governor of the prison concerned and a senior member of NHS staff. It ought to have been attended by all relevant members of SPS and NHS staff, if available, including those members of staff who had direct knowledge and experience of the management of the deceased prisoner. As a result of an earlier FAI recommendation, the prisoner's personal officer should attend. Representatives from social work services and Barnardo's might also attend.

[157] In preparation for, and to feed into a DIPLAR, the NHS prison healthcare manager should produce an Adverse Events Review ("AER") document, such as that found in Crown Production 14, page 952. SPS management will produce an Operational Debrief Report ("ODR"), such as that found at Crown Production 39, page 1906. These are both internal reviews, primarily directed at the organisation's response to an incident such a death in custody and learning points arising from this, not the cause or causes of the incident itself.

National Suicide Prevention Management Group

[158] SPS is responsible for implementation of TTM. The NSPMG is the SPS steering group with overall governance responsibility for TTM. The NSPMG is a multi-disciplinary group. Its membership includes representatives from SPS, NHS Health Boards, Health Scotland, Families Outside, Breathing Space, and the Samaritans. It meets quarterly. SPS estates division is represented on the group by the Head of Professional and Technical Services.

[159] The remit of the NSPMG is to monitor and review the national TTM strategy; review all self-inflicted deaths in custody and monitor progress against any actions identified through the DIPLAR process; review all FAI determinations and monitor any actions identified for SPS; monitor local activity and issues and agree any actions or changes to policy that are required; monitor national compliance with suicide prevention training; identify and agree any changes to prison facilities to improve the safety of at risk people in prison; communicate any changes to suicide prevention policies within the community and agree actions where there are implications for SPS; and to commission research to provide evidence and inform future review of the TTM strategy.

[160] Individual incidents of suicide or attempted suicide, or other issues of concern in relation to suicide prevention, are passed to the NSPMG from Local Suicide Prevention Coordinators ("LSPC") in individual prison establishments via the National Suicide Prevention Manager ("NSPM"). Currently the NSPM is Siobhan Taylor. In 2018 it was Lesley McDowall.

[161] The NSPMG is responsible for ingathering all information pertaining to FAI's and DIPLARs. A summary of any FAI determinations will be produced by SPS Legal Services, and sent to the NSPM, who should bring forward pertinent points or issues for discussion by the NSPMG. If there are no FAI determinations issued in the 3-month period prior to a meeting, then FAIs will not be discussed. FAIs are usually only discussed at the NSPMG if there are recommendations made - and they rarely are. The NSPMG also discusses learning points arising from DIPLARs, and a running action log

is kept at SPS headquarters. NSPMG monitors which learning points have been opened and closed, and what if any actions have been taken to resolve issues. An action point may remain open to the next meeting if not resolved. The Health Team at SPS HQ reviews all DIPLARS and FAIs for lessons learned.

[162] Issues in relation to ligatures and ligature anchor points are sometimes discussed at the NSPMG meetings if they are mentioned in FAI determinations. Proactive action may sometimes be taken in relation to ligature issues. For example, in the light of recent intelligence regarding telephone cables in cells a paper has been commissioned on this issue. Other items thought to pose a risk will be discussed as and when an issue emerges. For example, the use of belts as ligatures was discussed and was the subject of GMA 27A/22, considered further below. NSPMG has also been aware of risks relating to use of cell cubicle toilet doors as a ligature point, as from 2019 to 2020 there was a cluster of seven prisoner suicides in Scottish prisons related to this feature.

[163] As NSPMG meets quarterly, immediate issues in the interim will be dealt with by SPS Operations Directorate and actioned accordingly, either by the local prison management team, or with escalation to SPS headquarters for corporate oversight/action.

[164] The Minutes of 24 of the meetings of NSPMG between March 2015 and May 2023 are lodged as SPS Productions 39 to 63.

Katie Allan

Background

[165] Katie was born on 25 April 1997. Her parents are Linda and Stuart Allan. Her brother is Scott Allan.

[166] Katie's boyfriend at around the time of her death was Nick Belton. The couple had been dating for around 3 years but had never cohabited.

[167] Katie lived with her parents and brother in the Clarkston area of Glasgow until 2015. She regarded her family as close, loving and supportive, and described her childhood as a happy one. She worked hard at school and was successful academically.

[168] Katie's GP records show that she frequently required medical treatment for eczema. She had experienced this condition since childhood. It was triggered by allergies, but also by stress. It was treated by her GP by prescribing treatments such diprobase emollient, and eumovate or betnovate ointment.

[169] Katie began experiencing hair loss in early 2015. She was diagnosed with alopecia areata in April 2015. She was genetically pre-disposed to this condition, her maternal grandmother also having suffered from it. However it was also triggered by stress. When it occurred in 2015 it caused Katie distress, embarrassment, and loss of self-confidence.

[170] Initially Katie received treatment for alopecia from the NHS, throughout 2015 and 2016. She was thereafter treated privately by a consultant dermatologist at Ross Hall Hospital in Glasgow. This involved a series of painful injections into her

scalp. This treatment appeared to have been successful and her hair grew back relatively quickly.

[171] On 23 June 2015 Katie was referred to the local Community Mental Health Team by her GP. She had recently been self-harming by cutting herself. She reported to her GP that she had doubts about her sexuality and that this had caused some anxiety within her family. Katie denied suicidal ideation. She had self-harm marks on her thigh, but these were described by her GP as very superficial. Katie's parents arranged and paid privately for her to have six sessions with a psychologist, which appeared to help her.

[172] In autumn 2015 Katie began studying at Glasgow University and moved out of the family home. She initially lived in student accommodation. In 2016 she moved into a rented two bedroom flat in Glasgow, where she lived alone. Her parents helped her to buy a car. She worked part time in hospitality jobs, and had a strong work ethic.

Offence and sentence

[173] On 10 August 2017 Katie drove her car home from a pub whilst under the influence of alcohol. She lost control, mounted a pavement, and struck a pedestrian. She was subsequently prosecuted for causing serious injury by dangerous driving and for driving with a blood alcohol concentration above the prescribed limit: Road Traffic Act 1988, sections 1A, 5(1)(a). She pled guilty to these charges.

[174] In a criminal justice social work report dated 1 March 2018 Katie was noted to be highly remorseful, accepting of responsibility for her offence, and empathetic towards

the victim. She indicated to the social worker that she had no experience of significant physical or mental health difficulties. She was assessed as being at a low risk of reoffending. Community sentencing options were offered, but Katie was aware that given the seriousness of the offence the court might regard a custodial sentence as necessary.

[175] On 5 March 2018 Katie was sentenced in Paisley Sheriff Court to a total of 16 months' detention in a young offenders' institution. She had no previous convictions. She had no other charges outstanding. She had not previously been detained. She was distressed and shocked by the sentence. Immediately thereafter she was transported to and received into custody at Cornton Vale.

Reception risk assessment

[176] Upon arrival at Cornton Vale, Katie was subject to an RRA by a mental health nurse, Irene McKirdy. Katie disclosed to Nurse McKirdy that she had previously self-harmed by cutting herself on the wrists. She said that she had had no current thoughts of self-harm or suicide, and spoke about continuing her education once she had completed her sentence. Nurse McKirdy explained to Katie that there was a mental health team within the prison and she told her to approach staff if she had any concerns or issues. Katie also disclosed that she suffered from alopecia and eczema. On physical examination she was found to weigh 65kg.

[177] Nurse McKirdy entered the above examination findings on VISION. An RRA form should also have been completed by a prison officer and Nurse McKirdy. A paper

copy of that form should have been filed and retained within Cornton Vale. If such a form was ever completed, however, it has now been lost and was not available for the inquiry.

[178] The prisoner record for Katie is contained in Crown Production 14. It discloses that, upon admission to Cornton Vale, she had two marks and scars on her body. The first of these was a tattoo of a blossom tree on her left foot. The second of these was a tattoo of a globe on her right shoulder. No further marks and scars were recorded.

[179] On 6 March 2018 Katie was seen by a GP, Dr Craig Sayers, at Cornton Vale. As noted above, at the time it was still standard practice in this establishment that prisoners would be examined by a GP within 24 hours of admission. Katie disclosed to Dr Sayers that she suffered from eczema. He observed that she was "settling well so far". An entry was made on VISION relative to this consultation.

[180] On 7 March 2018 Katie was transferred to Polmont by security staff. They completed a PER relative to the transfer, now lodged within Crown Production 14. This form confirms that transfer staff assessed her as presenting no known risk, and in particular did not assess her as being at risk of self-harm or suicide.

[181] On reception at Polmont, Katie was subject to a further RRA. The form relative to that assessment is produced as Crown Production 19. The first part of the assessment was carried out by a Prison Officer Weaver, who noted on the RRA form the following:

> "First time in custody so very anxious. States she will get family visits, states she does not feel suicidal… no anger/anxiety issues, although anxious about first time in custody, made eye contact when spoken to, very pleasant. Nervous but states that she has no other concerns or issues at this time. States she is not suicidal."

Katie was accordingly assessed by Officer Weaver as being at "no apparent risk" of suicide.

[182] The second part of the RRA assessment was completed by a nurse, Alan Macfarlane, between around 1330 and 1345 hours. Nurse Macfarlane was at the time a very experienced mental health nurse who had worked in both Polmont and Cornton Vale. He had received training on both A2C and TTM. He reviewed Katie's clinical notes on VISION prior to assessing her. In assessing her he considered what she said, and how she presented. His assessment took around 15 minutes in total, which was normal in the context of a straightforward transfer. He assessed Katie as being at "no apparent risk" of suicide.

[183] Nurse Macfarlane noted on the RRA form the following:

> "Presented well on transfer. No concerns noted or voiced. Denies strongly any thoughts of self-harm or suicidal ideation… Good eye contact. Reactive in mood. No anxiety is voiced on transfer. No concerns based on current presentation."

Nurse Macfarlane was aware of Katie's history of self-harm from the VISION records, and he explored this with her. The RRA proforma states in particular that he should: "…determine if the individual has previously attempted suicide or self-harm or if they currently have any thoughts of suicide or self-harm" and that he should then "summarise [her] responses."

[184] Although Nurse Macfarlane was aware of Katie's medical history as regards self-harming, and discussed this with her, he did not note her responses on the RRA form. As prison officers do not have access to VISION, there was therefore no written

record of Katie's previous history of self-harm which was available to those officers responsible for Katie's care whilst in Polmont, and for ongoing assessment of her risk of suicide.

[185] Notwithstanding that Katie was starting a 16 month sentence, her GP records were not requested by SPS or NHS staff conducting the RRAs at Cornton Vale or Polmont. Nor were they requested at any time during her detention in Polmont.

[186] No information in relation to Katie's medical or mental health was sought from Katie's family by any member of SPS or NHS staff at any time during her detention in Polmont.

[187] On admission to Polmont Katie had a full head of hair, with no sign of the alopecia from which she had suffered in 2015 and 2016.

Katie's experience in Blair House - March to May 2018

[188] Katie was accommodated within cell 1/33 in Blair House. This was a single occupancy cell with a single bed and a toilet cubicle. Allocation of her particular cell accommodation was by the hall FLM.

[189] The prisoner population of level 1 in Blair House was below capacity. There were around 40 cells on this level but only around 12 to 14 other prisoners were accommodated there throughout Katie's time in Polmont.

[190] Prison Officers Scott Wilson and Heather Morrison were assigned to be Katie's first and second personal officers respectively. One or other of them had almost daily

contact with Katie. They liked her, and tried to get to know her and support her. She had a good relationship with both of them.

[191] Initially Katie got on well with the other prisoners on level 1 of Blair House. She was generally popular and well liked. She was however obviously of a different demographic than the other prisoners in Blair House, and stood out for this reason.

[192] Katie was also well liked by the other prison officers with whom she came into contact. She received no disciplinary reports during her detention in Polmont. She was seen by the officers as bright, pleasant, chatty, and with a good sense of humour.

[193] Soon after arrival Katie was given a job "on the pass", doing general housekeeping work around the hall. This was a position of trust and reflected the good impression that she had made on the officers in the hall. As a result, and unlike most other prisoners, Katie could be out of her cell throughout the day on weekdays, that is, between around 0700 and 2130 hours.

[194] Katie's parents and Nick Belton visited her for the first time on 10 March 2018. Thereafter she received a lot of contact and support from family and friends throughout the following 12 weeks:

a. She received frequent and regular visits. The record of visits contained in Crown Production 14 indicates around 50 visits between 10 March and 3 June 2018;

b. She made and received frequent and regular telephone calls. Crown Production 9 comprises the transcripts of 50 such telephone calls between 1 May and 2 June 2018;

c. Katie's family arranged for use of SPS email system, and she received many emails over her time in Polmont. Katie replied to emails by letter. Crown Production 8 comprises emails sent to Katie between 30 April and 3 June 2018.

The longest period that Katie had in Polmont without some contact with family and friends was no more than 2 days. That Katie had such contact was a protective factor in maintaining her wellbeing. Her family considered that Katie often put on a brave face for them during visits, that is, that she was more troubled by her situation than she disclosed.

[195] On 14 March 2018 Katie sought medical assistance for a recurrence of her skin problems through the Polmont health care self-referral process. It is not medically possible to say what caused this recurrence, although stress may have been a factor.

[196] On 16 March 2018 Katie's solicitors lodged an appeal against her sentence of 16 months' imprisonment.

[197] On 19 March 2018 Katie attended with Nurse Louise Liddell of the FVHB health team in Polmont. Nurse Liddell noted that Katie was suffering from eczema in her elbow flexures and that patches of alopecia were present. Katie was prescribed Zerobase cream for her eczema and referred to Dr Fiona Collier in relation to her alopecia.

[198] Dr Collier was a GP with special interest and experience in dermatology. She held an eight weekly, half day clinic in Polmont. Dr Collier had experience of treating hundreds of patients with alopecia over more than 20 years in practice. The 8 week

waiting time in Polmont compared favourably with waiting times for her clinics in the community.

[199] On 21 March 2018 Katie was selected at random for a strip search following a visit from her family. Nothing of concern was found. The search of Katie was conducted by Officer Claire Kemp in accordance with the above noted SPS procedures, but female recruits from SPS college were present for training purposes. Katie found this process very uncomfortable and distressing. In terms of TTM a concern form should have been completed by Officer Kemp, but was not.

[200] At or around the same date Katie was visited by Stuart MacQuarrie, chaplain at Glasgow University, who had become aware of her being sentenced. Katie appeared to him to be anxious and frightened, but became more relaxed as his visit progressed. Reverend MacQuarrie sought to reassure Katie that the management of Glasgow University had made it clear that she would be welcomed back following her release.

[201] From around the same date Katie also had regular contact with Reverend Donald Scott, chaplain at Polmont. This contact was both formal, in the sense of meeting with her in the chaplaincy - sometimes together with Reverend MacQuarrie - and informal, in the sense of chatting to her in the hall when he was there for other reasons. One way or another Reverend Scott had contact with Katie several times a week throughout her remaining time in Polmont.

[202] Reverend Scott's impression of Katie was that she was generally bright and cheerful, carried herself confidently and was relaxed, that she was not enjoying her time in prison, but was coping with it well in the circumstances. Reverend Scott was trained

in TTM. He was made aware by Katie of some difficulties in her relationship with Nick Belton. However at no point in his contact with her was he concerned that she might be at risk of suicide or self-harm. Nor did she exhibit distress. Katie expressed her frustration to Reverend Scott about the "window warriors", but did not at any point complain to him that she was being bullied. Although she disclosed that she had lost weight since admission, she joked about how the prison food was good for her diet.

[203] Between March and May 2018, Katie attended 15 drop in sessions with Barnardo's at Polmont. These were informal sessions and notes were not taken. The aim of these sessions was for youth workers to build positive relationships with the young people in Polmont.

[204] On 3 April 2018 Katie completed a Positive Futures Plan, now lodged as part of Crown Production 14. She described in detail many positives in her life, and her plans and hopes for the future. In relation to her wellbeing, she scored herself at 5 or 6 out of 6 on every question. This included a question which asked her whether she felt safe from harm and bullying, and knew where to get help and advice, on which she scored herself at 6 out of 6.

[205] On the same date, Katie's solicitor requested information from SPS in relation to her release on Home Detention Curfew ("HDC"). On 6 April 2018 SPS responded to the solicitor to advise that: (a) Katie's earliest date of liberation was 2 November 2018; (b) her earliest date of release on HDC was 3 July 2018; (c) the earliest date upon which work would ordinarily begin to risk assess her for HDC was 14 May 2018; and (d) there

was no impediment to her being considered for HDC. Appeals against sentence do not impede a HDC application.

[206] On 8 April 2018 Katie appeared visibly upset to Prison Officer Kirsty McIntyre during teatime. On being asked by Officer McIntyre, Katie stated that she was struggling with being in jail, was feeling low, but was not suicidal or going to self-harm. In terms of TTM a concern form should have been completed by Prison Officer McIntyre, but was not. Instead, Officer McIntyre made a narrative entry on PR2.

[207] At around the same date Katie was visited by Stuart MacQuarrie again. As Katie told Reverend MacQuarrie, two other prisoners had been bullying her and shouting abuse at her. They seemed to be following her about and this was worrying her. Reverend MacQuarrie sought to distract Katie by telling her that the University staff were asking after her and suggesting that some work could be sent into Polmont so that she could keep up with her studies. Reverend MacQuarrie was not trained in TTM. He did not pass on Katie's report of bullying to SPS staff.

[208] Katie was keen to continue her university studies whilst in Polmont. Reverend MacQuarrie and Officer Scott Wilson assisted in obtaining books to be brought in for Katie to enable her to continue work on her university course. She did so, and in particular, worked on writing a dissertation.

[209] On 12 April 2018 information was received into the SPS intelligence unit that a prisoner was bullying Katie and another prisoner for tobacco. It was recorded on the Polmont intelligence log, now lodged within Crown Production 14. This information

was correct. Katie smoked cigarettes, and had access to money. She had been seen as a soft touch for a prisoner or prisoners who were targeting her as a means to get tobacco.

[210] This information was not passed to residential officers involved with Katie in Blair House, and who did not have access to the intelligence log. Nor did Katie tell her personal officers about it. In terms of TTM a concern form should have been completed by the prison officer who received the intelligence regarding the bullying, but was not.

[211] On 13 April 2018 Katie was subject to a further random strip search following a family visit. Again, nothing of concern was found.

[212] Katie's alopecia continued to worsen, causing her significant hair loss, distress, and loss of self-esteem. She tried to remain positive and put a brave face on the situation. She was still waiting to see Dr Collier. She made a second self-referral for medical assistance on 20 April 2018.

[213] On 23 April 2018 Katie's appeal against sentence was passed at first sift, and accordingly the appeal was listed for a substantive hearing on 29 May 2018.

[214] On 25 April 2018 was Katie's 21st birthday. Consideration was given by Officer Scott Wilson to moving her to level 2 or 3 of Blair House to be accommodated with the adult female prisoners. They agreed that she would not make this move. Officer Wilson thought that Katie was not "jail-wise" and accordingly considered that she was better accommodated among the younger female prisoners. Further, she had struck up a friendship with a particular prisoner on level 1, and would lose that support if moved. Further, he reasonably anticipated that her remaining period of detention in Polmont was likely to be a relatively short. From Katie's perspective, she liked and trusted

Officer Wilson and wished him to remain as her personal officer, which would only happen if she remained on Blair House level 1.

[215] At around this same date Katie met again with Reverend MacQuarrie. He noticed that she appeared more anxious than on his previous visits, but spoke fondly of visits from her family. She did not give him any other cause for concern about her.

[216] On 26 April 2018 Katie's solicitor emailed SPS requesting that she be seen by a doctor imminently with a view to prescribing appropriate medication for her alopecia. The email advised, correctly, that Katie now had visible signs of baldness. The Governor replied by letter the same day advising that responsibility for prisoner healthcare was a matter for the NHS team in Polmont, not SPS, and that Katie's solicitor's letter had been forwarded to them.

[217] On around 27 April 2018 Officer Morrison asked Joanne Brogan, a mental health nurse working within Polmont, to come and speak to Katie. Katie had spoken to Officer Morrison about her history of alopecia and that it was now recurring. Officer Morrison thought that this was impacting negatively on Katie's mental and emotional wellbeing. She was aware that Nurse Brogan had suffered from alopecia herself in the past and felt that she might be well placed to offer some support to Katie. This was not a formal referral to the mental health team. Rather, Officer Morrison asked Nurse Brogan to see Katie as "a favour". In terms of TTM a concern form should have been completed by Officer Morrison, but was not.

[218] Nurse Brogan spoke to Katie in Blair House. Her hair loss was very visible, Katie told her that her alopecia was stress related. Nurse Brogan was aware that even if the

precise cause of alopecia is unknown, stress may be a factor in triggering it. Accordingly she recognised that Katie's hair loss could be a visual clue that she was not coping with stress. She also recognised, correctly, that Katie's self-esteem had been adversely affected.

[219] Nurse Brogan looked at VISION and saw the entries by Nurse McKirdy, made at Cornton Vale on 5 March 2018, in relation to Katie's history of alopecia, eczema and self-harm. She was aware, correctly, that self-harm was very common among young women, particularly those detained in Polmont. She also saw the VISION entry by Nurse Macfarlane, made at the time of the RRA on 7 March 2018, and Katie's denial to him of thoughts of self-harm or suicide at that time.

[220] Nurse Brogan had been trained under the A2C suicide prevention strategy which preceded TTM. She had been given 1½ hours training on TTM when it was introduced in 2016. And in any event she was an experienced mental health nurse. She did not consider that Katie was at risk of self-harm or suicide at this time. She thought that she had situational anxiety. However in terms of TTM a concern form should have been completed by Nurse Brogan, but was not.

[221] Nurse Brogan did make an entry on the VISION system on 27 April 2018. In particular she recorded that she had been asked by hall staff to review Katie due to

> "ongoing alopecia and impact upon MH [mental health] of same… The impact of hair loss upon Katie's self-esteem and coping is evident. Discussed the support that MHT [mental health team] could offer to help support her… Follow up by MHT."

Being on VISION, this assessment was not accessible to prison officers.

[222] Nurse Brogan saw her role as informal, providing empathy and emotional support to Katie in relation to her alopecia, rather than formal support for her mental health. Over the following month she often saw and spoke to Katie on this basis when she was in Blair House. Katie came to like and trust Nurse Brogan.

[223] Prison Officer Jenifer Wilson is a family contact officer at Polmont. She is married to Officer Scott Wilson. She often spoke to Katie when escorting her to and from the visiting area, and thought her to be a lovely girl, and a pleasure to be around. She became aware of Katie's hair loss and the distress it was causing her. Although not officially permitted to do so by SPS policy, she sourced two bandanas and on 1 May 2018 gave them to Officer Scott Wilson to give to Katie. Katie took to wearing them to try to conceal her hair loss. In terms of TTM a concern form should have been completed by Prison Officer Jennifer Wilson, but was not.

[224] Katie met with Dr Fiona Collier in her clinic at Polmont on 4 May 2018. Katie was quite composed and not tearful. She gave Dr Collier a history of her alopecia and past treatment. She did not mention eczema. On examination Katie was found by Dr Collier to have typical circular non scarring areas of complete hair loss affecting her scalp and eye lashes, indicative of alopecia areata. The scalp hair loss was less than 50%. Katie asked that she be given the injection treatment which she had received at Ross Hall in 2015.

[225] Dr Collier prescribed Dermovate scalp lotion, a topical steroid, and Forceval tablets, and arranged to see Katie again for follow up at her next clinic in 8 weeks' time. This was appropriate treatment. It was in accordance with clinical guidelines for good

practice first line treatment. There was a high chance of spontaneous regrowth of Katie's hair. The injection treatment which Katie had received in 2015 was invasive. Dr Collier did not have with her either the needles nor the medication to perform it. But in any event it was a procedure which was rarely used, and was not used in the FVHB area. Had Dr Collier seen Katie Allan at a clinic in the community, she would have prescribed the same treatment as she did, although the follow up would likely have been at 12 weeks, not 8 weeks.

[226] Dr Collier was aware that alopecia can have a devastating impact on self-esteem, especially in young people, and so adversely affect their mental health and wellbeing. She was aware that there was some evidence that stress can trigger onset of alopecia. She had been trained in TTM. She recognised the particular vulnerabilities of young people in prison settings, and had a low threshold for initiating TTM if she had concerns. She did not see any signs of mental ill health in Katie's presentation on 5 May. However she looked at VISION, and saw Joanne Brogan's entry of 27 April 2018. She took it from this, reasonably although erroneously, that Katie was being formally supported by the Polmont mental health team, and that any risks to her mental health arising from her hair loss were therefore the subject of ongoing assessment. In terms of TTM a concern form should have been completed by Dr Collier, but was not.

[227] Katie did not like Dr Collier and was not happy with the conduct of the consultation or the treatment that she had been offered. She later expressed her displeasure about this to Linda Allan, but had not done so to Dr Collier herself.

[228] At around the end of the first week of May Katie was again visited by Stuart MacQuarrie. Katie was more anxious than when he had seen her previously. She was more noticeably losing her hair. Normally impeccable in appearance, she was less tidy than before. She told him that a prison officer had told her that she had too many books in her cell and that she would have to give some away. She was continuing to be subjected to bullying and abuse. There were two prisoners who would scream at her and threaten her. They would call her a "baldy bastard" and would sneer at her appearance and try to make her an outcast from the other prisoners. Katie told Reverend MacQuarrie that she did not want to report these prisoners as it would not do any good and would probably make matters worse. She said that she could bear it. Reverend MacQuarrie did not think that Katie was at risk of suicide or self-harm.

[229] On around 21 May 2018 Katie became aware that a fellow prisoner had suicidal ideation and had planned to accumulate paracetamol in order to kill herself. Katie was unable to sleep for worrying about this. She told an unidentified prison officer about it. In terms of TTM this incident should have been the subject of a concern form in relation to Katie herself, but no such form was completed. Katie later discussed this matter with Linda Allan on the telephone. Mrs Allan sought to reassure her that she had done the right thing. Echoing the terms of TTM, quoted above, Mrs Allan correctly recognised that persons who are contemplating suicide often tell others about it, but "that it's the silent ones that are the big worries Katie", to which Katie replied "Yeah, yeah, I know."

[230] On 22 May 2018 Nurse Louise Liddell emailed Dr Fiona Collier regarding deterioration in Katie Allan's mental health due to her worsening alopecia. It is unclear

whether Dr Collier received this email, but if so, she did not act on it. By this time Katie had lost around 80% of her hair. In terms of TTM a concern form should have been completed by Nurse Liddell, but was not. By this time Nurse Brogan thought that a hairpiece would help Katie, but was conscious that this would normally require a prescription from a consultant and was unsure how to progress this.

[231] On 23 and 26 May 2018 Nurse Brogan made four entries on VISION relative to Linda Allan sourcing a hairpiece privately and making arrangements for bringing it into Polmont. These entries include the expressions "mental health review", "mental health assessment" and "follow up by [mental health team]". These entries were incorrect and therefore misleading, as Nurse Brogan was not formally reviewing or assessing Katie's mental health at this time.

[232] On the basis of her regular informal contact, however, Nurse Brogan did not consider that Katie was at risk of self-harm or suicide. Had she done so she would have initiated TTM. She believed that she had developed a good relationship with Katie. She believed that if she had any such difficulties Katie would have disclosed them to her.

[233] On or around 26 May 2018, Katie received a hairpiece which Linda Allan had sourced privately. Nurse Brogan helped facilitate the bringing of this hairpiece into Polmont, liaising with the SPS Operations Manager in this regard. Katie was delighted with the hairpiece. Nurse Brogan hoped that this would increase Katie's self-confidence and self-esteem. She agreed to work with Katie on relaxation and self-esteem techniques, but had not begun this work in earnest before going off on sick leave shortly afterwards.

[234] On 29 May 2018 Katie's appeal against sentence called in the Appeal Court. She attended the hearing remotely from Polmont via a CCTV link. On the advice of her counsel she abandoned the appeal at this hearing. She had been advised that the Appeal Court was unlikely to reduce the sentence but that there was a risk that it might be increased. This was a stressful and upsetting process for her. She had hoped that her appeal might be successful and that she would be released. She had debated with herself in the days prior to the hearing whether to follow her counsel's advice. She was anxious about appearing in court on her own without her parents present.

[235] Katie was subject to a RRA under TTM following her appeal hearing by Prison Officer Jane Goodsir. Officer Goodsir ticked a box on a "remote link form" to indicate that she did complete a RRA in respect of Katie. But the form relative to it has been lost and was not available for the inquiry. Officer Goodsir did not check Katie's previous RRA. In order to do so she would have had to have gone to the office and retrieved Katie's file, which would have taken her 5 or 10 minutes. This was not practical; at the time Officer Goodsir might have to complete 30 or 40 RRAs per day. In any event Katie was not made subject to TTM as a result of the RRA. Nor did Officer Goodsir refer her to a mental health nurse for further assessment. Accordingly if Officer Goodsir had any concerns in relation to Katie at this stage, falling short of initiating TTM, there is no record of them. Given Katie's concerns and anxieties regarding and on the day of the appeal hearing, and in terms of TTM, a concern form should have been completed by Officer Goodsir, but was not.

[236] Also on 29 May 2018, Joanne Brogan made an entry on VISION noting that Katie had been listed for Dr Collier's clinic on 6 July 2018, with a view to obtaining a prescription for a hairpiece. Again, the entry is misleadingly headed "mental health review".

[237] On 30 May 2018 Katie's solicitor made an application for her release on HDC. Although she had been anxious about her sentence appeal, after it was withdrawn she told her father Stuart Allan that she would "just get on with things and get through the next month", after which she would hopefully be released on HDC. It is likely that Katie would indeed have been released on HDC on 3 July 2018.

[238] On the same date Katie wrote to her boyfriend, Nick Belton. The tone of the letter was friendly and did not suggest or refer to any current difficulties in their relationship. Katie indicated that she was looking forward to being released on HDC 35 days later.

[239] On 31 May 2018 Katie wrote to Reverend MacQuarrie in reply to an email which he had sent her a few days before in relation to her (by now) abandoned appeal. The tone of her letter was positive and forward looking. She reflected that prison had been a

> "life changing experience and I'm determined to utilise what I've learned … to benefit others. It has took me a long time to realise that it actually doesn't matter what other folk think of you in here or outside - all that matters is that you love yourself (which for the first time ever) I'm beginning to do."

Katie also told Reverend MacQuarrie how much she appreciated the support which she was receiving and that she was looking forward to returning to university in September.

Events of 1 to 3 June 2018

[240] On around 1 June 2018, and although Nurse Brogan had tried to dissuade her from doing so, Katie shaved off her remaining hair.

[241] On 1 June 2018, Katie was visited by her boyfriend, Nick Belton. Mr Belton made derogatory remarks about Katie, in particular because she had shaved off her hair, and she was upset by this.

[242] On the nights of 1 and 2 June 2018 three or four of the prisoners in Blair level 1 were involved in shouting abuse from their cells. Katie was not involved in this, but was unable to sleep as a result and eventually shouted to these prisoners to shut up. Thereafter some abuse was directed towards Katie as well. The prison officers on nightshift duty were either unaware of this abuse, or were aware of it but did not intervene to stop it.

[243] On 2 June 2018 Nick Belton emailed Katie. The tone was affectionate and the content was chatty. There was no reference to any difficulties in their relationship, whether arising out of the visit of 1 June 2018 or otherwise.

[244] On 3 June 2018, a Sunday, at around midday, there was a fight between two prisoners in the hall. This was a violent and unpleasant incident lasting several minutes. The fight was between two of the same prisoners who had been shouting overnight. Two other prisoners joined in. Katie was working in the pantry at the time and was not involved in the fight, but she had been friendly with one of the girls who became involved, and tried to stick up for her. She was then herself verbally abused and

threatened with violence. In particular she was called a "baldy bastard", a "fat snob" and told to "go hang herself".

[245] Officers Scott Wilson and Tart were on duty at the time. They were unable to contain the situation themselves and used personal alarms to summon other officers. Together the officers intervened to stop the fight, and all prisoners were returned to their cells.

[246] The two prisoners principally involved in the fight were moved to empty cells at the end of the hall. They were also removed from association with other prisoners pending disciplinary proceedings being taken against them. However they continued to shout abuse from their cells throughout the afternoon, some of it directed at Katie. This was still audible, although it was less loud given that these prisoners were now in cells around 30 or 40 feet away from Katie's cell.

[247] At around 1515 hours on 3 June 2018 Katie was visited by Linda and Scott Allan. Officer Marie Claire Doherty was observing visits that afternoon. She noticed that Katie was quite upset and crying. Linda Allan asked Officer Doherty for a tissue, but she did not have one so gave her a cloth instead.

[248] At the end of the visit Linda Allan reported to Officer Doherty that Katie was being bullied and threatened by some girls in the hall and was terrified. Officer Doherty asked who the girls were and Mrs Allan said that she thought that they might be girls accommodated in the cells on either side of Katie's cell. Mrs Allan was worried and upset. Officer Doherty said that she would speak to hall staff and pass on Mrs Allan's concerns.

[249] Officer Doherty went out of her way to personally take Katie back to Blair House. There she spoke to Officers Scott Wilson and Tart and told them the gist of what Linda Allan had said. They told Officer Doherty that they were aware that something was going on and would speak to Katie about it. In terms of TTM a concern form should have been completed by Prison Officer Doherty, but was not.

[250] Officer Scott Wilson could see that Katie was upset. He suggested that she have a cup of tea in her cell with another prisoner, before returning to her duties on the pass. Towards the end of the shift, after the other prisoners had been locked up, Officers Scott Wilson and Tart spoke privately with Katie in the staff office. She stated to them in particular that she had had a "poor visit" and that Linda Allan "just didn't get it". Katie added that she was "fine now" and "just needed a good greet".

[251] Officer Scott Wilson discussed with Katie the fight earlier in the day. She told him that she was being involved in what had happened by one of the prisoners concerned, and that there had been verbal abuse directed at her. Katie underplayed her fears in relation to this incident - relative to what Linda Allan had said to Officer Doherty - and Officer Scott Wilson underestimated Katie's concerns in the face of it. However he discussed with her the possibility of moving to another level within Blair House. In the circumstances he was now supportive of such a move, and went to speak to the hall manager about it.

[252] Meantime Katie put two bags of clothes outside her cell for washing, and ordered some cosmetics. She also booked a visit to see her father for the evening of

4 June 2018. Officer Tart facilitated this, to support Katie, even though technically it would by now have been too late in the afternoon to book a visit for the following day.

[253] Officer Scott Wilson returned to the hall and, together with Officer Tart, spoke again with Katie. They were conscious that the prisoners involved in the fight had been removed from association with other prisoners, including Katie, and moved to cells at the end of the hall. Accordingly the officers were not concerned for Katie's safety. Officer Scott Wilson was content to leave it to Katie to decide whether she wanted to move levels. She said that she did not, in particular because she did not want to lose him as her personal officer.

[254] At around 1730 hours Officer Scott Wilson took Katie back to her cell and locked her in. She did not appear upset or distressed at this time. Neither Officer Scott Wilson nor Officer Tart considered that Katie needed to be subject to additional checks during the night, for example in relation to the possibility that further verbal abuse might be directed towards her. In terms of TTM a concern form should have been completed by these officers relative to their interaction with Katie following her return from the visit that afternoon, but was not. Nor was it recorded in any other format. Nor was contact made with Linda Allan by any officer to advise her of the outcome of the concerns which she had raised with Officer Doherty. Nor was any handover note given to the nightshift other than to advise them of the removal of the prisoners from association and that they had been placed in cells at the end of the hall.

[255] At around 1800 hours Linda Allan sent an email to Katie Allan, now lodged as Crown Production 6. This email states, in particular

> "… That was a hard visit for us all. You looked and sounded exhausted Katie and very frightened. I can't believe that after this time this is happening I can't imagine how hard it must be to deal with especially with no or very little sleep… When we were leaving the officer that had been sitting near us was incredibly kind and was only concerned about how you were. She had seen you were upset. I said you were very scared about what was happening in your hall and that you were very tired. I hope you got a chance to speak with her Katie…"

Katie did not receive this email. It would have been given to her the following morning.

Katie's death, night of 3 to 4 June 2018

[256] At approximately 2010 hours on 3 June 2018, Officer Lynne Watson did a routine numbers check in Blair House. She opened the hatch of cell 1/33 and saw Katie inside, smoking a cigarette and watching television. Katie said "Hi" to Officer Watson. She gave Officer Watson no cause for concern.

[257] At some point in the evening of 3 June or the early hours of 4 June 2018 Katie wrote three handwritten letters, now Crown Production 7, addressed variously to Linda Allan, to her grandmother, and to a female friend.

[258] In her letter to her mother Katie Allan wrote, in particular:

> "…I'm really sorry for my behaviour at the visit today. Things really aren't the best here today and I shouldn't have told you about it I'm sorry. I spoke to Scotty [Officer Scott Wilson] and the other officer when I got back to the hall tonight and I'll speak to Scotty again tomorrow to discuss the best option for my safety. Please believe me I will be okay just hate this place and a few of the people in it really aren't making things any easier. Don't see why people need to be so cruel… I've booked you in for 7:10 on Wednesday night – hope this is okay. Dad is booked in for 7:10 tomorrow night as well – hope this is okay too. Really missing home mum and my 'normal' life. Fed up with this place and the

people in it. Anyway if all goes well with the social work visit I will be home in four weeks time…"

[259] In her letter to her grandmother, Katie Allan wrote, in particular:

"I'm glad I got to talk to you yesterday for a wee while! Mum sure did make a good choice (with the wig). People have been saying how natural it looks and everything been nice to hear the comments about it. Please try to keep your chin up with all these appointments, Gran. Try and focus on the positives that you'll get to see me for more than 45 minutes in four weeks time at home [smiley face]… remember that's not long to go now!"

[260] In her letter to her female friend, Katie Allan wrote, in particular:

"… I'll try phoning again ASAP… If all goes well with the HDC (tag) I should be home the week beginning 2nd July – I'll keep you updated (one way or another) if anything changes… Can't wait to get out of here hon - really fed up with it! Shouldn't be too long though…"

[261] At some point afterwards Katie wrote a handwritten note to her parents, now Crown Production 4. It reads as follows:

"I'm really sorry it had to end this way but I just couldn't go on. I'm so sorry I failed you both as a daughter and Scott as a sister. I'm just not made for prison at all and could no longer deal with all the hurtful things that were getting said. I loved you both with all my heart but to be honest the thing that scared me the most was coming home. I've made some seriously poor choices in my life"

This note appears incomplete and was not signed.

[262] At approximately 0550 hours on 4 June 2018, Officer Stuart Pearce observed Katie through the hatch her cell. She appeared to be standing in the doorway of the bathroom, facing away from the cell door. She was not responding to banging on the cell door. Upon entering the cell, Officer Pearce found Katie suspended by the neck from a metal fixture.

[263] Upon initial examination, Officer Pearce concluded that Katie was deceased, and had been for some time. He alerted his colleagues using his radio. Officers David Nelson and Russell Turnbull attended. They shared the view that death had occurred some time earlier. The officers left the cell and waited for the arrival of the Scottish Ambulance Service and Police Scotland. Paramedics arrived at 0607 and pronounced Katie's life extinct at 0610 hours on 4 June 2018.

Examination of Katie's cell, 4 June 2018

[264] At approximately 1005 hours on 4 June 2018 Detective Sergeant Donna Roby, Detective Constable Grant Stronach, and Scene Examiner Victoria Simpson, arrived at Polmont and entered cell 1/33. Ms Simpson took the photographs now contained in Crown Production 3. Detective Sergeant Donna Roby and DC Grant Stronach took possession of relevant items.

[265] The letters now contained in Crown Production 7 were found on a book shelf in Katie's cell. The note now comprising Crown Production 4 was found on the desk.

[266] There was a piece of broken metal within an oval shaped box within Katie's cell. It had dried blood on it. This piece of metal is shown in Crown Production 3, photographs 29 and 30. Katie had used it to self-harm by cutting herself at some point in the evening of 3 June or the early hours of 4 June.

[267] A length of predominantly white, soft material was found secured around Katie's neck. This was the belt of her dressing gown, which she had used as a ligature. It is shown in Crown Production 3, photographs 17, 19, 20, and 21. A dressing gown

was found behind the cell door in Katie's cell. This is shown in Crown Production 3, photographs 7, 12, 13, and 15.

[268] Katie had been permitted to have her dressing gown cord within her cell. It was an item which was readily available and capable of being used as a ligature, without the need for ingenuity or adaptation.

[269] The metal fixture from which Katie had suspended herself was a rectangular door stop, designed to stop the toilet cubicle door from opening into the cell. It is shown in Crown Production 3, photograph 8. It is located at a height of above 1.7 metres from the floor: see Crown Production 92, photographs 107 and 108. It was a fixture which was readily available and capable of being used as a ligature anchor point, without the need for ingenuity or adaptation.

Post-mortem examination

[270] A post-mortem examination was carried out on Katie on 7 June 2018 by consultant forensic pathologists Dr Robert Ainsworth and Dr Ian H Wilkinson. Their report is produced as Crown Production 2. It contains a true and accurate record of the post-mortem examination and toxicological analysis carried out. The cause of Katie's death was confirmed to be asphyxiation through ligature.

[271] The said post-mortem examination revealed no significant internal abnormalities. The toxicology results within the report revealed 0.034mg per litre of Mirtazapine in Katie Allan's blood. Mirtazapine is an antidepressant medication. It had not been prescribed to Katie. It is not known when or how she had sourced, or taken, this medication. All other forensic analyses gave negative results.

[272] The post-mortem examination revealed three areas of scarring on Katie's body at the time of her death:

1) There were numerous horizontal linear abrasions/superficial incisions on the upper third of Katie's left forearm. These measured up to 7cms in length and covered a total area of 10.5cms up/down by 8cms across. These were inflicted in the hours prior to her death and are consistent with having been self-inflicted. They are shown in photographs 33 and 34 of Crown Production 3. They can be split into two sections. The first section of scars, which appear on the lower section of Katie Allan's arm towards her hand, were inflicted around the time of death, as Katie was suspended or shortly before she was suspended. The second section, which appear above the first section and are thinner and darker, were inflicted in the hours prior to Katie's death.

2) There were several faint scars on the lower half of Katie's left forearm running both vertically and horizontally. These marks measured up to 11cms in length. It is not possible to put a definitive timescale on when they were inflicted. These marks are not shown in the photographs in Crown Production 3.

3) There were a group of faint horizontal linear scars on her right thigh. These measured up to 3cms in length and covered a total area of 8.5cms up/down by 3cms across. It is not possible to put a definitive timescale

on when they were inflicted. These marks are not shown in the photographs in Crown Production 3.

[273] Katie did not suggest to anyone that she had been self-harming while Polmont, and no-one had noticed her doing so. Subsequent to being questioned by Officer McIntyre on 8 April 2018, no-one had asked her directly whether she had thoughts of self-harm. Nor had any member of SPS staff sought to access the RRA which had been carried out on Katie by Nurse McKirdy at Cornton Vale on 7 March 2018, which - if it exists - would have been the only written record available to them disclosing a previous history of self-harm. Nor had any member of FVHB staff, with access to Nurse McKirdy's VISION entry of 7 March 2018, told prison officers about it.

[274] At the time of her death Katie was found to weigh 58kg. She had lost 7kg - more than 10% of her bodyweight - during her 12 weeks in Polmont. As noted, Katie had told Reverend Scott about losing weight, but she had laughed it off and it did not cause him concern. None of the prison officers had noticed Katie's weight loss, nor recognised that it might be a cause for concern. Accordingly no concern form was completed by any member of staff in relation to this. Loss of weight is however not uncommon in Polmont due to the diet provided to prisoners.

Intelligence received after Katie's death

[275] Subsequent to Katie's death intelligence was received and recorded on an SPS intelligence log, now lodged as part of Crown Production 14.

[276] The first entry relates to an unspecified date in June 2018. It states that Katie had "received a lot of abuse over the telephone from her boyfriend Nick Belton", that he had told her that he was "dating other women" and that they argued about Katie getting her hair cut. It further states that Katie then "ended the relationship and entered into a brief relationship" with another named prisoner. This intelligence is graded E41. It does not accord with any of the transcripts of phone calls between Katie and Nick Belton in Crown Production 9, nor with the terms and tone of an email from Nick Belton to Katie dated 2 June 2018 now lodged within Crown Production 8.

[277] The same intelligence log entry states, in particular, that following her visit from Linda Allan on 3 June 2018 Katie was receiving abuse and threats from a named prisoner, some of which was in relation to Katie's alopecia. Again this is graded E41.

[278] A second entry made in the intelligence log post-mortem also relates to an unspecified date in June 2018. It states that two named prisoners "were shouting derogatory comments towards… Katie… prior to her taking her life." This intelligence is graded E21.

[279] A third entry in the intelligence log, again from an unspecified date in June 2018, indicated that a named prisoner had received drugs which she had supplied to two further named prisoners who in turn had sold the drugs to Katie. The nature of the drug - for example whether it was the mirtazapine found in her body post-mortem - is unspecified. Again, this intelligence is graded E41.

[280] A fourth and final entry in the intelligence log, from an unspecified date in October 2018, related to a threat by one prisoner to attack another whom she held

responsible for, by implication, Katie's death. There is no specification of the reasons for this. Again, this intelligence is graded E41.

DIPLAR

[281] A DIPLAR took place in relation Katie's death, which was initially held on 4 July 2018. A copy of the DIPLAR report is produced at Crown Production 20, from page 1093. The review was reconvened on 29 October 2018 to allow for Officer Scott Wilson to attend, and for transcripts of Katie's telephone calls from prison to be transcribed. A report of the reconvened DIPLAR is produced as Crown Production 20, from page 1110.

[282] In preparation for the DIPLAR the health care manager at Polmont produced an AER, now Crown Production 14. This included a summary of Katie's background and medical and social history, and reproduced the entries in relation to healthcare attendance for Katie whilst in Polmont from the VISION record.

[283] The issues for discussion identified by the AER included (i) requesting further details regarding Joanne Brogan's "mental health review" entry of 29 May 2018; and (ii) whether consideration was given to mental health assessment by a psychiatrist after Katie's mood dipped on 23 May 2018, or whether her positive response to receiving a hairpiece was seen as sufficiently managing concerns at that time. The review also noted issues raised by Katie's family regarding a perceived delay in obtaining treatment for her alopecia, and criticism of Dr Collier. A written response from Dr Collier was received, in which she rejected the suggestion that she had not taken Katie's alopecia

seriously, but which included her erroneous belief, from Joanne Brogan's entries on VISION, that Katie was having ongoing support from the mental health team including "expert risk assessments".

[284] The report of the DIPLAR concluded that there were no significant indicators to staff that Katie had any suicidal thoughts or intent, justifying her being put on TTM at the time of her death. It noted that she was a very well-liked young woman who staff felt had integrated well into prison life. It was noted that she had engaged well with available programmes and had several positive relationships with other prisoners and with prison officers, in particular her personal Officer Scott Wilson. On review of her telephone calls it was noted that Katie had had regular contact with a loving and supportive family. At no time did Katie say to them that she was unable to talk to staff, and only spoke of positive relationships with them.

[285] The learning points/recommendations in the DIPLAR included training support for NHS staff in relation to documenting formal/informal discussion and clinical notes. The action point arising from this was that FVHB should provide training for staff on clinical note taking and informal/formal discussions. This was a reference to the concern noted in the AER that the heading of Joanne Brogan's VISION note of 29 May 2018 did not properly reflect what she did on that day. It was also recognised that VISION notes should be structured to better reflect the content of the healthcare contact.

[286] The only other substantive action point arising from the DIPLAR was that use of the TTM concern form should be reiterated to staff at Polmont and that copies of the form should be made available in the visit room. As a consequence of this, a reiteration

email was sent to staff, including telling them where they could find blank consent forms. Copies of the forms were put in the visit area. Refresher training was brought forward for Polmont staff, which included training on concern forms.

[287] The issue of staff shortages at Polmont, and the consequent transfers of officers from Blair House and loss of staff consistency, was identified in the ODR following Katie's death: see Crown Production 14, at page 965 of the bundle. However this was not discussed at the DIPLAR, and no action points were identified in relation to it.

[288] There was no discussion or reference in the DIPLAR to Katie's cell environment, nor to the presence of the anchor point from which she self-ligatured. There was no reference to Katie having been permitted to have use of the dressing gown belt which she used as a ligature. No learning points, action points, or recommendations were made in relation to these matters.

The ligature anchor point

[289] Rectangular metal toilet door stops, such as that which Katie used as a ligature anchor point, were installed in the cells of Blair House in around 2009. By no later than 2012 these rectangular stops were recognised by SPS, correctly, to be an obvious potential ligature anchor point. Door stops of an anti-ligature design, with sloping tops, were installed in prisons built or refurbished thereafter. But SPS did not take steps to remove and replace the rectangular door stops from the cells in Blair House. This could have been done quickly and cheaply and did not require substantial capital investment.

Had such work been carried out prior to 3 June 2018, Katie would have been unable to die by suicide as she did.

[290] There was a circular hook fitting on the wall of Katie's cell. This can be seen in photograph 8 of Crown Production 3. This is an anti-ligature hook, designed so that it can take the weight of an item of clothing, but not the weight of a human body. Along with many others across the SPS estate. it was installed in around 2012. It was located a few centimetres from the rectangular toilet door stop. Accordingly action was taken by SPS to install an anti-ligature hook in Katie's cell in 2012, but no action was taken at the same time or subsequently to remove an obvious ligature anchor point, the rectangular door stop, located right next to it.

William Brown

Background

[291] William was born on 20 October 2001. His mother was Christine Lindsay, now deceased. His father is William Brown Senior[12]. William had a sister, Chloe Lindsay, and half-sister, Shannon Daniel. Both are now deceased. He had two half-brothers, John Reilly and Robert Daniel.

[12] William was also known as William Lindsay. He appears to have fluctuated between use of his parents' surnames, although his father William Brown Senior had very little involvement in his life. But in a note written by him very shortly before his death, William stated clearly that "my name is William Brown". For this reason he has been referred to in this inquiry by this surname. No disrespect is intended to those who knew him as William Lindsay.

[292] William Brown Senior's relationship with Christine Lindsay was marred by his problems with alcohol, and by domestic violence. William and his siblings suffered from neglect, and were placed on the child protection register in December 2001.

[293] Concerns about William's basic care needs, living environment, and exposure to domestic violence and drug misuse within his home continued through 2002. Grounds of referral were established at Glasgow Sheriff Court in 2003 and William was taken into care in February 2004, by which time his parents had separated.

[294] William's social work records from the age of 12 are lodged as Crown Production 67[13]. They extend to more than 1000 pages. In summary these records disclose that William remained in care throughout his childhood, and was subject to compulsory measures of supervision. He was placed with numerous different foster parents, in a kinship arrangement with his paternal grandfather, and in several specialist residential and/or secure group/care units.

[295] William Brown Senior had little or no further involvement in William's life after he was taken into care, and William did not want contact with him. However William continued to have contact with his mother and some of his siblings.

[296] William grew up with longstanding difficulties in regulating his emotions, with low mood, and social anxiety. His behaviour in placements was increasingly characterised by aggression, absconding, violence, risk taking, threats of self-harm, and abuse of drugs and alcohol.

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[13] A detailed account of William's placements and social work involvement up to 2013 can be found in an NHS Integrated Assessment Report, dated 15 February 2013, within Crown Production 67, at page 3409.

Self-harm and threats to self-harm 2016 - 2018

[297] On 14 April 2016 William attended at the Royal Alexandra Hospital Emergency Department following an overdose of paracetamol.[14] He was admitted to hospital and kept under observation until 17 April 2016 when he was discharged.

[298] On 8 June 2016 William was taken to the Royal Alexandra Hospital Emergency Department by police officers, following a report that he had threatened to take an overdose of paracetamol. He was discharged after a blood test revealed that he had not taken an overdose.

[299] At around this time William started receiving support from Includem, a charity which seeks to support young people and their families. A support worker, Stephen Cain, started meeting with William on a weekly basis and got to know him well. William presented to Mr Cain as someone who was intelligent, and could be very personable and likeable. However notwithstanding this presentation Mr Cain came to recognised that William was a very troubled young boy who was mentally unstable, impulsive, engaged in risky and self-harming behaviours, and was prone to periods of low mood and suicidal ideation.

[300] On 3 February 2017 William was referred to the Child and Adolescent Mental Health Services ("CAMHS") due to reporting suicidal thoughts, increasing low mood, and social anxiety. He was prescribed Sertraline, an antidepressant medication, on 9 February 2017.

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[14] William's medical records are produced as Crown Production 37.

[301] On 9 March 2017 William was further assessed by Dr Jane Duthie, Associate Specialist Psychiatrist at CAMHS, after telling a teacher at school that he was going to kill himself. He advised Dr Duthie that he had ceased taking the Sertraline around 5 days after it was prescribed. The prescription was discontinued.

[302] On 14 May 2017 William was taken to Glasgow Royal Infirmary Emergency Department by police officers. He had been removed from a train due to his intoxication, stating that he wanted to die by suicide. He denied suicidal ideation once sober. He was discharged with no follow up.

[303] On 17 May 2017 William was taken to the Royal Hospital for Children Emergency Department by police officers after being seen on railway tracks while stating that he was suicidal.

[304] On 18 May 2017 William was moved to St Mary's Kenmure Secure Accommodation in Bishopbriggs after exhibiting risk taking behaviours, absconding, presenting under the influence of substances, and suicidal ideation.

[305] On 14 June 2017 William was assessed by Dr Leighanne Love, Principal Clinical Psychologist at NHS GCC Forensic Child and Adolescent Mental Health Services, based in Kinning Park, Glasgow. This was sought to inform a broader appraisal of William's risk taking behaviour. During his first week at St Mary's Kenmure Secure Accommodation, staff found William with his T-shirt tied around his neck. Emergency psychiatric treatment was not sought.

[306] On 29 June 2017 William left St Mary's Kenmure Secure Accommodation and was moved to Milncroft Residential Unit in Glasgow.

[307] On 15 July 2017 William was taken to the Royal Hospital for Children Emergency Department by paramedics, having consumed excessive alcohol and cocaine. Whilst in the Emergency Department he expressed suicidal ideation. As a result, he was kept in hospital overnight.

[308] On 22 July 2017 William was taken to Glasgow Royal Infirmary Emergency Department by police after intentionally hitting his head off a police cell wall. This caused a superficial injury to his scalp.

[309] On 9 September 2017 William was taken to the Royal Hospital for Children Emergency Department after taking ecstasy and walking into the path of moving cars. This resulted in bruising and scraping. On 11 September 2017 he declined assessment by CAMHS.

[310] By September 2017, William's then placement in Milncroft Children's Unit had broken down due to his behaviour. His half-sister Shannon Daniel offered that he live with her for 5 nights per week. Christine Lindsay offered that he stay with her the other 2 nights. The children's hearing agreed to this arrangement.

[311] In around October 2017 Mark MacDonald was appointed to be William's social worker. William was designated a vulnerable young person, so Mr MacDonald met with him on a weekly basis.

[312] On 1 November 2017 William was taken to Glasgow Royal Infirmary Emergency Department by police officers after attempting to cut his own throat with a knife. He had superficial abrasions to his throat. He was referred to CAHMS for further assessment, but disengaged.

[313] On 16 November 2017 William was found by police officers attempting to get himself struck by cars whilst intoxicated. An ambulance crew attended, however he refused observation.

[314] On 29 January 2018 William was taken to Glasgow Royal Infirmary Emergency Department by police officers after attempting to get himself struck by cars whilst intoxicated.

[315] William attended the Emergency Departments of the above mentioned hospitals on a further seven occasions between April 2017 and July 2018 due to injuries reported to be from fighting, excessive alcohol intoxication, and use of illicit drugs. On three of these occasions his admission was coupled with disruptive behaviour towards the police and/or medical staff.

[316] By April 2018 William was living full-time with Christine Lindsay. The children's hearing formalised and approved this arrangement, which continued until William was remanded to Polmont. William remained subject to a compulsory supervision order.

[317] On 4 May 2018 William again self-harmed with a knife while heavily under the influence of alcohol, and following police involvement he was admitted to hospital.

[318] As William was designated a vulnerable young person, and because he was a Looked After Child, a Child Plan had been drawn up in respect of him by social work. On 23 May 2018 Mark MacDonald updated this plan, a copy of which is contained within Crown Production 67 at pages 2986 to 2991. This plan contains details of William poor mental health, substance and alcohol misuse, anti-social/criminal behaviour, and

his sometimes reckless and dangerous risk taking behaviour. It also details his self-harming behaviours of 1 November 2017 and 4 May 2018.

[319] In September 2018 William was still having frequent, regular contact with Stephen Cain of Includem. Mr Cain was aware that William's mood was fluctuating week to week, and that he was consuming a large amount of alcohol, cannabis and Valium. He was still self-harming by cutting himself, and would often talk to Mr Cain about suicide. Mr Cain was trying to support William to engage in schooling and to get him into employment.

[320] On 20 September 2018 William appeared in court and pled guilty to a charge of having an article with a blade in a public place. Sentencing was deferred until 18 October 2018 and William was bailed pending appearance on that date. On 29 September 2018 William was arrested for suspected housebreaking and released without charge.

Offence and arrest, Wednesday 3 October 2018

[321] On the morning of 3 October 2018, William walked into Saracen Police Station in Glasgow with a knife. He was arrested and charged with threatening or abusive behaviour contrary to section 38(1) of the Criminal Justice and Licensing (Scotland) Act 2010, having an article with a blade in a public place contrary to section 49(1) of the Criminal Law (Consolidation) (Scotland) Act 1995, and assaulting or impeding the police contrary to section 90(1)(a) of the Police and Fire Reform (Scotland) Act 2012.

[322] The police custody sergeant decided that William was to be retained in custody pending an appearance in court the following day, 4 October 2018. As William was subject to a compulsory supervision order a Child Detention Certificate was completed. William spent the rest of the day, and the night of 3 October 2018, in police custody. He was continuously monitored throughout.

[323] At approximately 1630 hours on 3 October 2018, William was visited in police custody by Agnes McKay. Agnes McKay was a social care officer. She provided emotional and practical support to young people and their families. She visited William to carry out a welfare check due to his known mental health difficulties and history of self-harm.

[324] Contrary to the police's account of events, William maintained to Agnes McKay that he had taken the knife into the police station to surrender it, not to threaten anyone with it. He admitted to having taken Valium and consumed alcohol the previous night. Agnes McKay asked William if he had any thoughts of attempting to harm himself. He replied "Like I'm going to fucking tell you for you to tell those scummy bastards out there". He then said that when he was released he would take Valium, put a bag over his head, fall asleep and suffocate himself. He then terminated the conversation.

[325] In the light of this Agnes McKay reported to the police officers responsible for William's care that she was worried that he would harm himself either deliberately or by misadventure.

[326] The social work department checked the availability of a secure bed in a children's residential unit in the event that William was ordered to be remanded

following his appearance at Glasgow Sheriff Court on 4 October 2018. They were advised at that time no secure beds were available.

[327] Stephen Cain was made aware by telephone that William was in custody. He spoke with Mark MacDonald about this and was made aware that William had been seen by Agnes Mackay and was due to appear in court the following day.

Court appearance and remand, Thursday 4 October 2018

[328] At approximately 0900 hours on 4 October 2018 the SCRA was notified by the police that William was due to appear at Glasgow Sheriff Court that day. They ascertained from William's case record that he was subject to a compulsory supervision order, that he had been involved with the children's hearing system for a number of years, and that there were recent concerns raised by social work about substance misuse. An officer at SCRA spoke to Mark MacDonald, who was still William's social worker, who advised that he was a vulnerable young man who struggled with his mental health and had a history of self-harm.

[329] William was conveyed to Glasgow Sheriff Court. Catriona Eaglesham was the court based social worker on duty that day. She was employed by Glasgow City Council. Glasgow City Council's guidance to court based social workers has been produced as Crown Production 67. Ms Eaglesham was responsible for liaising with other social workers at Glasgow City Council, the Intensive Support and Monitoring Service ("ISMS") team, and the Crown Office and Procurator Fiscal Service ("COPFS")

in relation to William's appearance in court. William was prioritised as he was subject to a compulsory supervision order.

[330] At around 0926 hours on 4 October 2018 Catriona Eaglesham emailed Mark MacDonald and Kenneth Miller to notify them that William was due to appear in court that day. Kenneth Miller worked with the ISMS Alternatives To Remand team. The COPFS position in relation to William was not yet known at this point.

[331] The police submitted a prosecution report to COPFS in relation to William. The report contained two charges: a contravention of section 49(1) of the Criminal Law (Consolidation) (Scotland) Act 1995; and a contravention of section 38(1) of the Criminal Justice and Licensing (Scotland) Act 2010. A summary of the evidence describing the offending behaviour was annexed to the report.

[332] SCRA checked the Secure Accommodation Network ("SAN") website to ascertain whether any beds in secure accommodation were available. This is a publicly available website enabling anyone to check whether there are beds available in secure accommodation throughout Scotland. On 4 October 2018 this website indicated that there were no beds available. SCRA carried out this check in order to assist with planning timescales for a custody children's hearing if COPFS decided to refer William to SCRA.

[333] SCRA then contacted COPFS to discuss whether William should be dealt with by SCRA or processed through the adult criminal justice system. This discussion was in line with the Joint Agreement between the SCRA and COPFS which governs the process to be followed when a 16 year old subject to supervision is taken into custody.

[334] COPFS decided that it would be necessary to retain the case and oppose William being granted bail given the nature of the charges reported and his prior analogous offending. He was deemed to present a potential risk to the public, given his recent conviction for possession of a knife and that he was on bail pending the diet of deferred sentence on 18 October 2018.

[335] Upon learning that bail was to be opposed, Catriona Eaglesham also made inquiries as to whether any beds in a secure unit were available for William. She contacted the placements team at Glasgow City Council. That team was responsible for checking the SAN website to ascertain whether any beds were available. They would also physically telephone each secure accommodation provider to ask if they had a bed available, as availability could fluctuate in the course of the day and changes might not appear on the SAN website until later in the day. There were four secure units which were routinely contacted by the team at Glasgow City Council. Having carried out these checks, the placement team advised Ms Eaglesham that no beds were available.

[336] At 1354 hours on 4 October 2018 Catriona Eaglesham emailed Mark MacDonald and Kenneth Miller to advise them that bail was to be opposed by COPFS and that there appeared to be no beds available for William in a secure unit. She also wrote a letter in relation to this, which was considered by the sheriff determining William's bail application. It stated that no place was available in secure accommodation and, as a result, if the court decided to remand William, he would be remanded in Polmont.

[337] Kenneth Miller prepared an ISMS supervised bail report which was also considered by the sheriff determining William's bail application. This is produced

as Crown Production 62. It summarised William's home situation, noted that he had mental health difficulties, that he consumed cannabis daily and that he had been under the influence of alcohol and Valium at the time of his arrest. It notes that William was the subject of a compulsory supervision order and was a Looked After Child who had previously been in secure accommodation. It noted that William had no friends and was extremely isolated in the community. It noted that he was supported by Includem. Mr Miller's report also detailed the support and supervision that would be available to reduce the risk of re-offending if William was granted bail, including engagement with a youth addiction worker and CAMHS.

[338] Meantime Stephen Cain had learned from Mark MacDonald what William had said to Agnes Mackay the previous day about intending to die by suicide by taking Valium and put a bag over his head. He went to the court and tried to visit William in the cells, but was not permitted to do so.

[339] William was represented by a solicitor when he appeared in court, and with whom he had consulted prior to his court appearance. That solicitor had also represented him previously. He pleaded not guilty to the charges and sought his release on bail. Bail was opposed by the Crown on the basis that given the charges, his previous offending, and his substance misuse, William presented a risk to public safety. The sheriff refused to grant bail.

[340] After William was refused bail, Catriona Eaglesham met with him in the cells. She asked him if he was feeling suicidal. He replied "No, not now but I don't know how I'll be in prison".

[341] Stephen Cain was notified by telephone voice mail that William had been remanded. He spoke to his family and tried to offer them support. He was concerned by the decision to remand William to Polmont, as he knew him to be a very mentally unstable young man, who had recently expressed suicidal ideation.

[342] Mark MacDonald was aware that William had been remanded. Because William was a 16 year old Looked After Child to whom WSA applied he should have produced an updated care plan in relation to him and sent this to Polmont. This would have provided background information from social work about William, the vulnerabilities with which he presented, and social work concerns for him given his remand, including concerns in relation to self-harm or suicide. Mr MacDonald had such an up to date plan, but failed to send it to Polmont.

Reception risk assessment, evening of 4 October 2018

[343] William was escorted to Polmont by G4S security staff and received into custody there at around 1911 hours on 4 October 2018. His PER is produced in Crown Production 39 at page 1818, and it was given by security staff to SPS staff on arrival. This form indicates that while in the custody of G4S William was treated as being at risk of suicide or self-harm, and that because of this risk he required a high level of supervision and constant observations.

[344] Catriona Eaglesham completed a VPR in respect of William. This report accompanied William to Polmont. It is produced as Crown Production 31. Its purpose, as it states, is "to notify prisons of prisoners who may be vulnerable and require additional support and monitoring within the prison environment." In it Ms Eaglesham

advised that William was a "Looked After Accommodated Child". She identified Mark MacDonald as William's social worker and gave his telephone number. She advised that she had spoken to William's mother and aunt but because of his mother's distress she was unable to get any meaningful discussion with her. Ms Eaglesham also advised that in speaking to William after his remand he was "responding to questions with no comment however stated that he is not currently suicidal although doesn't know how he will be later when locked up." Ms Eaglesham also gave her own phone number.

[345] Meantime COPFS faxed a letter to Polmont reception, dated 4 October 2018, advising that William was considered to be a suicide risk and should be dealt with accordingly ("the PF Fax"). This faxed letter is produced as Crown Production 30. It was sent due to the information conveyed to COPFS by Police Scotland, SCRA, and the social work department.

[346] Kenneth Miller's ISMS supervised bail report did not accompany William to Polmont, although as noted it contained information relevant to assessment of his risk of suicide, and was supportive of the suggestion that such a risk existed.

[347] On arrival at Polmont William was checked in by Prison Officer Christopher McAinsh. From around 1920 hours he was subject to an RRA by Officer McAinsh, and then Nurse Brian Leitch.

[348] The RRA form is produced as Crown Production 41. Officer McAinsh completed Parts 1 to 4. At Part 2 he confirmed that he had received and read the PER. Under "details of any relevant information" Officer McAinsh has noted "Social work letter

concerns + procurator fiscal fax stating suicide risk." He did not record that William was a Looked After Child. At Part 3 the question whether William had the ability to communicate effectively was answered "yes" by Officer McAinsh, but no narrative or comment in relation to this is given. At Part 4 Officer McAinsh summarised his interview with William as follows: "been suicidal in the past + says might feel it now that he is in custody." William was nervous, made poor eye contact, and was fidgeting, but Officer McAinsh failed to record this. He also failed to record that this was William's first time in custody, although the RRA form prompts consideration of this. There is also a prompt on the form in relation to family contact. Even if Officer McAinsh asked William about this, he failed to record his response. His only comment on William's presentation was "good communication".

[349] Officer McAinsh did not complete Part 5 of the RRA form, which should have stated the outcome of the assessment. He considered almost immediately that William should be assessed by him as being "at risk" of suicide, and accordingly should be placed on TTM. He therefore completed the TTM initiation form, now also produced within Crown Production 41. At Part 2 of that form he noted that the reason for initiating TTM as follows: "First time in jail a bit overwhelmed and scared doesn't know if he will do anything to harm himself as he tried it when was in secure but never came to anything."

[350] As a case conference could not be convened immediately, Officer McAinsh completed Part 3 of the TTM form, "Actions to address precipitating factors and risks", as follows: "30 mins obs to make him feel secure and safe to make him feel ok and to

reassure him that nothing is going to happen to him." Part 4 of the TTM form is headed "Care Plan and Regime". It prompts consideration of "support to be provided and any change to location, regime or restrictions on clothing or items allowed in use. Clear rational must be provided for all decisions." In relation to this Officer McAinsh wrote "30 mins observation, use of phone all items in use. Just for reassurance and safety."

[351] Officer McAinsh did not consider it necessary to stipulate that William be on 15 minute observations. He wrongly proceeded on the assumption that he could only stipulate 15 minute observations, or removal of potential ligature items such as belts, if he also stipulated a Safer Cell. He did not consider that a Safer Cell was necessary in William's case. Nor did Officer McAinsh consider it necessary to look behind the written documents that he had, for example, by telephoning Ms Eaglesham or Mr MacDonald. The COPFS letter he recognised as a standard one, which he was used to seeing on a daily basis. He regarded a prisoner's presentation as the critical factor in considering whether to institute TTM, not their past history.

[352] Nurse Brian Leitch was at the time a mental health nurse of nearly 40 years' experience, seven of which had been in Polmont. He was working a 1230 to 2130 hours shift, dealing with admissions, as he had done on many occasions before. Shortly after 1920 hours he was called from the health centre to the admissions area and met with William. Officer McAinsh passed to Nurse Leitch the partially completed RRA and TTM forms, the PER, the VPR and the PF fax. Nurse Leitch did not have any other background information in relation to William prior to meeting with him.

[353] Nurse Leitch carried out a basic physical examination of William and entered his observations onto VISION. He asked William what had happened, and William told him that he had walked into a police station with a knife when he was drunk. He asked William about previous suicidal behaviour. William said that he had attempted suicide when in a secure unit, about 9 months previously, by jumping in front of cars. He disclosed that he suffered from depression and anxiety, and had been seen by CAMHS. He denied that he was suicidal at present. In the light of his assessment of William's presentation and rapport, Nurse Leitch accepted this denial at face value.

[354] Nurse Leitch attached little weight to the PF fax, which like Officer McAinsh he regarded as a common pro-forma letter the likes of which he would see on a weekly basis. Nor did he attach much weight to the VPR given that it referred to William not currently being suicidal. He saw the PER, but did not attach weight to it either. Notwithstanding the references to William being a looked after child, that he was only in Polmont because there was no secure unit available, and the provision of Mark MacDonald's phone number, he did not think it necessary to attempt to make contact with him. In any event it was now well after office hours.

[355] Nonetheless Nurse Leitch was aware that given Officer McAinsh's decision, William would remain on TTM pending a case conference, and that this could not now take place until the following day. He did not think that TTM was justified by William being a suicide risk. But he thought that William was perhaps a bit overwhelmed and scared by being in Polmont and of going into the hall. He spoke to William about this and tried to allay his anxieties. He felt that keeping William on TTM observations

would help reassure him and settle into the hall, although this is not the purpose of TTM nor a justification for its use.

[356] William was taken to the hall and Nurse Leitch then completed his entries on VISION and on the RRA and TTM paperwork. At Part 6 of the RRA form, his assessment of behaviour, attitude and risk, he ticked that he had seen the PER, and wrote "history of involvement with CAMHS whist in care. Self-harm history and court expressed concern. Would benefit from 30 minute observations to help him settle." As to William's presentation, Nurse Leitch wrote simply "very nervous". Initially, he circled "No Apparent Risk" but then crossed that out and circled "At Risk". In relation to the TTM form, Nurse Leitch agreed with and did not add to what Officer McAinsh had already written regarding the immediate care plan. Nurse Leitch signed the TTM form at 1947 hours. The entire RRA and TTM initiation process had taken 27 minutes.

[357] On VISION, Nurse Leitch noted in particular:

> "Very anxious. History of self-harm and anxiety. Denies current thoughts of self-harm but appears very vulnerable. Due a visit from his auntie tomorrow he thinks which will settle him… Thoughts of deliberate self-harm. [History of] deliberate self-harm. Tried to self-harm nine months ago. Jumped in front of cars. No current thoughts. Placed on TTM with 30 minute observations due to concerns raised from court and social work. [History of] psychiatric disorder. Depression and anxiety. Saw CAMHS in secure (St Marys)… Current drinker. Alcohol intake within recommended sensible limits."

[358] Nurse Leitch was not aware that because William was a 16 year old Looked After Child his case would be subject to a WSA initial custody review in accordance with Polmont SOP 41. He was therefore not aware that this review should (as a matter of best practice) take place within 72 hours, and that if it did that it was likely that more

background information - in particular from social work and William's family - would be available at that review.

[359] At around 2105 hours William was taken to Monro Hall and accommodated in cell 2/45. William was noted by Prison Officer Ian Shanks, who received him into the hall, to be apprehensive, it being his first time in custody.

[360] Monro Hall had 76 standard cells and two Safer Cells. At the time that William was admitted around 50 prisoners were accommodated there.

[361] Cell 2/45 in Monro Hall was a standard cell, not a Safer Cell. In accordance with the general policy at Polmont, William was accommodated by himself in this cell. However it had a double bunk bed in it. No consideration was given by hall staff, in allocating this cell, to the risk to William presented by this potential ligature anchor point within the cell.

[362] That William was allocated to cell 2/45 was a matter for decision by the nightshift hall manager. Neither Officer McAinsh nor Nurse Leitch knew, when carrying out the RRA, which standard cell within Monro Hall William would be accommodated in. They therefore did not know, and did not give any consideration, to whether the fixtures or fittings within William's cell might facilitate self-ligature, and they did not take account of this when assessing his risk of suicide.

The early morning events of 5 October 2018

[363] At around 0600 hours on 5 October 2018, a Friday, William was checked by an Officer McBride. He noted on the TTM care plan report that "William slept through the

night, gave no cause for concern." This was not entirely accurate, as William had been kept awake past midnight by other prisoners shouting from their cells.

[364] On the morning of 5 October 2018 the two residential officers on duty on the west side of Monro Hall were Officers Robert Baird and Natalie Cameron. Their shifts started at 0630 and finished at 1230 hours. Officer Baird had more than 30 years' experience as a prison officer in Polmont. Officer Cameron had previously been employed by SPS at Cornton Vale, but had been a residential officer at Polmont only since February 2018.

[365] Officer Baird had not met William the previous night. But when he came on duty he saw that William was on TTM with 30 minute observations. He read the TTM documents. After breakfast had been served he and Officer Cameron went to William's cell and introduced themselves. They chatted for a couple of minutes. Officer Baird found William to be softly spoken and polite. William said that there had a lot of shouting from other prisoners the previous night which had kept him awake, but said that it had not been directed at him.

[366] Thereafter Officer Baird was responsible for checking on William every 30 minutes in accordance with the TTM care plan. He was keen to get to show his face to William, so rather than just checking on him through the hatch he would open his cell door and chat to him briefly. William told Officer Baird that he was anxious to get his mother's phone number as he had forgotten it and wanted to contact her. William told him that he was being supported by Stephen from Includem. Officer Baird was

aware of Includem, because he had had contact with this organisation in the past in relation to other prisoners.

[367] Nurse Leitch was also on duty on 5 October 2018. His shift was from 0800 to 1400 hours. He was scheduled to participate in four case conferences that day, including that with William. That he would be the mental health nurse who did both the RRA and the case conference for William was a matter of chance, not policy. He contacted Officer John Dowell, the Monro Hall FLM, to arrange holding William's case conference shortly after 0930 hours.

[368] TTM required that a case conference be held within 24 hours of initiation. However that did not require that it be held first thing in the morning of 5 October 2018, given that by this stage William had only been in custody for 14 hours. Nor did TTM preclude maintaining a prisoner on TTM and holding a further case conference on a later date, should the first case conference not have all the information relevant to assessing whether a prisoner was no longer at risk. No consideration was given to holding William's case conference later in the day, nor of convening and adjourning it until the WSA review, which ought to have taken place the following Monday.

[369] Officer Baird became aware that William's case conference was to take place at around 0930 hours, and having met and spoken to William it was his intention to participate in it. Having read the TTM documentation he recognised, correctly, that William presented with a number of risk factors, and that more background information was required. Given this, he anticipated that the case conference would readily decide that William should remain on TTM.

[370] Material to Officer Baird's view was his awareness that in practice prisoners were rarely taken off TTM on a Friday. This was because given the restricted weekend regime in Polmont William would likely be locked up in his cell from around 1630 hours on Friday 5 October until 0730 hours on Monday 8 October, with relatively little time out of cell, staff contact or activities.

[371] Sometime between 0800 and 0830 hours Tara Duthie met with William in the hall. Ms Duthie was a prison health care addiction worker employed by Signpost Recovery, a charity operating within Polmont. Her meeting with William was a routine interview as he was a new admission. It lasted around 10 minutes. William indicated that he did not wish to pursue assistance through addiction services. In the course of the interview he told Ms Duthie why he was in custody, and indicated that he had been feeling suicidal when he had gone into the police station. She asked him if he still felt suicidal, and he said "no but I wouldn't tell anyone anyway".

[372] Concerned by this information, Ms Duthie checked the whiteboard in the hall after her meeting with William and saw that he was on TTM. Accordingly she did not herself put William onto TTM as a result of what he had said to her - as she otherwise could have done. But nor did she record or pass this information on to anyone else at this point, whether via a concern form or otherwise. Like Officer Baird, she did not envisage William being taken off TTM on a Friday.

[373] Sometime between around 0845 and 0930 hours Officer Baird phoned Includem, in particular, in an attempt to get William's mother's telephone number. He spoke to an unidentified worker there, who did not have William's mother's number, but said that

they would get Stephen Cain to phone Officer Baird back with it later on during the day. Officer Baird said that he would be going off duty at 1230 hours and that Officer Ross Cormack would be on duty thereafter and would deal with it. The Includem worker told Officer Baird that William had had a hard life, and had been in and out of care. Officer Baird passed this information on to Officer Cameron, but did not record it either in a concern form or in the TTM documentation.

The pre-case conference assessment

[374] At around 0930 hours Nurse Leitch met with William one to one in a room in Monro Hall for the TTM pre-case conference assessment. Nurse Leitch thought that William presented as more relaxed and settled than the previous evening. William said that he had met someone he knew in the hall and it was not as bad as he had thought. He said that he was trying to make phone contact with his family to come and visit him. He denied any thoughts of suicide when asked. This meeting lasted around 5 minutes. On the basis of it Nurse Leitch had no concerns that William was at risk of suicide. He did not consider it necessary to obtain any further background information on William, for example by contacting his social worker on the phone number which he had been given, in order to inform the case conference.

[375] Nurse Leitch completed the TTM paperwork relative to the pre-case conference assessment. There is a proforma to be completed in relation to this. It requires the healthcare professional to consider a number of factors in relation to risk, and to tick a box if any of them are found to be present. Nurse Leitch ticked boxes in relation to

the following factors: (i) "history of self-harm or suicide attempts (highlight methods used in the record of interview)"; (ii) "history or diagnosis of mental health issues"; (iii) "history of drug or alcohol misuse"; and (iv) "expression of suicidal intent/ideas". Under the heading "record of interview" Nurse Leitch noted the following:

> "William has been in secure unit before. Very nervous about time in jail. History of self-harm whilst stressed. Unsure how he will get on but no current thoughts. Contact with CAMHS whilst in secure but no medication. Appears to have a poor level of understanding."

Accordingly Nurse Leitch did not, as required by the form, highlight the methods used by William in his history of self-harm or suicide attempts. Nor did he note any change in William's presentation from the previous evening. He signed and dated the form at 0935 hours.

The case conference

[376] Shortly before 0945 hours Officer Baird was unexpectedly called to a disturbance involving another prisoner. Officer Cameron said that she would attend the case conference in his place, as she had not participated in a case conference at Polmont before. Officer Baird agreed that she could do so.

[377] The case conference began at 0945 hours. In attendance were Nurse Leitch, Officers Cameron and Dowell, and William. It was chaired by Officer Dowell. He had not met William previously and therefore had no knowledge of how he might normally present. Officer Cameron had briefly encountered William in the hall earlier that morning and had explained the general regime and the likely timetable for the day.

Therefore she too had minimal knowledge of William's normal presentation. Both Officers Dowell and Cameron had read the RRA and TTM documentation prior to the case conference, but they did not read, nor ask to read, the PER, the VPR, or the PF fax. Nor did they have sight of Nurse Leitch's minute of the pre-case conference, and were not aware of all the risk factors noted there, for example, William's drug and alcohol abuse and mental health problems.

[378] The case conference lasted around 5 minutes. Nurse Leitch took the lead. William was asked how he was settling in. He said that he was a lot happier. He admitted that he had been worried about coming into prison, but that it was not as bad as he had feared. He said that he had met somebody whom he had been with in care, and that they had been playing pool. He asked if staff could help him with phone calls to his family. He was asked if he had any thoughts of self-harm or suicide and he said no. There was no discussion about any previous suicide attempts, for example when, how or why they had happened. There was no discussion in relation to his history of mental health or drug and alcohol issues. There was no consideration given to obtaining background information, in particular from William's social worker or his family. William appeared to be relaxed, and to be making good eye contact. In the light of this his denial that he had thoughts of self-harm or suicide was accepted at face value.

[379] Officers Dowell and Cameron and Nurse Leitch agreed that William was at no apparent risk of suicide. They therefore decided to remove him from TTM. Officer Dowell deferred to Nurse Leitch, as he was an experienced mental health nurse, well known to him. Officer Cameron deferred to Officer Dowell in relation to this

decision, given his seniority and experience. No consideration was given nor effort made by any of them to obtain any background information about William prior to making the decision.

[380] In particular, no consideration was given by Nurse Leitch to seeking background information from Mark MacDonald, nor to inviting him to participate in the case conference. This was notwithstanding that he knew that Mr MacDonald's telephone number was on the VPR. Officers Dowell and Cameron were not aware that William's social worker's name and telephone number was readily available because they had not read the VPR, and because it had not been written on the RRA or TTM documentation by Officer McAinsh or Nurse Leitch the previous evening. Nor was any consideration given to contacting William's Includem support worker, or his family, or seeking information from CAMHS about his mental health history.

[381] No transitional care plan was put in place following William's removal from TTM. Officer Dowell did not consider such a plan was necessary, as he thought that there would be a review of William's case within 72 hours under the WSA.

[382] The minutes of the case conference are set out on a TTM proforma document, now lodged within Crown Production 41. They were written by Officer Dowell. At Part 2, "Precipitating Factors (events and triggers)" he wrote "Concerns raised at court. First time in court." At Part 3, "Progress against care plan and response to care regime (if applicable)" he wrote "Care plan has kept William safe and secure at this time." At Part 7, "care plan and regime" he wrote

> "MHN Leitch spoke to William as he had interviewed him on admission. William stated he was fine and had no thoughts of self-harm or suicide. William stated he didn't need to be on TTM and after our discussion all at the C/C agreed to remove him from TTM."

There is accordingly no reference to William's age, his background, the available documentation pointing to suicide risk, nor the suicide risk factors which Nurse Leitch had recorded in his note of the pre-case conference.

[383] Nurse Leitch also later made an entry on VISION, as follows:

> "TTM CASE CONFERENCE. Settled well into hall overnight. Knows a few boys in the hall which has greatly helped. Slightly worried as he is related to a famous crime family in Glasgow and does not want it known. Denies thoughts of self-harm. PLAN 1. Remove from TTM."

Events following the case conference

[384] At around 0955 hours Officer Baird, having dealt with the other prisoner issue which had prevented him from attending the case conference, met with Officer Cameron in the hall. She told him that William was no longer on TTM. Officer Baird was shocked. He said "Please tell me that's a fucking joke." Officer Cameron said "He's fine". Officer Baird saw Officer Dowell in passing and asked him whether he was sure about taking William off TTM. Officer Dowell told him not to worry.

[385] Officer Baird considered immediately putting William back on TTM. He could have done this, but had never previously encountered a situation where a prisoner had been put back on TTM by an officer immediately after a case conference had removed him from it. He also had respect for Officer Dowell and Nurse Leitch. So he decided not to. He spoke to William and tried to reassure him. He got for some confectionary

for him. He found him to be more relaxed than earlier in the morning. They discussed making contact with another prisoner in the hall whom William knew. Officer Baird phoned the front gate and asked officers there to expedite any visits that William might get that day.

[386] William continued to be anxious to make contact with his mother. Accordingly Officer Baird phoned Includem again to try to speak to Stephen Cain and get her phone number. His call went to voicemail, so a worker called Quddsia Iqbal emailed Stephen Cain to get him to call Officer Baird back.

[387] At around 1030 hours Mark MacDonald telephoned Andrew Doyle, a social worker working in Polmont, to make a referral in respect of William and pass on his concerns in relation to him. Mr MacDonald should also have emailed William's Child Plan - which was in existence and up to date - to Polmont, but failed to do so. Mr Doyle explained to Mr MacDonald that social workers based at Polmont would not be working with William, as he was not within their remit, but that he would pass on the concerns to those members of staff who would be.

[388] Mark MacDonald recorded in William's social work file a note of his contact with Mr Doyle. He noted, correctly, that he had "pass[ed] on his concerns regarding William's low mood, suicidal ideation and impulsiveness [and that he] will probably be putting on a brave face."

[389] At around 1100 hours Andrew Doyle telephoned Monro Hall and spoke to Officer Baird. He told him the details of the referral from Mark MacDonald.

Officer Baird told Mr Doyle that William had been on TTM but had been taken off it earlier that morning.

[390] Mr Doyle made a written record of his conversations with Mark MacDonald and Officer Baird on a form used for recording referrals made to his social work team from external agencies and individuals. This form is now contained within Crown Production 32. Mr Doyle noted that Mr MacDonald had said that William was: "Just remanded: poor mental health, previous self-harm (superficial cuts), suicide threats, currently very low mood, though puts on a front. V impulsive." Mr Doyle noted the gist of his conversation with Officer Baird on the external referral form as follows:

> "Was on T2M until C/C this morning. Called M2 and spoke to Rab Baird. He will go for a chat with him and keep a close eye. Rab advised he does appear to be coping okay and has a close friend on the hall who he is being allowed time with…"

[391] At around 1130 hours Andrew Doyle emailed a formal referral to the FVHB mental health team in Polmont in respect of William. This email and referral form are also produced within Crown Production 32. The referral form contained further details in relation to William's risk of suicide obtained from Mark MacDonald:

> "William is a 16-year-old male who was remanded yesterday. I have just received a call from Mark MacDonald (Glasgow social work) who wish to pass on concerns regarding William's mental health to the MHT.
>
> William has a long history of poor mental health which has recently dipped and led to a violent episode. He has a history of self-harm (superficial cuts) and suicide threats, as well as one known suicide attempt in which he threw himself in front of an oncoming car. He stated earlier this week that he wanted to 'take a bunch of Valium and put a bag over his head'. He apparently 'puts on a front', but is distraught whilst he is also very impulsive."

Mr Doyle also included reference to his conversation with Officer Baird:

> "He was on T2M when he came in but was removed following a c/c this morning however I don't believe the prison were aware of the above. I have also spoken with hall staff (Rab Baird) regarding the above and they are keeping a close eye and offering support."

The external and internal forms reflect the information which Mr Doyle had passed on to Officer Baird, and in particular that William had made a very recent threat of suicide but might "put on a front", that is, seek to conceal mental health difficulties or suicidal ideation.

[392] Mr Doyle's faxed referral was received by an administrator in the Polmont mental health team. It should have been uploaded to VISION via the DOCMAN system, but was not. It should have been physically passed on to one of the mental health nurses immediately, but was not. Had it been, William should then have been reassessed and put back on TTM. Instead, the referral was printed out and put into a tray to await collection and action. It had still not been collected or acted on prior to William's death more than 36 hours later.

[393] Officer Baird should have put William back on TTM in the light of the information from Mark MacDonald received via Andrew Doyle, but he did not do so. Nor did he record the information received from him on a concern form. In particular this was because he considered, incorrectly, that he and the other hall staff already had all the information which Mr Doyle had passed on.

[394] At around 1200 hours, shortly prior to going off shift, Officer Baird did a verbal handover to Officer Ross Cormack. Officer Cormack was another very experienced

prison officer, with nearly 30 years' experience as a residential officer in Polmont. He had been assigned to be William's first personal officer. Officer Baird told Officer Cormack that William was vulnerable and asked Officer Cormack to "keep an eye on him". He told him that someone would be phoning from Includem with William's mother's phone number.

[395] At around 1230 hours Stephen Cain telephoned Polmont, returning Officer Baird's calls from earlier in the day. As Officer Baird had by then gone off shift, he spoke to Officer Cormack. He passed on William's mother's telephone number. He told him that William had cut himself and talked about hanging himself, and that while he might act "the big man" he was in fact a scared boy who might not disclose suicidal thoughts. The call lasted around 5 minutes. Mr Cain made the following note on the Includem phone log:

> "…reiterated WB mental health issues and how he may act cocky but he is vulnerable yp [young person] and is prone to self-harm and I have real concerns for him in Polmont."

Officer Cormack understood from the call that Mr Cain was of the view that William would hide his true feelings very well. Incorrectly, he did not regard this information as new or surprising.

[396] Accordingly Officer Cormack did not put William back on TTM in the light of the information from Stephen Cain, as he should have. He did not fill out a concern form, as he otherwise should have. He did not otherwise record it nor bring it to the attention of the hall FLM, as he could have.

[397] Stephen Cain made arrangements to take William's mother to visit him in Polmont. Whatever Officer Baird had said to the staff at the front gate that morning, however, the earliest time that Mr Cain was offered for this visit was Monday 8 October 2018.

[398] At around 1300 hours Tara Duthie went to the health centre for a handover meeting. Nurse Leitch was present, along with around 16 to 18 other members of healthcare staff. Ms Duthie became aware that William had been taken off TTM at the case conference. However she did not pass on to Nurse Leitch, or anyone else, the information relative to William's suicide risk which he had given her at their meeting at around 0800 hours that morning. Nor did she put William back on TTM, as she should have done. Nor did she record the information in a concern form, as she otherwise could have done. She finished her shift at around 1615 hours that day. By that time she had not yet updated VISION in relation to her meeting with William that morning.

[399] Notwithstanding Officer Baird's request at handover, Officer Cormack did not give William any special attention or observation in the hall on the afternoon of 5 October 2018. He saw William when he was out of his cell, but did not see any signs of anything out of the ordinary about him.

[400] On the evening of 5 October 2018 William spoke to a "peer mentor" for approximately 5 minutes. A peer mentor is a fellow prisoner who provides reassurance and support to those who have not been in prison before. The peer mentor explained to William some of the Polmont routines and procedures, for example, showers, phones, and recreation.

William's death, 6 to 7 October 2018

[401] Officer Cormack was on duty again on Saturday 6 October 2018. He spoke with William that day when he was issuing breakfast and dinner, but again did not give him any special attention or observation. In the relatively brief periods when he was allowed out of his cell, William was left to his own devices. Officer Cormack went off duty at 1800 hours. He left no handover note in relation to William for the nightshift staff.

[402] At approximately 2055 hours on 6 October 2018 Officers Jill Morrison and Alan Lochrie did a hatch check on all prisoners in level 2 of Monro Hall to ensure that they were safe and well. No concerns were noted in relation to William.

[403] Prison Officer Lindsay Bland began her shift at 2100 hours on 6 October 2018. She was observing another prisoner who was on TTM every 30 minutes, a few cells along from William's cell. William did not request or otherwise attract Officer Bland's attention over the course of the night.

[404] At approximately 0740 hours on 7 October 2018, Officer Bland carried out a hatch check on all prisoners on level 2 of Monro Hall. On opening the hatch of cell 2/45 she observed William to be suspended by the neck from a noose attached to a rail of the bunkbed. Officer Bland alerted colleagues using her radio.

[405] Two other prison officers attended and all three officers entered the cell. William was already dead. More prison officers arrived and untied the ligature from the bunkbed. An ambulance was called and arrived at approximately 0750 hours. Paramedics pronounced William's life extinct at 0755 hours on 7 October 2018.

[406] At approximately 1030 hours on 7 October 2018 police officers and a scene examiner arrived at Polmont and entered cell 2/45. The scene examiner took the photographs now produced as Crown Production 29.

[407] On examination a length of red bed sheet, one edge of which had been torn to create a ligature, was found secured around William's neck. A knot had been tied in the material. This was positioned below William's right ear. This ligature is shown in the photographs in Crown Production 29 at pages 11 to 21.

[408] Within the cell police officers found and retained handwritten notes written by William, running to a total of 16 pages. Although undated, their content indicates that all were written on Saturday 6 October 2018 or the early hours of 7 October 2018.

[409] In the pages now lodged as Crown Production 35 William describes how his name was "getting shouted out the window tonight" and how another prisoner had instructed him to rip his sheet up to make a rope to drop down to another cell to get drugs. He wrote that he did not want to do it but feared having his "head kicked in".

[410] Part of the pages now lodged as Crown Production 36 is addressed to William's family:

> "Its night time now. Been crying a lot. I just want to get better now… I love you all so much. I know I don't show or say it but I do. I just don't like showing my feelings… I can't handle it in here… One of the boys [is] already making threats… Terrorising me Mum and I'm not a hard man…"

[411] In the pages now lodged as Crown Production 34 William describes the events giving rise to the charges against him as a cry for help:

> "I was upset I put the knife on the reception desk then backed away… I apologise for my actions… Please I'm not a bad guy I just want the help…

> I've been unwell in the head most my life, I've been in the care system all my life. I'm not looking for any sympathy I just want you to understand… I just wanted someone to talk to because I felt like ending my life."

He ended this note with the following:

> "I've only been in here for two sleeps… I hate this. I need out. I just want to get better. This shit's not for me. Please help me… Everyone's terrorising me… only so much I can take. I've already tried hanging myself three times now. I just can't. I don't want to leave my baby niece without no uncle but there's only so much I can take. This was none of your faults it was mine…"

The retrospective VISION entry, 8 October 2018

[412] On Monday 8 October 2018 Tara Duthie attended for work and learned of William's death. She spoke with the health centre manager, Denise Allan regarding what William had told her at their meeting on Friday morning. Ms Allan instructed Ms Duthie to make a retrospective entry on VISION in relation to this meeting. Accordingly she did so, and her entry included the following:

> "Client disclosed reasons for custody and when asked if he still felt suicidal client stated 'No but I wouldn't tell anyone anyway'. Informed by hall staff client on TTM when passed on concerns".

Ms Duthie's entry makes no mention of her becoming aware, by no later than 1300 hours on 5 October 2018, that William had been taken off TTM. Nor does it make any mention of her having passed on the information which she had received from William to Nurse Leitch, or anyone else, at that time.

Post-mortem examination

[413] On 11 October 2018 a post-mortem examination was carried out on William by consultant forensic pathologist Dr Robert Ainsworth. His report is produced as Crown Production 28. It contains a true and accurate record of the post-mortem examination and toxicological analysis carried out. The cause of William's death is confirmed to be due to asphyxiation by ligature.

[414] Included in other injuries and marks which were observed on William's body were numerous horizontal linear scars on the front of the left forearm. These measured up to 5cm in length.

[415] The internal examination revealed no significant abnormalities. The toxicology report within the post-mortem report revealed 13mg per litre of an inactive cannabis metabolite. This indicates past use of cannabis. This metabolite continues to be detectable in the blood for some time after cannabis is used. All other analyses gave negative results.

DIPLAR

[416] On 20 November 2018 a DIPLAR in relation to the death of William was carried out. A copy of the report is produced as Crown Production 46.

[417] Prior to the DIPLAR, on 19 November 2018, SPS management at Polmont produced an ODR. A copy is now produced at Crown Production 39, page 1906. Under the heading "learning points" there is a subheading "what went well?" in relation to

which four bullet point items are listed, including the "management of post-incident by all involved". Under the subheading "what could be learned?" there are no items listed.

[418] The general view of the DIPLAR, however, was that William should have been maintained on TTM until all information from relevant external agencies had been obtained.

[419] The following action points, among others, were identified in the DIPLAR report: (i) that consideration should be given by SPS to court reports and documentation being transported with young people remanded to custody; (ii) that staff should be reminded of the concern form process in relation to information from external agencies; (iii) that NHS should ensure staff should obtain information from external agencies as soon as possible, with a clear email point of contact; (iv) that NHS should ensure robust initial assessment occurs through use of a standardised assessment template with clear assessment fields, and should be monitored, audited and supervised; and (v) that the TTM case conference guidance and training should be reviewed to ensure staff understood the importance of keeping someone on TTM until information is received from external agencies; and (vi) that consideration should be given to teleconference facilities being available so that external agencies could actively participate in case conference discussions.

[420] As regards point (i), above, this was not a matter for SPS alone to action, but required intervention by SM, in particular through Scottish Courts and Tribunals Service. The Deputy Governor of Polmont accordingly raised this recommendation with

senior SPS management. As at the date of the hearing of the inquiry in January 2024, no action had been taken to give effect to it.

[421] As regards point (ii), nothing further was done in addition to the action resulting from the similar recommendation made in the DIPLAR which related to Katie. As discussed further below, such action as may have been taken by SPS pursuant to this recommendation has been ineffective to significantly improve use of concern forms in accordance with TTM policy.

[422] There was discussion at the DIPLAR regarding FVHB's operating procedure in relation to receipt of mental health referrals at Polmont, such as that sent by Andy Doyle on 5 October 2018. It was suggested that a specific point of contact should be identified by FVHB to deal with social work referrals. However this matter was not directly reflected in any action points arising out of the DIPLAR. There was no evidence before the inquiry as to whether any action was taken, whether disciplinary or by way of re-training, in relation to the particular member of staff who had placed Andy Doyle's referral in the tray rather than passing it on to a mental health nurse.

[423] There was no discussion or reference in the DIPLAR to William's cell environment, or to the presence of the bunk bed which he had used as a ligature anchor point. There was no reference to William being permitted to have normal bedsheets notwithstanding that he had been able to rip these without apparent difficulty to use as a ligature. No learning points, action points, or recommendations were made in relation to these matters.

The ligature anchor point

[424] William used the double bunk bed in his cell as a ligature anchor point. Double bunk beds, when located in single occupancy cells, were already well known by SPS to be a potential ligature anchor point. For example, in July 2014 a prisoner named Jordan Barron had used a double bunk bed to complete suicide within a cell in Monro Hall. Nurse Brian Leitch gave evidence at the subsequent FAI. The sheriff's determination[15] was discussed by the NSPMG at its meeting of 7 December 2016. A prisoner named Kirk Leggatt had self-ligatured from a double bunk bed in HM Prison Low Moss in July 2015. This death was discussed at the NSPMG meeting of 8 December 2015, and was later the subject of an FAI determination[16].

[425] Suicides by using double bunk beds as a ligature point have also repeatedly occurred in prisons in England and Wales. No later than 2015 the failure of the prison authorities there to remove double bunk beds from single cells had been publicly recognised and commented on adversely: see Crown Production 51, at page 2228.

[426] Removal of the double bunk bed in William's cell, and its replacement with a single bunk, could have been done quickly and cheaply. It did not require substantial capital investment. Had this removal and replacement been carried out prior to 6 October 2018, William would have been unable to die by suicide as he did.

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[15] *Inquiry into the death of Jordan Barron* [2016] FAI 9.
[16] *Inquiry into the death of Kirk Leggatt* [2018] FAI 14.

Prisoner suicide in Scotland

[427] Around 123 prisoners died by suicide in all Scottish prisons in the years 2011 to March 2024[17]. This is a relatively small data sample and therefore should be treated with caution when seeking to extrapolate trends.

[428] The suicide rate in prison in Scotland is significantly higher than the suicide rate in the general population. For example, the suicide rate in Scottish prisons for the period 2015 to 2019 was 12.5 per 10,000, which was around ten times the rate for the Scottish population as a whole over the same period.

[429] Data from England and Wales indicates that men are at a higher risk of suicide in the community than women. For men in prison, the rate of suicide is around 5 or 6 times higher than for men in the community. For women in prison, the rate of suicide is around 15 to 18 times that for women in the community.

[430] The risk of suicide among young men, and particularly young women, is significantly higher when they are in prison than when they are in the community. Put another way, all young prisoners are statistically at substantially higher risk of suicide compared with young persons in the community, and young women even more so.

[431] Comparative analysis of prisoner suicide rates in different jurisdictions is problematic, particularly given differing definitions of suicide (for example, whether deaths due to drugs overdose, although self-inflicted, should be categorised as suicide),

[17] An analysis of the then available data on prison suicide in Scotland was carried out in 2019 by the Scottish Centre for Crime and Justice Research for ERoMH, and was annexed to it: see Production 1 for William Brown Senior. Further data was supplied to the inquiry by SPS in tabular form, and in oral evidence.

differing prisoner populations, and variable data quality. However a recent Council of Europe survey[18] has found that in 2022, across 48 member states, the median prisoner suicide rate was 5.3 per 10,000 inmates with an average of 7.1. The suicide rate in Scottish prisons was reported as 18.9 per 10,000, a rate only exceeded by three other states.

[432] The rate of prisoner suicide in Scotland has consistently been reported as being higher than that in England and Wales in recent studies, although the differing size of these countries and the nature of their prison populations, and other factors, prevents any straightforward interpretation of this. In the recent Council of Europe survey the prisoner suicide rate in England and Wales was found to be 9.3 per 10,000, that is, around half that in Scotland.

[433] The rate of prisoner suicide in Scotland appears to have increased between 1980 through to the late 1990s, followed by a decline through to 2014. At the time when A2C was replaced by TTM, there were around eight suicides per year across the whole Scottish prison estate. Since then the rate has again appeared to be increasing. In the last 3 years there have been around ten suicides per year.

[434] The death of a young person by suicide while in prison is a relatively rare phenomenon in Scotland. There were between one and four such deaths per year between 2005 and 2014. Between 2010, and Katie and William's deaths in 2018,

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[18] Aebi, M F & Cocco, E (2024). *Prisons and Prisoners in Europe 2023: Key Findings of the SPACE I report*. Series UNILCRIM 2024/1. Council of Europe and University of Lausanne, Table 4, now lodged as Production 2 for William Brown Senior.

six young prisoners between the ages of 17 and 21 died by suicide whilst detained at Polmont. Further young prisoners died by suicide in Polmont in 2021 and 2023[19].

[435] Suicide is the leading cause of death of young people in custody in Scotland: when a young person dies in custody it is typically due to suicide. The rate of suicide for young people in prison is much higher compared to the rate in relation to older age groups in prison.

[436] The disproportion between the suicide rate for people in prison and in the general Scottish population is even greater for younger persons. While younger people accounted for around 12% of prison suicides in the period 2016 - 2018, the same age group accounted for only around 4% of suicides in the overall population. No other group had such a large disparity.

[437] The data from Scotland is consistent with international research, showing that the vast majority of young people who die by suicide in prison (for example, 79% of total suicides in the period 2005 - 2018), do so within 3 months of being detained. Suicide by young prisoners often occurs in the first week in custody (42% of total suicides in the period 2005 - 2018). Statistically, the first 24 - 72 hours are recognised to be particularly critical, and that is so whether the individual is entering prison as a new admission, or entering a new prison after a transfer from another prison.

[438] It is also widely recognised, nationally and internationally, that it can be very difficult to identify those who might or intend to take their own life, and therefore that

[19] A further suicide of a 17 year old prisoner at Polmont was reported in the national media in July 2024, in the course of the writing of this determination.

not all suicide attempts can be predicted. Suicide and self-harm are complex issues and many of those who go on to die by suicide while in custody do not display any obvious presentation that would identify them as being at risk, even to trained and competent staff employing appropriate person centred risk assessment strategies.

[439] A basic issue widely recognised as affecting accuracy in person centred risk assessment is the underreporting by prisoners of their histories or current feelings of distress. There is evidence to suggest that fewer than 40% of those prisoners with medically validated histories of self-harm disclosed this during screening. Not disclosing vulnerability, and the pressure to be seen to be coping, are familiar and embedded dynamics of custodial environments.

[440] There is a statistical link between prisoners who self-harm and those who attempt or complete suicide. Self-harm is indicative of a higher risk of suicide, but the extent of that increased risk cannot be accurately quantified on the available data. Some prisoners who self-harm go on to attempt or die by suicide, but by no means do all do so.

[441] Hanging is by far the most common means by which prisoners in Scottish prisons die by suicide, accounting for some 90% of all cases. In the period 2011 to 2024 some 111 out of the 123 prisoner suicides in Scotland were by this means.

[442] There was no data available to the inquiry, in relation to these 111 prisoners, identifying and/or analysing their custody status at the time of their deaths, or when during the day, or where within the prison, or by what ligature anchor point, they died.

[443] Of the ten young prisoners (aged 21 and under) who died by suicide at Polmont between 2010 and 2023 (including Katie and William), all did so by self-ligature in their cells. Eight of the deaths occurred overnight, one in the late afternoon and one in the mid-evening. Other than Katie, all were male. Four were convicted prisoners, six were held on remand. Two used light fittings as a ligature anchor point, three used their bunk beds, and one used the toilet cubicle door. Data in relation to the ligature anchor points used by the remaining four prisoners was not available.

[444] None of these ten young prisoners were subject to TTM (or A2C) at the time of their deaths. Accordingly all were regarded by SPS as being at no apparent risk of suicide under TTM (or low risk of suicide under A2C) at the times when they hanged themselves.

[445] Other than in relation to Katie and William there was no data available to the inquiry on how many of these ten young prisoners had previously been on TTM or A2C. However there is some evidence to suggest that most prisoners who have died by suicide in recent years have previously been on TTM or A2C, for example, 71% of the 34 suicides in all Scottish prisons in the years 2016 to 2018.

[446] The SM's stated position, correctly, is that no death by suicide in prison should be regarded as either acceptable or inevitable. However the available evidence suggests that existing prison suicide prevention policies and practices based on person centred risk assessment - notwithstanding the considerable effort and expense which have been put into improving them - have not been sufficient to reduce the suicide rate,

particularly among younger prisoners. It appears to be at a high level relative to other jurisdictions, and may even be increasing.

Ligatures in Scottish prison suicides: bedsheets and belts

[447] A belt was used as a ligature in nine (8%) of the 111 suicides by self-ligature in Scottish prisons between 2011 and 2024. Clothing was used in ten of these suicides (9%), shoelaces in nineteen (17%), a towel or other material in nine (8%), an aerial cable in one (1%), and other unidentified items in six (5%). By far the most common ligature item was bedding material (sheets or pillowcases), which was used in 57 suicides (51%).

[448] Of the ten young prisoners who died by suicide in Polmont between 2010 and 2023 four used bedding materials as a ligature, four used an item of clothing, and two used other unspecified material.

[449] The bedding (sheets and pillowcases) issued to prisoners in standard cells across the SPS estate are of domestic quality. They are not, and are not designed to be, anti-ligature, in the sense of having greater resistance to being ripped so as to form a ligature than might be found in bedding in a non-prison environment. They can, with relatively little ingenuity or effort, be ripped and used to create a ligature.

[450] Prisoners assessed under TTM as being at a high risk of suicide can be issued with anti-ligature bedding materials, such as the duvet cover lodged as SPS Production 38. These are made from very heavy weight fabric with strong double stitching designed to prevent them being ripped or cut. The weight and inflexibility of

such bedding materials reduces their comfort substantially and makes them unsuitable for anything but short-term use in acute cases of risk.

[451] There are a range of other bedding materials available on the market for use in secure settings which provide greater rip resistance than the materials presently used as standard by SPS, but which do not involve the substantial loss of comfort associated with heavy weight anti-ligature bedding. Such intermediate materials may be able to reduce, rather than remove, the risk of their being ripped so as to form a ligature, by increasing the effort and ingenuity required to do so. The evidence available to the inquiry was insufficient to reach clear conclusions on the availability, utility, or cost of using such materials in Polmont.

[452] Where prisoners are assessed under TTM as being at a high risk of suicide, they may be required to wear anti-ligature clothing. An example of an item of such clothing is lodged as SPS Production 39. Such clothing is made from very heavy weight fabric with strong double stitching designed to prevent the possibility of ripping or cutting it. The weight and inflexibility of such clothing reduces their comfort substantially and makes them unsuitable for anything but short-term use in acute cases of risk.

[453] Although the NSPMG has touched in passing on the items used as ligatures by prisoners in its meetings since 2015, rarely has it directly addressed this issue. At the NSPMG meeting of 5 June 2019, under "other competent business" Lesley McDowall, then NSPM, questioned the purchase of kettles with short cables on the grounds that they were more expensive, and that prisoners were allowed other items with longer cables. The NSPMG agreed not to purchase any more such kettles, and so to sanction

the use of cables on the face of it more readily usable as a ligature. Ms McDowall also raised the issue of belts, and the consensus of the NSPMG was the decision whether the prisoner should be allowed to use them should be a matter for the TTM case conference: see SPS Production 51.

[454] At its meeting of 27 April 2021 the NSPMG discussed a 2019 suicide at HMP Glenochil in which a prisoner, not then assessed as being at risk of suicide, used a belt as a ligature: see SPS Production 57. Ms McDowell raised the question of whether the TTM guidance should be amended to include that prisoners not be permitted to have belts in their possession. After discussion, she agreed to produce an options paper. She did so[20], and it was discussed at the NSPMG meeting on 19 August 2021: see SPS Production 58.

[455] At that meeting the NSPMG was advised that belts had been used in three suicides in Scottish prisons in recent years. This was incorrect, as there had been seven such suicides between 2012 and 2019. Ms McDowall advised that in two recent FAIs the Crown had advised against belt use within prisons. The policy options proposed were (i) complete removal of belts from all prisoners; (ii) that prisoners be allowed to have belts as long as they were not on TTM; (iii) that prisoners be allowed to have belts so long as they were not being held in a Safer Cell, or (iv) that the status quo and current process should remain, that is, that all prisoners be allowed belts. Five members of the NSPMG voted for option 2, three for option 3 and one for option 4.

[20] A copy of the options paper was not provided to the inquiry.

[456] The minutes record the discussion as follows:

> "Some of the key feedback received from members included the importance of preserving the dignity of those in our care and highlighted that responsibility should not be stripped from individual case conferences and care plans.
>
> L McDowall also believed it was important to highlight to the group that none of the individuals who died by suicide using a belt were on Talk to Me at the time of their death.
>
> The general agreement was that if the organisation were to remove belts entirely, where would the removal of materials end. For instance, bedding cannot be removed, even though this is the most common ligature of choice.
>
> L McDowall agreed that option number 2 would be the most defensible decision. Following discussion, the group consensus was to back option 2 as agreed through the feedback to the options paper. A GMA will be drafted…"

Accordingly the NSPMG agreed not to remove one known ligature item (belts) because of the presence of another more common ligature item (bedding). It agreed to leave decisions about whether to remove belts to TTM case conferences, even though they had been used as ligatures by prisoners who had not been considered by a case conference because they were not on TTM.

[457] In July 2022 SPS issued GMA027A/22 ("*Use of belts for those presenting as a risk of suicide*"): SPS Production 35. This advised that in an FAI determination a sheriff had suggested that the SPS "may wish to consider the use of belts for those in custody who may be at risk of suicide". It was advised that the NSPMG had considered the issue and decided that "a decision as to whether or not to remove belts from anyone on TTM should be determined by the case conference based on an individual risk assessment". The case conference

> "should carefully consider all aspects of risk in determining the most appropriate location for the individual, the items of clothing and bedding that they are provided with and the items they are allowed access to within their accommodation".

This GMA gave effect to the decision of the NSPMG of 19 August 2021.

Polmont Ligature Anchor Point Review, November 2018

[458] In the light of the deaths of Katie and William, the then Cabinet Secretary for Justice requested the then Chief Executive of SPS to "carry out a review of all ligature points across the SPS Estate". On 15 November 2018 this request was passed indirectly to Gordon McKean, architect, then Head of Technical and Professional Services within the SPS estates department. He was not told that it was related to the deaths of Katie and William, and was not told the mechanisms of their deaths. He was told to carry out the review immediately, that is, within a week.

[459] This was not realistic, given the scale of the proposed task and the short timeframe suggested. No one else in SPS had ever done such a review previously. Mr McKean was not given any detail nor guidance as to how to carry it out. Nor did he have any particular qualifications in relation to such a review. By chance, he had contact with the Royal Edinburgh Hospital, which had carried out a similar assessment, and so was able to share their experience. He also carried out a brief internet search. He accordingly became aware that there were already policies, processes and procedures commonly in place across the NHS estate - particularly in secure mental health settings - in relation to evaluating ligature anchor points as an aspect of suicide risk assessment.

Although different NHS Trusts' policies varied, each had generally based its process on the Manchester Took Kit ("MTK").

[460] The MTK is an anti-ligature assessment toolkit developed by Greater Manchester West Mental Healthcare Trust. It is a quantitative assessment tool which uses a scoring system across four dimensions (with a fifth qualitative dimension as a guide to aid scoring). The individual scores are multiplied to provide an overall score which is then translated into a low, medium or high risk factor. Policies based on the MTK are not intended to, and do not, assess the potential suicide risk presented by any given individual. They are environment centred and intended to complement, not replace, person centred risk assessments. The four scored dimensions are (i) room designation rating; (ii) patient profile rating; (iii) ligature anchor point rating; and (iv) compensating factors. These are all scored on a scale of 1 to 3. The fifth dimension relates to identification of different types of ligature anchor points.

[461] The "room designation rating" is an assessment of the opportunity that a patient could have to use a ligature point. For example, a single bedroom or bathroom area would be classified as a high rating (score 3) as the occupant may be alone in it, whereas a communal corridor area or locked office would be classed as a low rating (score 1), as it is unlikely that the patient would be alone in it, or be able to access it.

[462] The "patient profile rating" is a factor that identifies the risk associated with a variety of patient types. This is a general group profile not an individual profile. Patients with severe or acute mental illness, who are depressed, or are young persons,

may be classed as high rating (score 3) whereas patients in rehabilitation or in self-care groups may be rated as low (score 1).

[463] A ligature anchor point is defined by MTK as a fixture or fitting that can be found within an internal or external environment which can be accessed by a patient and "could be used to secure a ligature to, where the whole, or significant part of their body weight can be suspended." The "ligature anchor point rating" system in the MTK depends on the height of the point from the floor. If it is less than 0.7 metres from the floor it is scored as 1, that is, low risk. Points between 0.7 and 1.7 metres from the floor are scored as 2, that is, medium risk, those between 1.7 and 4 metres as 3, that is, high risk, and those above 4 metres as 1, that is low risk (being out of reach). This rating reflects the ease with which the anchor point can be used to self-ligature.

[464] The compensating factor is a review of things that could reduce the overall risk of a person using a ligature. This assesses aspects such as the level of and effectiveness of staff supervision, the level of observation, the sightlines, and the ingenuity required to prepare a ligature anchor point and to potentially form a ligature. The scoring tends to be based on a matrix system using a number of factors. For example a room with limited observation potential and limited staff may attract a high rating (score 3), whereas the same room with good staffing may attract a moderate rating (score 2), as may a room with good observation potential but limited staffing.

[465] Multiplying the scoring for the various risk factors together gives an overall score and a designated risk factor. The designated risk factors related to the scoring are "low risk" (score up to 12), "moderate risk" (score 16 to 36), and "high risk" (score 54

to 81). Accordingly, and for example, where a vulnerable young person with mental health problems (patient rating profile score 3) is accommodated on their own in a single room (room designation rating score 3), in which there is a ligature anchor point located between 1.7m and 4.0m from the floor (ligature anchor point rating score 3), and where they are not subject to observation for lengthy periods (compensating factor score 3), overall assessment would result in a total score of 81, and a high risk rating.

[466] Most NHS Trusts using MTK undertake to remediate a score of 81 as a matter of course. Certain Trusts have a stated aim to remediate scores of 54 or higher. Lower scores are frequently designated as requiring potential action over the longer-term taking into account other priorities and budgets. Most Trusts' policies recognise that responsibility for ligature review and audit should fall in the first instance on the clinical manager in control of the particular area, not the estates department. Most Trusts' policies also place responsibility on the clinical manager for proposing and following through any action, for example by requesting direct work from the estates department, advising business managers of budgetary requirements, or agreeing long-term changes. Further guidance is provided on how actions are defined, recorded and delivered, and in relation to staff awareness and training. The requirements for independent internal auditing of the process are also often defined.

[467] As Mr McKean quickly and correctly recognised, the MTK approach could be adapted for use by SPS, and could be dovetailed with other processes such as TTM. The room designation factor could be adapted by identifying the typical cell types within a prison, and recording whether or not a prisoner would be likely to be left in

the room unsupervised, alone, etc. The patient profile rating could be adapted into a form of prisoner type rating, for example those recognised to be at greatest risk of suicide compared to the general population, such as women, young men, and those early in their sentence. The ligature anchor point rating could directly adopt the height from floor approach taken in the MTK, with specific guidance developed regarding the SPS environment. For example the rating could score both the height of the ligature anchor point, and how easy it would be to use it, or how much ingenuity would be required to do so. The compensatory factors could include such aspects as supervision, staffing, and levels of observation, but could also include other aspects such as the overall environment (whether the prison is old or modern, whether the activity regime for prisoners is rich or impoverished, etc). However the MTK approach is not just about risk assessment of the physical estate, but must also take into account both operational aspects of the particular institution, and the particular profiles and vulnerabilities of the populations accommodated within them.

[468] As Mr McKean also recognised, there needed to be a process in place for acting on the results of an MTK style audit in the Scottish prison estate. SPS has a means of reporting physical defects for attention, but not for repairing, altering or replacing fixtures and fittings simply because they present a ligature anchor point risk. Overall, the approach to each dimension would require to be developed and an overall process agreed and defined, having regard to SPS governance, operational processes, strategic aims, reporting structures and audit functions. A cross directorate approach within SPS would therefore be required. Mr McKean, however, could focus only on assessment of

the physical environment, the other dimensions not being within his field of expertise. He therefore proposed carrying out a survey of a 10% sample of room types within Blair, Monro and Iona Halls in Polmont, including standard and Safer Cells, and ancillary rooms.

[469] Mr McKean submitted this proposal to Kate Hudson, a senior official within the Chief Executive's department, and met with her and other SPS officials on 21 November 2018, at which it was discussed and approved. Mr McKean understood that SPS already intended to reduce potential ligature anchor points through design and the redevelopment of the SPS estate, particularly in new build prisons. However he considered that there was potential for the proposed audit process to be implemented so as to achieve further improvements in the existing estate, and to raise awareness as part of a risk management approach.

[470] On 26 November 2018 the Cabinet Secretary wrote to the Chief Executive, stating that while he appreciated the need to balance ligature point reduction with maintaining positive living spaces for prisoners, he supported steps to "consider the potential to reduce opportunities for suicide, particularly with regard to ligature points, drawing on relevant guidance" and welcomed that this was being looked at "as a matter of urgency": SPS Production 67.

[471] On 27 and 28 November 2018, together with other SPS colleagues Mr McKean carried out the proposed ligature anchor point survey and produced a report, *Sample Review of Ligature Anchor Points, HMYOI Polmont*, dated November 2018, now lodged as Production 24 for SPS ("the LAP Review"). It was a substantial piece of work. Together

with detailed annexes and numerous photographs of identified ligature anchor points it runs to 176 pages. It applied the MTK ligature anchor point rating system to a random but representative sample of rooms within Blair, Monro and Iona Halls. It identified the presence of numerous fixtures or other items which could be used as ligature anchor points due to their inherent design (for example, bunkbeds, toilet cubicle partition doors and the rectangular metal door stops therefor, ventilation outlets, windows, wash hand basin plugs, heating pipes, etc), but also numerous other potential ligature points which were present due to wear and tear, poor maintenance, or unauthorised modification (for example, defective fittings, inappropriate additions or changes, broken safes, holes in panels where bolts had been removed but not replaced, etc). The survey also identified fixtures and fittings which could be adapted could be adapted by the prisoner for use as a ligature anchor point (for example, light fittings in which holes could be melted by use of a lighter).

[472] Mr McKean and his colleagues did not survey cells 2/45 in Monro Hall (William's cell) nor cell 1/33 in Blair House (Katie's cell). They did however survey very similar cells, namely cell 2/48 in Monro Hall and cell 1/34 in Blair House. In cell 2/48 ten ligature points were identified with a "high" height category in terms of the MTK scoring system, including the bunkbed frame. Six further ligature points were identified with a "medium" height category, and "four" with a low height category. In cell 1/34 five ligature points were identified with a high height category (including the rectangular toilet cubicle door stop), eight with a medium height category, and six with a low height category. Accordingly both of these cells fell to be scored 3, or high risk,

applying the MTK ligature anchor point scoring system. Given that these were both single occupancy cells, were a young, vulnerable prisoner to be accommodated in them, without regular observation by staff, the resulting MTK scoring would likely have been 81. As noted, this was the highest score, and indicated a high risk calling for remediation as a matter of course.

[473] Having completed his review, Mr McKean attended an NSPMG meeting on 5 December 2018 and outlined the MTK approach: see SPS Production 49. He sent his base report to Kate Hudson, and to the personal assistant to the then Chief Executive of SPS, on 7 December 2018. He also sent the annex which related to Monro Hall only, as he did not have the IT capability to send the remaining annexes, given their size. He did not get a direct response. He was never asked to provide the full report to senior SPS management. Instead, Mr McKean was invited to attend what was described as a "Safer Spaces workshop" on 10 January 2019. This was not a group that he had previously attended, he did not know how it had been formed, or why he was being asked to attend. There was no agenda given to him in advance, although he assumed it was to discuss the LAP Review.

[474] On 11 December 2018 the Chief Executive wrote to advise the Cabinet Secretary for Justice of the LAP Review. He summarised the approach taken in the review and its use of MTK. He concluded however that while "broken fixtures or fittings" presenting a higher than average risk would be addressed, "for the most part, the majority of ligature anchor points identified cannot be addressed without significant capital investment", and that therefore the findings of the LAP Review would merely "inform a corporate

Safer Spaces work stream", for use alongside TTM: see SPS Production 68/3. However the rectangular door stops in Blair House and the double bunk beds in single occupancy cells in Monro Hall were not "broken fixtures or fittings", but both presented high ligature anchor point risks. Neither required significant capital investment to remove the risk they presented.

[475] The minutes of the meeting of the Safer Space group on 10 January 2019 are lodged as Production 26 for SPS. At paragraph 3 there is reference to the Chief Executive having agreed "an audit of the safer cells". Mr McKean was not involved in nor aware of this. Mr McKean presented to the meeting a list of 15 bullet points relative to the LAP Review and these were discussed. These included bringing forward the SPS annual cell certification maintenance review, so as to address the repair of ligature anchor points arising from misuse or disrepair, and to review the cell certification system generally, for example, as regards the frequency of checking for ligature related defects, reporting, and recording them. Given the level of disrepair which he had identified in the LAP Review, Mr McKean suggested that a GMA was required in this respect. But more generally he proposed developing a ligature assessment toolkit along MTK lines. He also proposed the setting up of a group to focus on anti-ligature fixtures and fittings within both standard and Safer Cells, for example as a subset of NSPMG, to reinforce awareness that anti-ligature policy was not just a matter for the estates department, but an operational issue too.

[476] Given that SPS policy was to move to single cell occupancy within Polmont, and the high height ligature anchor point risk which was presented by double bunk

beds, Mr McKean specifically proposed to the Safer Spaces group on 19 January 2019 that they be removed from single cells. There was however no discussion about what would happen in relation to the remaining risk factors identified in the LAP Review. Mr McKean remained unsure of the purpose of the meeting and was not asked to attend another.

[477] Mr McKean did however receive a verbal instruction, relayed from the Chief Executive's office, to "fix everything". He indicated that he could not do this. He had only surveyed 10% of the cells at Polmont. He considered that those ligature anchor points arising from disrepair or inappropriate adaptation could better be addressed in the SPS full annual cell maintenance and repair process already scheduled for May 2019. But other ligature anchor points were inherent to the design of the cells and their fixtures, and so required removal or replacement, and thus capital investment. It was not within his remit to authorise the necessary expenditure for this.

[478] At around the same time Mr McKean was asked by the Chief Executive's office to produce a report as to the cost of bringing all cells within the SPS estate up to Safer Cell standard. He was aware that the costs of doing this would be huge and unrealistic. He was also aware that it would not be desirable to accommodate all prisons in what might be the relatively austere environment of a Safer Cell. This was not what he had been suggesting in the LAP Report. However his advice was not sought on what costings to provide. Had it been, he would have proposed a more realistic approach to making improvements to existing standard cells, short of trying to bring them up to Safer Cell standard, and to provide costings for this work instead.

[479] Nevertheless Mr McKean produced a costing report in the terms instructed, a copy of which is lodged as Crown Production 90. It explains, correctly, that the costs of bringing standard SPS cells up to Safer Cell standard varied, depending in particular on whether the cell was in the old Victorian estate (for example, HMP Barlinnie), in the redeveloped estate rebuilt between 2002 and 2009 (for example, Polmont) and the new estate built since 2013 (for example, HMP Grampian). Cells in the old estate would require a complete and expensive refit. Cells in the redeveloped estate would require, in particular, new anti-ligature windows, replacement sanitary ware, and new anti-ligature furniture. Redecoration and re-flooring would also be required given the damage to existing finishes which would be involved in carrying out the work. In cells in the new estate, on the other hand, most of the furniture, sanitary ware and windows were already reduced ligature design. The main items requiring alteration were the bed, protection of services to the cell, and the provision of an anti-ligature toilet cubicle door.

[480] The cost of bringing all cells in Polmont up to Safer Cell anti-ligature standard was estimated by Mr McKean to be around £24,000 per cell, or a total of around £17 million. This compared with estimates of around £35,000 per cell in prisons in the old estate, and around £5,000 per cell in prisons in the new estate. The total cost in relation to all the cells in the entire SPS estate was estimated at around £155 million. These estimated costs will have risen greatly in the period since 2019, due to in particular to increased materials costs and inflation.

[481] On 15 February 2019, the Chief Executive of SPS wrote a report to the then Cabinet Secretary for Justice, a copy of which is produced as Production 71 for SPS.

In his report the Chief Executive acknowledged that "some potential ligature points could be removed fairly easily e.g. coat hooks" and that "common ligature anchor points" such as bunk beds, furniture, and partition doors "could be eliminated by [replacement] as new materials and designs have evolved since the establishment was built." However under reference to the costings report he concluded, in summary, that to create a ligature free environment at Polmont would involve accommodating prisoners in a "restrictive sterile environment", which would involve considerable cost and would be likely to exacerbate the problems arising from mental ill-health rather than addressing them. He suggested that this might contravene prisoners' human rights. He suggested that prisoners might find other ways to die by suicide than by self-ligature. He suggested that individualised risk assessment under TTM was preferable. In the light of this, and again in summary, he recommended that SPS should not seek to bring all standard cells up to Safer Cell anti-ligature standard, but that it should rather invest in the provision of further Safer Cells, make procedural improvements in relation to TTM assessment, and provide revised staff guidance and training.

[482] The Chief Executive did not acknowledge to the Cabinet Secretary (i) that in the LAP Review Mr McKean was not proposing a "restrictive sterile environment" for all prisoners, but rather works to audit and reduce self-ligature risk within the existing standard cell environment - particularly those which could be "easily removed" or "eliminated by replacement"; (ii) that removal and reduction of ligature anchor point risks in standard cells was already SPS policy in relation to design of new build prisons

such as such as HMP Grampian - and that this did not result in a "restrictive sterile environment" for prisoners; (iii) that the high figures quoted in the costings report related to works of a nature and scale - in effect turning all standard cells into Safer Cells - which Mr McKean had not proposed, and was not proposing, and (iv) in any event, that a reduced ligature point cell environment could and should - as was by then widely accepted by the NHS across secure mental health settings - be seen as complementing and strengthening person centred suicide risk assessments such as TTM, and not as an alternative to them.

[483] By email of 21 February 2019 the Cabinet Secretary of Justice advised the Chief Executive that he was content with the Chief Executive's approach to increased provision of Safer Cells, reviewing TTM, and - impliedly - not systematically seeking to identify, remove or reduce the ligature anchor points in standard cells in Polmont as identified in the LAP Review, particularly where those points were inherent to the design of fixtures or fittings within the cell.

[484] Pursuant to Mr McKean's recommendation to the Safer Spaces meeting of 19 January 2019, a GMA was later issued in relation to repair and maintenance of cells where ligature points were identified as a result of disrepair or inappropriate adaptation, as an aspect of the existing annual estates cell certification. Other than this, Mr McKean was not involved in any further work arising out of the LAP Review. Notwithstanding his recommendations, no audit toolkit along MTK lines was developed by SPS. No further anti-ligature audit of standard cells was carried out by SPS. Nor were any systematic works carried out to remove or replace any of the fixtures or

fittings in standard cells which had been identified in the LAP Review as presenting an inherently high anti-ligature risk, even those which could have been quickly and cheaply replaced.

[485] In his role as Head of Technical and Professional Services Mr Mckean was a member of the NSPMG between 2012 and the end of 2019. The subject of ligature anchor points was not specifically raised or discussed by this group during Mr McKean's membership of it. The LAP Review was not discussed or referred to at any meeting of NSPMG which he attended after its production. Stephen Coyle, who was chair of NSPMG between 2020 and 2022, did not see and was not aware of the LAP Review until it was drawn to his attention shortly before he provided a statement for the inquiry in March 2024.

[486] Notwithstanding (i) that the rectangular toilet door stops such as those in cells 1/33 in Blair House were a recognised ligature anchor point risk no later than 2012; (ii) that Katie had in fact used such a door stop as a ligature anchor point to die by suicide in June 2018; (iii) that the LAP Review identified the same door stops as a high ligature anchor point risk using MTK methodology and scoring following the survey in November 2018; and (iv) that these door stops could have been cheaply and easily replaced with sloping, anti-ligature door stops, without significant capital investment, no action was taken by SPS to remove them. They continued to be in use in cells in Blair House as at March 2024: see Crown Production 92, photographs 95 - 112.

[487] Notwithstanding (i) that the use of double bunk beds in single occupancy cells such as that in cell 4/56 in Monro Hall were a recognised ligature anchor point risk no

later than 2014; (ii) that William had in fact used such a bunk bed as a ligature anchor point to die by suicide in June 2018 (as other young prisoners had done before him); (iii) that the LAP Review identified the same double bunk beds as a high ligature anchor point risk using MTK methodology and scoring following the survey in November 2018; and (iv) that these double bunk beds could have been cheaply and easily replaced with single bunks without significant capital investment, no action was taken by SPS to remove them. They continued to be in use in cells in Monro Hall as at January 2024.

HMIPS Expert Review of the Provision of Mental Health Services, for Young People Entering and in Custody at HMP YOI Polmont

[488] On 28 November 2018, in parallel to his instruction to the Chief Executive as regards the LAP Review, the Cabinet Secretary for Justice commissioned HMIPS to carry out a review of the provision of mental health services for young people at Polmont in accordance with section 7(2)(d) of the Prisons (Scotland) Act 1989: see SPS Production 64. The terms of reference for the review were very wide: see SPS Production 70/4. They included review of (i) the information available to SPS prior to young persons entering custody; (ii) their reception, screening and assessment arrangements; (iii) the health and well-being culture in custody linked to ongoing support and supervision: (iv) treatment and interventions during their time in custody; and (v) arrangements by SPS for their return to the community.

[489] In May 2019 HMIPS published ERoMH, in response to the Cabinet Secretary's instruction. A copy of the report is lodged as Production 1 for William Brown Senior.

Two strategic issues were highlighted: (i) the lack of proactive attention to the needs, risks and vulnerabilities of young prisoners on remand and in early days of custody; and (ii) the systemic interagency shortcomings of communication and information exchange across justice, that inhibited the management and care of young people entering and leaving Polmont.

[490] At paragraph 1.3 of the Executive Summary to ERoMH it is noted that:

> "what has become clear in the evidence reviews and academic research is that being traumatised, being young, being held on remand and being in the first three months of custody increases the risk of suicide."

It is also noted that while previously Scotland had been thought to perform comparatively well in relation to having low levels of suicide in custody relative to other European jurisdictions, the evidence review conducted on behalf of ERoMH (noted above) had challenged that finding. Indeed it had produced an alternative analysis indicating that Scotland may have one of the highest rates of prison suicide among developed countries. The challenges that exist in comparative analysis were noted and more research was called for.

[491] ERoMH made a total of 80 recommendations, set out at Appendix F the report. These recommendations were wide-ranging and the implementation of them was not limited to actions within Polmont, the wider prison estate, or indeed the justice system. Many were in general and aspirational terms. Many called for more research, and/or invited "consideration" of difficult issues by SM, SPS and/or FVHB, rather than suggesting concrete proposals to implement in relation to them. Some recommendations were repetitive and/or overlapping. There was no obvious order to

them. Many called for a collaborative approach across a range of policy portfolios and operational interests relevant to young person in custody, and to mental health service provision in Scotland more generally. Many are concerned with processes rather than outcomes.

[492] The ERoMH recommendations were grouped under seven thematic headings:

(i) Social isolation, as a key trigger for self-harm and suicide, should be minimised, with a particular focus on those held on remand and during the early weeks in custody;

(ii) To support more effective risk management, Scottish Government and other agencies should work together to improve the sharing and transmission of information for young people entering and leaving custody;

(iii) A bespoke suicide and self-harm strategy should be developed by the SPS and FVHB for young prisoners;

(iv) FVHB should develop a more strategic and systematic approach to prison healthcare, with accompanying workforce capacity review and improved adolescent and young people specific training;

(v) An enhanced approach should be developed for TTM, with more intensive multi-disciplinary training and a more gradual phased removal for those placed on TTM;

(vi) Enhanced and more consistent DIPLAR processes were required to maximise learning from previous incidents;

(vii) Further work should be undertaken by Scottish Government to provide a central coordination point for Government reviews, use the existing analytical expertise to analyse comparative performance on suicides, and consider how the justice system can better respond to international evidence about maturation and alternative models of secure care.

[493] In particular, ERoMH recommended that:

1) SPS and FVHB should consider the use of holistic age-appropriate risk assessment tools on induction, to inform the management of young people in their care who arrive with little significant information about any risk and arrange a 72-hour case conference once further information has been gathered (Recommendation 9);

2) SM should consider developing and adopting a standardised approach, including developing minimum information data sets, conforming to the Getting It Right For Every Child ("GIRFEC") principles, across the justice system to ensure relevant history and information accompanies all young people entering custody (Recommendation 11);

3) On the day a child or young person is remanded or sentenced, their Child's Plan and the Criminal Justice Social Work Report (where completed) should be shared electronically (Recommendation 15);

4) The greatly increased risk of suicide during the first 3 months in custody should be emphasised in the TTM strategy and staff training (Recommendation 19);

5) A bespoke suicide and self-harm strategy for young people should be developed (Recommendations 20 - 22);

6) There should be a change in the legislation and organisational practice which seeks to minimise re-traumatisation and stigma, for example body searching should be intelligence led only (Recommendation 30);

7) A competency framework and essential CAMHS training should be considered for NHS staff (Recommendation 41);

8) FVHB should work closely with the Excellence in Care programme leads to ensure that national assurance and quality framework for nursing is implemented (Recommendation 47);

9) All of the recommendations from the 2018 HMIPS review report in relation to Polmont should be embedded, in particular recommendations regarding mandatory training and appraisal of staff, standardised assessments, detailed and accurate clinical recording, multidisciplinary decision-making, and clarification of pathways processes and agreed assessment and risk tools (Recommendation 48);

10) There should be improved links between FVHB and SPS at all levels of seniority to improve leadership of the health and well-being approach and accountability (Recommendation 51);

11) A systemic framework should be developed by FVHB to embed the newly created multidisciplinary team meetings and clinical and caseload supervision (Recommendation 53);

12) Refresher training in TTM for all staff in contact with young people should be regularly undertaken and adaptations made for specific populations such as adolescence. This training should not just include the processes and paperwork of TTM but broader aspects of trauma informed behaviour child and adolescent development, self-harm and suicide (Recommendation 60);

13) Consideration should be given to the benefits of appointing an independent Chair for greater independence and consistency during DIPLAR reviews (Recommendation 68);

14) Further consideration should be given to the Chair meeting with the family prior to the DIPLAR to understand their concerns (Recommendation 69); and

15) Further work was required to analyse FAI determinations and recommendations against DIPLARs in order to enhance learning (Recommendation 72).

[494] The Cabinet Secretary responded to the ERoMH recommendations in a statement to the Scottish Parliament on 19 June 2019. An Action Group was established comprising representatives from SPS, NHS and Scottish Government, with a view to

taking forward the recommendations. This group met a total of seven times following publication of the report.

[495] The Cabinet Secretary was updated by Scottish Government officials in August 2019 relation to progress in taking action in respect of the commitments made in that statement, a copy of which is lodged as SPS Production 73. He was also updated in relation to SPS ligature review in the light of the Chief Executive's report of 15 February 2019. The policy focus remained, as recommended by the Chief Executive, on systematic audit, improvement, and procedures in relation to the use of, Safer Cells only. There was no work being done to systemically identify and remove ligature anchor points in standard cells, nor to create a MTK style audit in relation to standard cells.

[496] On 22 March 2021 the Cabinet Secretary was further updated by Scottish Government officials in relation to implementation of the ERoMH recommendations, in a briefing note now lodged as SPS Production 75. This update was provided to the Scottish Parliament. It made no reference to progress or otherwise in relation to audit, removal or reduction of ligature anchor points within the SPS estate, whether in relation to Safer Cells or standard cells.

[497] On 28 June 2022 the Cabinet Secretary for Justice wrote to the Convenor of the Health, Social Care and Sport Committee of the Scottish Parliament, providing a summary report and final action plan of work in relation to implementation of the ERoMH recommendations: see SPS Production 4. This report contained an Action Plan responding to each of the recommendations made in the report: some were regarded

as unnecessary; some were said to have been implemented, some were rejected, some were said to be still ongoing. In relation to the particular recommendations set out above, Scottish Government's responses were as follows:

1) Recommendation 9 was said to be an "action in progress". Reference was made to standardised assessments and care plans which had been introduced by FVHB and could be access via the Care Partner system. However these are distinct from TTM assessments. Reference was made to transfer of young prisoners from secure accommodation, but no response was given to the specific recommendation for a 72 hour post admission case conference for all those arriving without significant information about suicide risk. Under WSA, as noted above, such a case conference would only normally take place in relation to 16 and 17-year-olds.

2) Recommendation 11 was not implemented. Reference was made to resource prioritisation in the light of COVID.

3) Recommendation 15 was said to have been implemented. An SPS email address had been created for all reports to be sent electronically and further work was said to be ongoing in relation to this. No reference was made to transmission of documents which had been before the sentencing or remand court, other than the Child's Plan (which would relate to 16 and 17-year-olds only) and any CJSWR (which would likely only relate to sentenced prisoners, not remand prisoners).

4) Recommendation 19 was said to be implemented and ongoing. SPS had reviewed training and guidance and was satisfied that it was sufficient for the purpose of emphasising risks of suicide within the first 3 months of custody. Additionally, however, it was acknowledged that new data was casting doubt on this proposition in any event and that further research was to be undertaken.

5) Recommendations 20 to 22 were not implemented. As a matter of policy SM did not (and does not) accept that a bespoke suicide prevention strategy for young prisoners should be developed.

6) Recommendation 30 was said to have been implemented. It was noted that routine body searching of under 18s within Polmont, as part of routine cell searches and within the reception area, had been discontinued. Body scanning technology was being utilised, but 16 and 17-year-olds might still be required to be subject to intelligence led body searching. No reference was made to body searching of young prisoners between the ages of 18 and 21.

7) Recommendation 41 was recorded as having been implemented. A mental health assessment competency framework, in relation to the mental health problems of young persons, was said to have been introduced by FVHB for the prison setting.

8) Recommendation 47 was recorded as a work in progress, with the local Forth Valley Practice Development Team supporting the implementation of care assurance within Polmont.

9) Recommendation 48 was said to be implemented and ongoing. The introduction of the Care Partner recording system, provision of clinical template documents, the new assessments and current caseloads, and reviews at a weekly clinical team meeting, were all noted. There was said to now be annual FVHB staff appraisals, with monthly caseload and managerial supervision and monthly reflective practice groups.

10) Recommendation 51 was said to have been implemented, in that a Senior Joint Management Group had been established since 2019 to oversee recommendations in EroMH.

11) Recommendation 53 was recorded as having been implemented, it being noted that FVHB had established a new Prison Psychiatry Team with a new Prison Oversight Group and a new Mental Health Improvement Group. It was stated that a new pathway for delivery of mental health assessment and treatment services within Polmont having been successfully designed, and that weekly clinical team meetings had been established, with multidisciplinary attendance, to provide updates and discuss cause for concern cases.

12) Recommendation 60 was said to be implemented and ongoing. It was noted that TTM refresher training had been delivered to 87% of available

staff as at June 2022, covering key points of vulnerability, including remand, early days in custody and social isolation.

13) Recommendation 68 was said to have been implemented by the appointment of a named SPS non-executive director to chair all DIPLARs in cases involving a drug overdose or apparent suicide.

14) Recommendation 69 was said to be an action in progress, with a revised process to support the families following a death in custody having been launched in November 2020.

15) Recommendation 72 was said to have been implemented, in that SPS had reviewed 70 FAI reports between 2008 and 2018 in order to analyse the means of suicide used (with particular focus on the ligature point and ligature used), given that 93% of suicides in custody were caused by death by self-ligature[21]. Training was said to have been delivered to all governors, deputy governors and senior managements on arrangements necessary to ensure the success of the DIPLAR process.

[498] A particular aspect of the response to ERoMH related to Scottish Government's policy intention that 16 and 17-year-olds should no longer be remanded to or sentenced to detention in Polmont, but rather should be detained in secure accommodation settings. This is the policy which was given effect by the coming into force of the

[21] If this analysis is contained in a document, it was not placed before the inquiry.

2024 Act. The problems of suicide prevention in relation to detainees of this age have accordingly been transferred from Polmont to secure accommodation.

Changes to body (strip) searches since 2018

[499] As noted, in response to ERoMH, by 2022 SPS had discontinued the routine body (strip) searching of prisoners in Polmont under the age of 18. Body scanning technology was being made use of for this purpose. Intelligence led body searches might however still take place for prisoners of this age, under authorisation of a senior officer. As prisoners under the age of 18 will now no longer be detained in Polmont, this development in body search policy has been overtaken by events.

[500] On the evidence before the inquiry, the present position in relation to body searching of 18 to 21-year-olds in Polmont - and adults - was unclear. However body scanning technology having been installed in the reception area at Polmont, it is in principle is available for use so as to eliminate the need for random body searching of all young prisoners. The rationale for continuing intelligence led body searches in relation to such prisoners remains sound.

Safer Cell Review

[501] ERoMH raised concerns regarding the use of Safer Cells, and recommended consideration of this. In response, SPS commissioned a review of all Safer Cells across the Scottish prison estate. The review report was presented to NSPMG in November 2019 ("the Safer Cells Review"). A copy is lodged as SPS Production 74.

[502] The Safer Cells Review noted that there were 72 Safer Cells across the SPS estate, of which nine were located at Polmont. Only 22 were in use at the time of the survey in October 2019. The review found that there were differing standards across the estate, with different layouts and materials used. They also found that some of the cells were of a poor standard, dirty, very bleak, and that adjustments had been made to them over time which resulted in some ligature points still being present.

[503] Twelve recommendations were made in relation to use of Safer Cells. These included the procedures for their use and recording of same, their location, their condition, cleanliness and maintenance, and the items and personal belongings which might be permitted to prisoner held in them. The Review concluded that "many of the issues identified could be remedied through an approved list of fixtures and fittings for safer cells and a quality assurance process for any maintenance." No substantial change to the use of Safer Cells was proposed; they were to still be used for the short-term accommodation of those prisoners assessed under TTM as being at high risk of suicide.

[504] The Safer Cells Review also noted that Safer Cells in new build prisons had a "more comfortable feel to them" and that "future new builds and upgrades should ensure all Safer Cells comply with this standard." This reflected SPS policy in relation to new build prisons such as HMP Grampian, whereby standard cells had been designed to be as far as possible free of obvious ligature points, and Safer Cells had been designed to be closer to standard cells in terms of amenity and appearance.

[505] On 17 February 2021, Annette Dryburgh, an SPS official whose role was unclear to the inquiry, drafted a memo to Sue Brookes, SPS Interim Director of Strategy & Stakeholder Engagement. A copy is lodged as Production 29 for SPS. The purpose of the memo was to provide an update on, among other things, the Safer Cells review and implementation of its recommendations. Ms Dryburgh advised, in summary, that NSPMG had referred the report to another named SPS official, but that it had not been returned, and therefore its recommendations had not been actioned.

[506] Additionally, Ms Dryburgh noted Mr McKean's recommendations to the Safer Spaces meeting on 19 January 2019 regarding removal and reduction of ligature points from standard cells, and development of a ligature audit toolkit, but that it was "unclear how these were taken forward", and that they were "at present an inactive workstream". "Overall" as Ms Dryburgh put it, "it has been difficult to establish who has been allocated responsibility" for either set of recommendations. In any event SPS had not acted on them.

TTM developments since 2018

[507] SPS has previously carried out national audits of TTM. These have identified some common failures to comply with the policy. In October 2018 SPS provided instruction in relation to these: see GMA064A/18 Crown Production 85. The issues identified included (i) the need to reconcile RRAs with prisoner movement numbers to ensure that RRAs were in fact being completed; (ii) that a FLM should not proceed to a case conference in the absence of a pre-case conference nurse assessment; (iii) that

if a prisoner was located in a Safer Cell for more than 72 hours a Unit Manager must attend the case conference; (iv) that a FLM must assign responsibility to ensure compliance with the agreed maximum contact/observation period for checks on a prisoner; (v) that written shift handover arrangements should be put in place in relation to prisoners on TTM; and (vi) that all TTM documentation should be scrutinised daily.

[508] Part 2 of the TTM guidance was revised in December 2019 as respects the RRA, and amended forms were introduced: see GMA61A/19, now Crown Production 86. The revised Guidance states that a RRA should be completed for all admissions, transfers, returns from court, returns from external escort, court video appearance, tribunal or parole hearings and receipt of a decision in relation to parole. It states that the RRA should include a risk assessment by a healthcare professional if the prisoner concerned was entering Polmont as a new admission or a transfer from another prison, and where they had returned from court following a change in status from remand to convicted prisoner, or with a changed liberation date.

[509] In June 2020 SPS revised the TTM booklets: see GMA021A/20 now Crown Production 87. Space in the booklet for four case conference minutes was now provided. Space was also included for a "change of circumstances immediate care plan" for use where there was determined to be a need for change due to an increased risk. A section was added to the daily report to record which prison officer was responsible for maximum contact levels. And the care plan section made clear that the prisoner's location, maximum contact level, items in use and clothing, should all be considered.

[510] In July 2020 guidance was issued by SPS in relation to processing and recording TTM concerns. This guidance has been produced as Production 1 in the First Inventory of Productions for SPS. GMA032A/20 was issued to introduce the new guidance to prison staff: see Crown Production 75. In particular the revised process introduced for the first time an electronic concern from, accessible via SharePoint.

[511] GMA032A/20 reiterated that the concern form was still for use by anyone receiving communication of concern from the community, but also where the source of the concern was internal to the prison. It stated that the form should be forwarded to the FLM where the prisoner it relates was located. The action taken should be recorded on the form, which when completed should be uploaded to PR2. The FLM should provide feedback to the person who provided the communication. A printed copy of the electronic concern form is produced as Crown Production 78.

[512] Notwithstanding these changes and instructions, residential staff at Polmont generally continue, in 2024, to not utilise the concern form other than in relation to concerns received from external sources. SPS auditing of the concern forms has not been effective to recognise this failure, and therefore it has not been effectively addressed. The audit has been of those relatively few concern forms which have in fact been submitted, not of the systemic failure to complete them within Polmont.

[513] RRA forms are still not available in electronic form. It would be beneficial if they were, from the point of view of ease of recording, secure storage, and accessibility.

[514] From May 2021 SPS directed that governors and managers should follow a TTM assurance process: GMA022A/21, now Crown Production 88. This process required

managers to ensure that live TTM case files should be checked by a FLM daily, that there should be a weekly audit by a senior manager of at least ten RRAs and 25% of live case files, and that there should be a monthly audit by an allocated Suicide Prevention Coordinator of all electronic concern forms and 20% of closed TTM case files, these audits to be maintained and made accessible on SharePoint.

[515] From June 2021 SPS directed that further changes be made to the TTM paperwork: GMA032/21 now Crown Production 89. This added space for a second change of circumstances immediate care plan. It reiterated that any single member of staff trained in TTM could place a prisoner on the policy by completing an initiation form. It advised that as soon as a prisoner is placed on TTM there should be planning for family and/or friends to attend the case conference. Further guidance was given in relation to seeking continuity of staff in case conferences, facilitating family participation at case conferences via a telephone call, making further provision for transitional care plans, and introducing a support on release case conference for those within 6 weeks of liberation.

Review of TTM

[516] In around 2017 SPS commissioned research to examine the impact, utility and effectiveness of the introduction of TTM. There were two phases to the evaluation: Phase 1, between January – April 2018, involved evaluating the TTM training, through care, DIPLAR process and Audit and Governance arrangements. Phase 2, between

May – October 2018, involved Evaluation of the TTM processes, including assessment, care, supportive environment, multidisciplinary working, and support on release.

[517] The evaluation was completed by an independent researcher who concluded that the strategy was effective at promoting person-centred care, which kept individuals safe. The evaluation also made some suggestions for improvement, many of which related to increased and improved training and were addressed through the TTM refresher training package. Some others have been taken forward in the action plans relating to other reports eg, the Independent Review of the Response to Deaths in Prison Custody ("IRRDPC").

[518] In particular, IRRDPC had flagged up the continuing difficulties experienced by external agencies, families, etc, in making contact with prisons in order to notify a TTM concern in relation to a prisoner. As a result, at the time of the inquiry, SPS was in the process of creating a dedicated 24 hour phone line for this purpose within each prison, with the phone number available on the SPS website. The policy in relation to this is that any concerns so notified will be recorded on an electronic concern form, which is passed immediately to the FLM or night shift manager of the hall in which the prisoner is located, and then uploaded to PR2. It was unclear to the inquiry whether this process had yet been put into place.

[519] In any event SPS is currently reviewing the whole TTM strategy. It had originally intended to do so within 5 years of implementation, that is, by 2021. The delay was in part due to the Covid pandemic. The review commenced in May 2023 and is ongoing. It is intended that the review will take cognisance of the SM revised

Suicide Prevention Strategy and action plan, the new SM Mental Health Strategy and SPS Mental Health Strategy, once available, as well as recommendations from all relevant reports. It will also take cognisance of the recommendations of the present inquiry.

[520] The first full steps in the TTM review have been to undertake a literature review and survey the views of people in custody, staff groups, including NHS staff, and families. All recommendations will require to be submitted to the NSPMG. Once approved by the NSPMG, the review report would then require to be submitted to the SPS Executive Management Group ("EMG") for final endorsement.

[521] One recommendation, which arose from EroMH in 2019, has already been put before the NSPMG and rejected. This is the recommendation for the creation of separate mental health strategies for Young People and Adults. The NSPMG agreed unanimously not to change TTM, with the Samaritans and NHS 24 strongly voicing their opposition to the proposal for separate strategies for young people. The consensus was that when someone is in distress and at risk of suicide, the process during the period of crisis is the same regardless of the individual's age, though the content of the response may differ. As a result, SPS is working towards one overarching Mental Health Strategy with a series of outcomes that will reflect the needs of the whole population with the specific needs of young prisoners referenced where relevant.

[522] As part of the overall TTM review, SPS is also reviewing all TTM training. It is anticipated that it will be very different from the present training, and will consider meeting the individual needs of specific staff groups via a range of modules.

[523] As part of the overall TTM review, consideration is being given by SPS to providing that all TTM documentation is available electronically, including RRA and TTM initiation forms as well as the concern form. It is currently unclear whether this change will be made.

[524] SPS has no current plans to increase the frequency of TTM training for prison staff from its current frequency of once every 3 years, although this too is to be considered as part of the ongoing review.

Review of DIPLAR

[525] SPS has recently carried out a full review of the DIPLAR policy, in particular following recommendations made in this regard in IRRDPC. Since August 2023 changes have been made, most of which are administrative in nature. Since then the process has been as follows.

[526] Following a death in custody the Governor of the establishment where the death occurred will appoint a DIPLAR coordinator to arrange a meeting, comply with timescales, support completion of the DIPLAR paperwork and monitor local actions identified for completion. DIPLAR meetings should be held within 12 weeks of the death in custody.

[527] Following the death, the family should be notified by the police who will advise them of the contact details for the establishment duty manager. The Governor/Deputy Governor should then contact the family within 24 hours. The Governor should then appoint a member of their management team to be the main contact for the family,

along with providing them with family support booklet that also confirms the contact details for chaplaincy and NHS. A record will be kept of the engagement with the family and any questions or concerns that may arise. Responses to any family questions or concerns should be agreed and recorded and the action included in the action plan. The DIPLAR should be clear who will provide feedback to the family.

[528] The following people should attend the DIPLAR meeting: the Chair, the Governor in charge of the establishment (or Deputy Governor), a NHS member of staff, the local DIPLAR coordinator, a minute taker, the chaplain, a representative from SPS HQ Health Team, the FLM for the area in which the prisoner was located, the personal officer or a member of prison staff who worked closely with the deceased, the lead professional/main person for anyone under 18 and all staff involved in the incident. In addition, health or social care providers, social workers, escort providers, Scottish Ambulance Service, Police Scotland and any other relevant staff or agencies, may attend.

[529] It is the responsibility of the DIPLAR coordinator to mark compliance with the DIPLAR process timescales and standards ensuring that the DIPLAR meeting is held within 12 weeks of the death in custody. The draft DIPLAR report should be uploaded to the establishment working area on SharePoint for SPS HQ Health Team and, where relevant, for the independent chair to review within 4 weeks of the DIPLAR meeting. The final DIPLAR report should be uploaded to the establishment working area on SharePoint within 8 weeks of the meeting.

[530] SPS HQ Health Team should then transfer any action points to the National DIPLAR Learning and Action Plan and share the DIPLAR with Legal Services. Thereafter there will be a monthly update to the National DIPLAR Learning and Action Plan on progress against actions and recommendations.

[531] Originally, DIPLARs were chaired by the prison Governor or Deputy Governor and a senior NHS colleague. Questions were raised by IRRDPC about the independence of the process. Now, as noted, a non-executive director on the SPS board is to chair all DIPLARs except for deaths from natural causes. Their responsibilities are to: (i) check that all staff attending are comfortable with the DIPLAR process in advance of the meeting and have been offered support; (ii) confirm all required attendees are present and, if not, decide if the meeting should go ahead or be rescheduled; (iii) welcome and advise those in attendance of the purpose of the DIPLAR meeting; (iv) use the DIPLAR meeting checklist to ensure that all required information is available and considered as part of the DIPLAR meeting; (v) ensure that all attendees have the opportunity to contribute; (vi) summarise learning points, best practice and actions; (vii) review the draft report when received from HQ Health Team; (viii) review and sign off the final DIPLAR when received from SPS HQ Health Team.

[532] Local and national databases exist where information and learning points from DIPLARs are collated. Local establishments are required to report on progress in relation to actions arising from DIPLARs. Where national issues arise, these are to be actioned at a national level.

Changes to NHS operating procedures within Polmont

[533] Following the DIPLAR in relation to Katie, FVHB gave further induction training to staff in relation to note taking on VISION - albeit that such note taking should be a basic skill for health care staff. FVHB already had a system for audit of VISION records by a deputy team leader, with a view to providing supported learning where there was found to be a problem with any particular member of staff.

[534] Nurse Brian Leitch was provided with such support following William's death. The health centre manager at Polmont also spoke directly to Joanne Brogan to impress on her the need for accuracy in relation to the purpose and content of VISION entries, and in relation to use of the drop down menus. A competency framework was said to have been developed as part of ongoing clinical supervision, requiring individual staff to demonstrate competency under supervision, including as a requirement for promotion to higher grades. No documentation in relation to this framework was provided to the inquiry.

[535] Following the DIPLAR in relation to William, FVHB revised its Standard Operating Procedures in relation to information received from outside agencies in relation to a prisoner. The intention was to seek to safeguard to prevent a referral such as Andy Doyle's mental health referral of 5 October 2018 from sitting unactioned in a tray. It was suggested that there should be a dedicated email address and a single point of contact for incoming concerns. It was said that a robust process was now in place to identify and pass on relevant clinical information coming into the team. The precise nature of these changes, and how they differed from the system in place on 5 October

2018, was unclear to the inquiry, and was not supported or explained by documentary evidence.

Suicide prevention technology

[536] Technology is in the process of being developed which may be effective to detect and monitor a prisoners' movement, respiratory activity, and heart rate, whilst within their cells, and to do so without requiring prisoners to wear a device such as a wrist or ankle bracelet. This "signs of life" technology involves a sensor being installed in the cell. Where a prisoner's heart or respiratory rates deviates from pre-set thresholds - indicating for example an attempt to self-ligature - an alert is sounded allowing for early intervention by staff and preservation of life. Because such monitoring does not generate visual or audio data it involves minimal if any intrusion in prisoners' residual privacy within the cell; it does not involve watching or listening to prisoners whilst they are in their cells. If effective, signs of life technology could significantly complement (but not replace) existing prison suicide prevention policies and measures.

[537] In particular signs of life technology has been developed over the last 10 years by a company called The Lava Group, based in Northern Ireland. This company has developed a variety of products to monitor signs of life in care homes, custodial and secure mental health settings, and this technology is currently in use in such settings. In the prison context, trials have involved installing sensors into the corner of a cell, within an anti-ligature designed casing. Sensors have been developed which have heat, CO2, and optical monitors. At present, multiple sensors are required in order to adequately

monitor signs of life using The Lava Group technology. Although none of the sensors create or transmit visual images, in tests prisoners have suspected them to be cameras, and so have taken to covering them up with toothpaste or paper, or damaging them, thus rendering them ineffective.

[538] Work is however continuing in relation to this technology. Unlike heat, CO2 and optical sensors, radar sensors cannot be covered up by a prisoner, in that they will "see through" any covering in like manner to an airport scanner looking through clothing. And in the last 5 or 6 years signal processing for radar sensors has been improved significantly. They have become sufficiently sensitive to detect breathing by a cell occupant, and to distinguish it from the movement created by, for example, a breeze through an open window or water moving in a toilet bowl. Signals from the sensor can be fed through an algorithm in a prison hall control room device in order to decide whether an alarm should be raised in light of the pattern of activity - or inactivity - detected in a cell. The alarm can be connected to mobile pagers which can be worn by prison staff, for example while out of the office and on patrol in the halls.

[539] Signs of life technology is currently being piloted in prisons in various countries around the world, for example, Canada, the United States, Australia, Singapore and Hong Kong. There are indications that it may be effective to save life, but the present data is limited. The Lava Group is currently running a pilot in four cells in HMP Maghaberry in Northern Ireland, and is finalising installation of a pilot for HM Prisons and Probation Service of England and Wales. Further piloting seems likely. The sensors being promoted by The Lava Group cost around £3000 to £4000 each. There are also

costs in relation to installation and cabling, updates and maintenance. Installation costs are greatest in old prison buildings, given the need to drill and run cables through thick walls. However in principle this can be done, as has been shown in the pilot at HMP Maghaberry. Installation is easier and significantly cheaper in new build prisons, however, in that the sensors and cabling can be incorporated within the overall design.

[540] Similar signs of life technology is also being developed by Safehinge Primera, a Glasgow based design company. This company has been working to date mainly in mental health and secure care settings. Its technology is also intended to assist in prevention of patient self-harm/suicide by providing alerts for front line staff which can prompt therapeutic interactions. Safehinge Primera is currently seeking to develop a radar sensor model for use in Scottish prisons. The technology aims to detect if a prisoner is moving within a cell, and where within the cell they are. It utilises a panel that is installed in the cell ceiling, within an anti-ligature housing. If it works as described it would also be able to detect breathing when an individual is in bed, and would alert staff if a prisoner was collapsed on the floor or spending significant amounts of time in "high risk areas" of the cell (that is, those areas which might be used as a ligature anchor point, for example, a doorway).

[541] SPS is aware of the developing signs of life technology and has had contact with both The Lava Group and Safehinge Primera. SPS is considering a number of issues arising from the possible use of the technology including the use of mobile devices within the Scottish prison estate, how best to monitor data from the cell in real time, and the feasibility of installation of sensors within old prison cells (akin to those at

HMP Maghaberry) where there is no ducting for cables. The information available to the inquiry does not suggest that there are insuperable obstacles to overcoming all of the identified technical difficulties. SPS is currently conducting a pilot scheme to assess how best they can be. However it is also necessary to test the operational utility of the technology.

[542] SPS current plan is that a pilot test will be run in a maximum of ten cells across the Scottish prison estate. Safehinge Primera are funding this pilot. It will allow SPS to have sight of how the technology could work in a prison environment and evaluate its utility and any advantages it might provide. There is currently no timescale for how long this pilot will last, given that it is not known exactly what problems will be encountered and how best they can be overcome. At present, therefore, it is not clear how the technology will function effectively in the existing Scottish prison estate or what adaptations will be required. However SPS recognise that introduction of signs of life technology is likely to be easiest to achieve in more modern prison establishments, such as HMP Stirling, opened in 2023, and is accordingly focusing its current pilot on this prison. Consideration is also being given to "future proofing" the design of the new prison HMP Glasgow, estimated for completion in 2027, to include installation of signs of life technology.

[543] In principle, signs of life technology might be used to monitor any prisoner in any cell within a prison. It does not have to be restricted to use in those cells designated by SPS as Safer Cells. It might have application in relation to standard cells for particular classes of prisoner who fall within groups found in empirical studies to have

a higher rate of suicide, for example, those in the early days of their admission to prison, or who are chronic users of controlled drugs. Or it might complement and reinforce observation checks in respect of a particular prisoner believed to be a suicide risk, but not such as to justify their placement in a Safer Cell. Or it might have application in respect of those prisoners about whom there are concerns for their mental health or well-being but who have not been assessed as being at such risk of suicide as to justify their being placed on TTM.

(F) SUBMISSIONS

[544] As noted above, detailed written submissions were lodged on behalf of all seven participants in the inquiry. These ran to a total of around 300 typed pages. They were discussed and elaborated on at the hearing on 25 June 2024. Copies of the written submissions are available within the inquiry papers, and what follows is therefore a summary of the participants' position on the key issues and points of dispute.

The Crown

[545] In relation to Katie, the Crown accepted that her decision to take her own life was likely to have been an impulsive one, made late in the evening of 3 June 2018 or the early hours of the following morning. However the evidence suggested that she did so against a backdrop of being in fear for her safety. No member of staff fully understood Katie's risk of suicide because none of them were in possession of all the relevant information. Concern forms, a fundamental part of the TTM strategy, had not

been used. Accordingly Katie's personal officers, Scott Wilson and Heather Morrison, lacked key pieces of information relevant to Katie's risk of suicide. This devalued their otherwise positive relationship with her, and their attempts to support her. There was an overreliance on an assumption that, if Katie was contemplating suicide, she would share this with staff.

[546] In particular the Crown submitted that:

1) Katie had difficulty adjusting to her time in custody, recognised in TTM as a key indicator of a risk of suicide.

2) Katie suffered from alopecia, which impacted badly upon her self-esteem, but the support which was sought for her in relation to this was on an ad hoc basis, not by way of a formal support for her mental health.

3) The record of a deterioration in Katie's mental health which resulted from her alopecia was not shared with SPS staff by FVHB staff. Her history of self-harm was also not accessible to SPS staff.

4) Katie was bullied during her time in Polmont, but because this was recorded on a SPS intelligence log with restricted access, neither FVHB staff nor her personal officers were aware of it.

5) Katie's relationship difficulties with her boyfriend were known to staff, but no concern was recorded, nor assessment made.

6) Katie reported a fellow prisoner's suicide attempt on 21 May 2018, itself recognised as a possible suicide trigger factor under TTM, but hall staff were unaware of this.

7) Katie lost 7kg in bodyweight whilst in Polmont, a non-verbal cue or clue in terms of TTM, but no member of hall staff noticed it.

8) Katie abandoned her appeal against sentence on 29 May 2018, but there is no trace of the RRA completed following that hearing.

9) The events of 3 June 2018, as reported by Katie's mother to Officer Doherty, suggested that Katie had been threatened and was terrified, yet no concern form was completed.

[547] In the light of all this the Crown submitted that no one individual factor could be singled out as being a reasonable precaution which might realistically have resulted in Katie's death being avoided in terms of section 26(2)(e) of the Act. However it might have been avoided had the following precautions been taken *in cumulo*:

1) The RRA completed by Nurse Macfarlane on 7 March 2018 should have been comprehensive, and should have recorded Katie's history of self-harm by cutting herself.

2) Concern forms should have been completed, in line with the TTM strategy, in particular in relation to Katie's hair loss, her observed distress on 8 April 2018, and Linda Allan's report to Officer Doherty on 3 June 2018.

3) The information that Katie's hair loss was affecting her mental health and that she had previously self-harmed should have been shared between FVHB and SPS staff and systems.

4) Intelligence reports suggesting that Katie had been subject to bullying should have been shared, at least with Katie's personal officers.

5) SPS and FVHB staff should have been more familiar with the lists of "cues and clues" and "triggers" set out in the TTM guidance and training, and should have properly assessed and recorded such factors in Katie's case.

6) Katie's weight loss, given her particular vulnerabilities, should have been noticed and monitored.

Had all these reasonable precautions been taken, the Crown submitted, Katie's death might have been avoided. Her risk could have been more accurately assessed. Counselling or other supports could have been put in place. SPS staff would have viewed the events of 3 June 2018 through the correct lens, that is, the lens of suicide prevention.

[548] Further and in any event the Crown submitted that it would have been a reasonable precaution to not accommodate Katie in a cell with a toilet cubicle door stop capable of being used as a ligature point. Had this been feature been absent, this might realistically have resulted in Katie's death being avoided, as it would have made it more difficult for her to take her own life. It would have been inexpensive and straightforward to have installed an angled door stop, as is customarily done when cells are refurbished or newly built.

[549] The Crown submitted that the following defects existed in systems of working which contributed to Katie's death, in terms of section 26(2)(f) of the 2016 Act:

1) There was no system in place within SPS at the time to regularly audit the physical cell environment, to identify and remove the ligature point risk presented by the toilet cubicle door stop in Katie's cell. Nor did TTM

address the issue of reducing ligature points within ordinary cells as an aspect of suicide prevention.

2) The TTM strategy was unduly static and failed to implement an adequately dynamic system for assessing risk of suicide. It failed to ensure that there is an ongoing assessment of risk during a prisoner's time in custody. The RRA is a snapshot of risk at the time of admission or transfer, but does not list protective and risk factors which can be monitored during the sentence.

3) Although the concern form is integral to the TTM strategy, prison staff showed at best a fundamental misunderstanding of the purpose of the form, and at worst a complete disregard for it. No effective action was taken by SPS management to rectify this. This was a systemic failure which prevented the proper recording and sharing of available information which could have led to additional support being provided to Katie. It also prevented proper ongoing risk assessment of her.

[550] The Crown submitted that there were other facts which were relevant to the circumstances of Katie's death, while not contributing to it, per section 26(2)(g) of the 2016 Act:

1) Katie's GP records should have been requested, and had they been they would have disclosed additional details of her alopecia and previous self-harm.

2) The entries made on VISION by Joanne Brogan were factually inaccurate, presenting a misleading picture of the mental health care being provided by her to Katie.

3) There was an inconsistent approach to recording narratives on the PR2 system. A weekly narrative enabling staff to monitor significant events during Katie's sentence would have been good practice.

4) The DIPLAR into Katie's death wrongly concluded that there were no significant indicators to staff that Katie had any suicidal thoughts or intent, but in any event did not consider risks arising from her cell environment, and in particular the door stop used as a ligature point.

5) Although the DIPLAR into Katie's death notes the need for (a) training for FVHB staff on clinical note taking, and (b) use of concern forms to be reiterated to staff, both these issues later featured in William's case too.

[551] In relation to William the Crown submitted that there were a number of precautions which could reasonably have been taken in terms of section 26(2)(e) of the 2016 Act, and by which his death might realistically have been avoided:

1) The RRA carried out on 4 October 2018 could have been more comprehensive. Either William's social worker should have been contacted or, if that was not practical, the RRA should have highlighted the need for the case conference to do so. In any event, consideration should have been given by Officer McAinsh and Nurse Leitch to the physical environment of the cell in which William was to be accommodated. He should not have

been accommodated in a cell with a double bunk bed, a known ligature anchor point.

2) The pre-case conference carried out on 5 October 2018 could have been more comprehensive. It was apparent that there would be background information relevant to assessment of William's suicide risk. This could have been obtained from his social worker. Although it was recorded that William had a history of self-harm and suicide attempts, there was a failure to properly explore or record the repeated, dangerous and spontaneous nature of it. Had this been done, information would have been available to the case conference which would have confirmed the need to maintain William on TTM.

3) The case conference carried out on 5 October 2018 could have been more comprehensive:

   a. All three members of staff present at the case conference should have read the available paperwork in full. They did not all do so;

   b. There was a failure to share information obtained at the pre-case conference, in particular William's history of self-harm or suicide, history of mental health issues, expression of suicidal intent/ideas, and history of drug or alcohol misuse;

   c. Although all three members of staff at the case conference held an individual as well as a collective responsibility to assess William,

the SPS staff in practice deferred to the healthcare professional's assessment;

d. No proper analysis of William's suicide risk was carried out by the case conference. It relied on William's self-report and presentation without any exploration of background information, or balancing it against such information. This it did even though there was no reason to believe that William was a reliable narrator;

e. No consideration was given to whether William's social worker should attend the case conference, although TTM requires that such consideration be given;

f. Insufficient time was taken by the case conference to explore and assess William's risks. It was recorded as lasting only 5 minutes;

g. It should have been obvious that further background information relevant to William's suicide risk was available, and the case conference should not have removed him from TTM prior to obtaining this information;

h. The wrong decision was reached by the case conference. There was sufficient information before it to conclude that William should not have been removed from TTM at that point.

Had the case conference been conducted more comprehensively, William would have been maintained on TTM.

4) A transitional care plan could have been put in place for William following his removal from TTM by the case conference, which could have provided him with additional care and support, at least until a review under the WSA took place the following Monday.

5) The information received about William in the course of the morning of 5 October 2018 following the case conference should have been recorded on concern forms, and in any event acted upon by placing him back on TTM.

6) William could have been accommodated in a single occupancy cell without a double bunk bed in it. A double bunk bed was a known ligature point, as FAIs prior to 2018 had shown.

[552] The Crown submitted that in William's case the following defects existed in systems of working which contributed to his death, in terms of section 26(2)(f) of the 2016 Act:

1) TTM did not provide guidance to staff to assist them in assessing when background information and community records should be sought, and how to do so. Had such guidance been available, it would have applied to William's case. Further information would have been obtained, and he would not have been removed from TTM at the case conference.

2) The TTM strategy relies too heavily on, and is biased towards, self-reporting. TTM should place more emphasis on ingathering and assessing information from background sources. Had this been required

in William's case he would not have been removed from TTM at the case conference.

3) As in Katie's case there was a systemic failure by prison staff to understand the central purpose of the concern form within the TTM strategy, and to utilise it. But for this, concern forms would have been created in relation to the information received by prison staff on the morning of 5 October 2018.

4) There was no mechanism in place in the FVHB mental health team to ensure that the referral made by email in respect of William by Andrew Doyle was dealt with timeously. There should have been a system to ensure that it was passed immediately to a mental health practitioner, rather than being printed by an administrator and left in a tray.

[553] The Crown submitted that there were other facts which were relevant to the circumstances of William's death, while not contributing to it, per section 26(2)(g) of the 2016 Act:

1) In the DIPLAR relating to William's death there was no reference to the physical environment in which he was accommodated, and in particular the presence of a double bunk bed, a known ligature point, in his single occupancy cell.

2) The DIPLAR included action points reminding staff of the importance of accurate and complete record keeping, and refreshing the staff training in relation to detailed note taking on decision-making at case conferences.

However both these had been the subject of action points in Katie's DIPLAR but had still not been sufficiently addressed.

[554] Pursuant to sections 26(1)(b) and 26(4) of the 2016 Act the Crown submitted that the inquiry should make the following recommendations which might realistically prevent other deaths in similar circumstances to those of Katie and William:

1) The following issues should be considered by the ongoing review of the TTM strategy:

   a. Whether there should be a move away from a binary system to a less static system with ongoing risk assessment at its core;

   b. Whether the RRA and case conference forms should be amended to contain a guided process and include prompts, making clear that both risk and protective factors should be noted and properly weighed against prisoner's presentation and self-reporting;

   c. Whether RRAs, or any new equivalent, should be used as a reference point in the future risk assessments, and should be reviewed prior to carrying out a subsequent RRA, a case conference, or a meeting following submission of a concern form;

   d. Whether RRA, case conference and TTM documentation, or new equivalents, should be electronically recorded and accessible to staff in the same way as the concern form now is;

e. Whether guidance should be provided on when and how to obtain background information, the process to be followed, and who should undertake this task;

f. Whether the concern form is fit for purpose, given that in practice it is largely dismissed by prison officers;

g. If the concern form is to be retained, whether it should be amended, in particular to identify who is concerned, and why;

h. If the concern form is to be retained, whether it would be beneficial to require such a form to be submitted while a person is subject to TTM;

i. Whether issues of ligature reduction and related audits should fall within SPS suicide prevention strategy;

j. Whether there should be use of in cell technology to supplement the risk assessment process in the existing SPS estate.

2) Pending completion of the review of TTM, SPS should issue further guidance and specific training in relation to when and how a concern form should be completed by prison staff.

3) The RRA should be used to record both risk and protective factors that can be monitored during a person's time in custody, rather than simply assessing a prisoner's risk of suicide at the point of admission.

4) The RRA form should be made readily accessible to both SPS and NHS staff on VISION and PR2.

5) TTM should be amended to emphasise the increased risk of suicide at weekends, given that the more rigid regime presents a greater risk to vulnerable prisoners.

6) A system should be established to ensure that all information and documentation available to the court at the time of remand is passed with the prisoner to SPS.

7) TTM guidance and training should be amended to emphasise the importance of past history in following up on information provided on admission, rather than overreliance on self-reporting and presentation. Specific guidance should outline when it is necessary to obtain such information, with reference to key criteria, the process to be followed, and who should undertake this task.

8) TTM guidance should be amended to require staff to obtain social work and or medical records where certain (specified) risk factors are present.

9) TTM training should be provided annually rather than once every 3 years, and should place particular focus on the importance of accurate record keeping, obtaining information from external agencies, how to properly conduct a case conference, the use of concern forms, and any changes implemented as a result of the present inquiry.

10) A transitional care plan should be initiated for all young people to ensure appropriate supports and follow-up checks are in place when they are

removed from TTM. Guidance and training should be provided on the options available to staff when compiling a transitional care plan.

11) SPS guidance should be issued to ensure that intelligence in relation to bullying is shared, where possible and in an appropriate format, with those responsible for the care of the prisoner.

12) SPS should clarify the circumstances and forum in which prison officers should record information, that is, whether in a narrative entry on PR2, on a concern form under the TTM strategy, on a SBR form under the TT bullying strategy, in an intelligence report, or in a staff handover booklet.

13) SPS and NHS should review their guidance in relation to information sharing, such that key medical information relevant to a prisoner's risk of suicide can become known to SPS staff responsible for that prisoner's care and safety.

14) FVHB should implement a system for ensuring that referrals to the mental health team at Polmont are reviewed by a mental health nurse and acted upon timeously.

15) FVHB should provide further training to staff working within Polmont in relation to the importance of accurate record keeping, with particular reference to the VISION system.

16) Bunk beds should be removed from cells in all SPS establishments which have adopted a policy of single cell occupancy. No prisoner should be placed in a cell which has a bunk bed in it on a single occupancy basis.

17) Door stops identical to that used as a ligature point by Katie should be removed from cells in all SPS establishments.

18) SPS should develop a ligature assessment toolkit to provide a mechanism for ongoing review of the risks posed by ligature points within ordinary cells, the feasibility of reducing these, and prioritisation of work based on the level of risk posed.

19) SPS should commit to an official audit programme of its full estate, using the developed toolkit referred to in Recommendation 18.

20) Issues of physical environment, including potential ligature anchor ligature points, should be considered as part of the DIPLAR process.

Katie Allan's next of kin and John Reilly

[555] The Crown's submissions regarding reasonable precautions under section 26(2)(e) in relation to Katie were generally adopted by her next-of-kin:

1) In relation to point (5) thereof, however, it was submitted that it would have been a reasonable precaution for staff to have been familiar with assessing self-neglect in a prisoner, the effect of removing Katie's university books, the effect of strip searching her, the effects of both personal officers being on leave at the same time, incorrect information about when an application for home detention curfew could be made, signs of tiredness and exhaustion, and the effect that the "window warriors" might have had.

2) It was also submitted that it would have been a reasonable precaution to have not permitted the use of belts, particularly by vulnerable prisoners such as first offenders, young offenders, those on remand or in the first weeks of sentence, and those with identified mental health problems. Had this precaution been taken, Katie would not have been permitted to have a dressing gown belt in her possession, which could be readily used as a ligature, and accordingly her death might realistically have been avoided.

[556] The Crown's submissions regarding system defects under section 26(2)(f) in relation to Katie were also adopted. It was submitted however that the system whereby all prisoners could have use of belts or cords unless a risk was identified was defective.

[557] The Crown submissions regarding other circumstances relevant to Katie's death were adopted without modification.

[558] In relation to William, the Crown submissions as regards reasonable precautions, system defects, and other circumstances relevant to his death, were all adopted by John Reilly without significant modification.

[559] As to recommendations under section 26(1)(b), while adopting all of the submissions by the Crown and by William Brown Senior, it was submitted that the following further recommendations should be made:

1) SPS should review whether there is any need within the prison setting for prisoners to have belts, whether for dressing gowns or trousers, given that they are not essential to such clothing.

2) Strip/body searches of female prisoners and young male offenders under the age of 18 should cease forthwith and body scanning machines should be installed in every prison. Strip/body searches should only be carried out in exceptional circumstances.

3) The review of TTM should involve the expertise of an academic suicidologist and/or forensic psychologist in order to provide staff with better insight into the verbal and non-verbal cues and clues.

4) Given the lack of accountability for failures by SPS and NHS staff, there should be an effective system of governance with national oversight put in place to ensure compliance with all systems, guidance, and accurate and timeous recording and sharing of information.

William Brown Senior

[560] William Brown Senior accepted and adopted the position advanced by the Crown with regard to William, subject to some additional observations and recommendations:

1) It was submitted that it would have been a reasonable precaution for the night shift manager and nightshift residential officer who received William into Monro Hall to have applied their minds to the potential environmental risks within his cell;

2) It was submitted that further circumstance relevant William's death were that:

a. The failure to pass the mental health referral to a member of the mental health team was not raised or discussed at the DIPLAR; and

b. The reduced work and education opportunities afforded to remand prisoners could have had a detrimental impact on William's mental health.

3) It was submitted that in addition to the matters recommended by the Crown under section 26(1)(b) the inquiry should also recommend:

a. That SPS consider whether, as a matter of course, young offenders should be monitored on a two hourly basis, this being the procedure adopted in England and Wales;

b. That SPS and NHS should consider ways to improve the culture amongst staff at Polmont to ensure that they feel free to raise any concerns regarding decisions under TTM by other more senior or skilled staff;

c. When allocating a prisoner to a cell an environmental risk assessment of it should always be carried out;

d. SPS should introduce an audit process for case conferences;

e. SPS should provide more support to remand prisoners, and allow them access to classes and work on the same terms as sentenced prisoners;

f. SPS should consider introducing procedures to allow a more ready flow of information from the community, for example a secure portal

where social work, medical staff and third sector organisations can provide reports or records; and

g. SPS should consider the introduction of an electronic online concern form to allow family members, social workers and others to record a concern they may have regarding a prisoner.

4) It was further submitted that Recommendation (4) by Katie's next-of-kin and John Reilly could go further. There should be an effective system to identify patterns, or systemic issues, across the prison estate allowing the shared learning in relation to suicide to be actioned by SPS. Correlation of information could also assist sheriffs by making them aware of previous deaths in similar circumstances, the learning points, and steps following recommendations which had been taken in the light of previous determinations by FAIs.

Brian Leitch

[561] Nurse Brian Leitch confined his submissions to the circumstances of his involvement with William. In relation to the Crown submissions regarding reasonable precautions, it was accepted (a) that he had failed to seek further information from external sources at any time prior to the case conference, (b) that he could - and should - have done so, (c) that if he had done so the decision of the case conference would have been different, and (d) that William's death might thereby realistically have been avoided.

[562] Nurse Leitch further accepted, by extension, that the pre-conference assessment which he carried out was not adequate, again because he could and should have obtained external information before carrying it out. However he submitted that it should not be looked at in isolation, in the sense of criticising it for not being comprehensive, in that much of the significant information which might otherwise have been obtained by that assessment had already been obtained by him at the RRA the evening before. As regards the adequacy of the case conference, the same argument applied. He had brought the PF fax and VPR to the case conference and specifically referred to them in the course of it.

[563] Nurse Leitch accepted that with hindsight more could and should have been done to explore the risks with William at the case conference. However considered in the light of the information which was taken from William and explored with him over three meetings (the RRA, the pre-case conference assessment, and the case conference), the improvement in William's demeanour, his forward planning and self-report, and the agreement of the prison officers, the decision to remove William from TTM was not necessarily unreasonable, or was at least capable of being better understood in context.

[564] As regards the Crown submissions regarding defects in systems of working in relation to William, these were accepted by Nurse Leitch, although it was noted that FVHB systems regarding immediate actioning of mental health team referrals have now changed.

[565] As regards the Crown recommendations, these were all accepted by Nurse Leitch. Recommendations 6 (court documentation to accompany a prisoner);

8 (obtaining social work and/or medical records), and 14 (timeous review of mental health referrals) were wholeheartedly supported by him.

SPOA, John Dowell and Natalie Cameron

[566] On behalf of SPOA it was submitted that the inquiry should make formal findings only, in terms of subsections 26(2)(a) and (c). Accordingly SPOA's position was that there were no reasonable precautions by which either death could realistically have been avoided, that there were no systemic defects in any system of working in either case, that there were no other relevant facts, and that no recommendations should be made in terms of section 26(1)(b).

[567] SPOA sought to emphasise the daily challenges and realities faced by staff working within Polmont. The court should be cautious before concluding that staff ought to have done more to keep Katie and/or William safe. All prison staff were regularly trained in TTM and were alert to the risk factors which may be applicable. There was no catch all approach to suicide management. The ultimate decision as to risk assessment would always fall upon staff tasked with the prisoner's care, who required to balance historical risk and protective factors including a prisoner's own expressions or denials of suicidality.

[568] Prisoners should not lightly be placed into Safer Cells. If they were, suicide rates would be reduced, but this was not a viable strategy. Prisoners' mental health was best served by allowing them as much "freedom" as can be expected in a custodial setting. Risk assessment is and must always be bespoke.

[569] SPOA accepted that the evidence showed that prison staff rarely if ever utilised concern forms, but regarded them as tools to be utilised by external agencies to communicate concerns to hall staff. The rationale was that as officers had direct access to prisoners, any concern form lodged would make its way to them in any event. Therefore they considered the process superfluous - in effect sending forms to themselves - as they would go and speak to the prisoner anyway. If having done so they had any concerns, the officer would simply place that prisoner on TTM.

[570] It was submitted that this rationale for this was sound. Concerns were not ignored or dismissed; officers acted to protect prisoners' welfare where appropriate. Prioritising form filling might even be counter-productive in time critical situations. SPOA accepted that the poor utilisation of concern forms might lead to important events or moments being missed from a prisoner's records, but suggested that this was a distinct issue from those central to the inquiry.

[571] As regards Katie, it was submitted that the absence of the use of concern forms in her case did not materially impact on the care and attention that prison officers gave to her throughout her time in Polmont. Officers were aware of her upset in relation to her alopecia and engaged with her appropriately about this. Moreover she had a high degree of interaction with prison officers and staff, and none considered that she should be placed on TTM. She never reached the threshold whereby intervention was called for. The lack of concern forms did not impact on staff action in this regard.

[572] TTM is reliant on staff carrying out an ongoing and constant triage of all prisoners, during every interaction. They did this in Katie's case. Her general

presentation to staff was that despite stressors she was managing okay and appeared generally positive. No member of staff thought, at any point, that Katie was at risk of self-harm or suicide - indeed they felt that she was one of the least likely prisoners to die by suicide, and were in disbelief when she did so.

[573] As for bullying, SPOA submitted that there was mixed evidence in this regard. Although Linda Allan said that Katie had reported multiple instances of bullying, she added that Katie had chosen not to report this to staff. There was the intelligence log from 12 April 2018 which indicated that Katie was being bullied for tobacco. However the officers who dealt with Katie on a daily basis said that they were not aware of any bullying towards her. Had they been they would have dealt with it.

[574] Megan Sandeman, Katie's fellow prisoner, was also not aware of Katie being bullied, bar a number of barbed comments about her hair shortly before she died. It was important to recognise the distinction between trivial sniping, and *bone fide* bullying - it was not necessary to record every cross word. Overall the evidence did not support the notion that Katie was a victim of bullying, beyond a small number of minor isolated incidents which were dealt with in an appropriate manner by staff.

[575] As regards the events of 3 June 2018, it was understandable that Katie would be distressed during her mother's visit, she having witnessed the fight in the hall earlier that day. But when Mrs Allan disclosed Katie's concerns to Officer Doherty, these were relayed back to Officers Scott Wilson and Tart, who acted promptly in immediately approaching Katie, speaking with her, reassuring her, and assessing the situation.

[576] Although there was a discrepancy between the officers as to what precisely Officer Doherty told her colleagues, that was not material. Officers Scott Wilson and Tart would have taken the same action as they did, and there was no good reason to suppose that there would have been a different outcome. Katie presented as primarily upset due to an issue between herself and Linda Allan during the visit. There was no good reason to suppose that Katie would have been moved to a different flat on the evening of 3 June 2018. She wished to think over such a move, in particular because she did not wish to lose Officer Scott Wilson as her personal officer.

[577] Further and in any event, Katie was future planning even at this stage. She requested a visit to be booked with her father the following day, and this was arranged. As the expert evidence indicated, such future planning mitigates against an individual being suicidal in that moment. Furthermore, the letters and notes which Katie wrote on the evening of 3 June 2018 also suggest future planning, and therefore that she was not considering suicide at the point that her cell door was locked. This evidence suggested that Katie suicide was an impulsive act which by definition was hard to predict.

[578] Against this background, SPOA submitted that the inquiry should not pour over the evidence and seek to extract key points that might retrospectively act as red flags as regards Katie's mental well-being. Suicide is an extremely complex area of human behaviour, difficult to both predict and manage. The challenge was to manage persons who were inherently vulnerable, and stay alert to changes in status and presentation suggesting self-harming behaviour. It was overly simplistic to suggest with hindsight that Katie may have met a certain number of verbal and/or non-verbal cues and clues in

terms of TTM that could have alerted staff to her increased risk status. In particular that approach disregarded factors mitigating against potential suicide risk in her case, in a process which was a balancing act not a tick box exercise.

[579] Accordingly there were no reasonable precautions which if taken would have likely resulted in Katie's death being avoided. There were clear stresses for her while in Polmont, but the evidence suggested that she presented as coping with them well in the circumstances. She did not present in such a way as to suggest that she would contemplate self-harm or suicide. Her presentation did not justify putting her on TTM at any point. As the expert evidence suggested, either she had been extremely guarded about thoughts of suicide, or it may only have entered her head as an unplanned and impulsive act in the evening of 3 June 2018.

[580] As regards systems of working, SPOA accepted that the various record-keeping systems within Polmont were, on the face of it, sub optimal. PR2 did not contain the RRA forms or medical information held on VISION. VISION did not have the same totality of information as PR2. These systems did not speak to each other. Only FLMs and intelligence officers had access to the intelligence logs. Therefore nobody tasked with Katie's caring Polmont had a complete picture as to her history and current status. But it was submitted that even had the full picture been available to either prison or healthcare staff Katie would not have been managed differently.

[581] The failure to use concern forms should not be criticised as a systemic defect in Katie's case. They were not used because staff did not have concerns about her. Had they had concerns, they would have put her on TTM. Good practice as regards other

incidents or discussions with prisoners would have been to record them as a narrative entry on PR2, as had been done by Officer McIntyre on 8 April 2018. That there were not more such entries lent credence to the notion that Katie was generally coping well with the prison regime. Even in situations where TTM policy called for a concern form - for example Linda Allan's report to Officer Doherty on 3 June 2018 - there was no evidence to suggest that had such a form been filled in Katie's management would have differed.

[582] As regards recommendations, SPOA submitted that none were required in respect of Katie's death. This was an unpredictable event against the background of presentational signs that largely mitigated against the tragic outcome. SPOA submitted that it was for other participants to comment on matters of prison policy, healthcare practice, cell environment or electronic system management.

[583] As regards William, SPOA again recognised the general non-use of concern forms by frontline prison officers. There were concerns for his well-being that ought to have been logged via the concern form process. The key component was the information from Mr MacDonald passed via Mr Doyle to Officer Baird after the case conference on 5 October 2018. Had Officer Dowell been aware of this information he would have reconsidered the decision to remove William from TTM and would likely have reversed it. This represented a missed opportunity to reassess William. Use of the concern form would have aided the process.

[584] SPOA submitted that it was appropriate to place William onto TTM on admission to Polmont, with 30 minute observations, and to allow him to have all

personal items in use. Because he did not die or attempt to die by suicide on his first night in custody, while subject to these measures, it was submitted that the RRA process was performed correctly and proportionately. The following morning, 5 October 2018, William presented as largely well, and he stated no concerns to any of the many staff members he interacted with. Risk assessment is a dynamic process, and can fluctuate from hour to hour, and minute to minute. It was therefore submitted that at the time of the case conference, in all the circumstances, William did not present as being at risk of suicide.

[585] As for the case conference, SPOA submitted that William told staff he did not need to be on observations, and had no thoughts of self-harm or suicide. The members of the case conference understood that these answers should not dictate the determination. They were alert to the cues and clues which might signify potential concerns. Nurse Leitch was aware of the PF fax and the VPR, although it was not clear whether he had showed these to Officers Dowell or Cameron. However Mr Leitch was best placed to provide a view on William's risk. It was understandable that Officer Dowell allowed him to "take the lead". The information from the PF fax and VPR was factored into the decision-making process. At this moment in time William did not present as being at risk of suicide.

[586] SPOA accepted that William met certain risk criteria set out in TTM, but submitted that it would be speculative to say how they ought to influence decision-making. It accepted that a case conference lasting only a maximum of 10 minutes seems "disconcertingly brief". But William had spent further time with

Nurse Leitch previously, and the conference may have lasted longer than the time recorded on the form. It followed that if William did indeed present well and settled, and expressed his view clearly, then given that Nurse Leitch was able to make a comparison with his demeanour from the previous evening, it was understandable that the decision to remove him from TTM was then swiftly made. In any event there was no set time for a case conference.

[587] SPOA accepted that the information obtained by Officers Baird and Cormack after the case conference - that William may have been putting on a front - should have been relayed to Officer Dowell. Similarly Tara Duthie was in a position to raise a specific concern as to William's deliberate masking of his true demeanour, and it was not clear why she did not do so. Had this information been recorded on a concern form and in any event relayed to Officer Dowell, it is likely that William would have remained on TTM, or been placed back on it. Additionally, SPOA acknowledged the failure to action Mr Doyle's mental health referral. Had it been, again it is likely at the very least that William would have been reassessed.

[588] In the light of all this, SPOA submitted that the totality of evidence lent itself to a finding that William ought to have been maintained on TTM, or at least returned to it, on 5 October 2018. It was accepted that this would have been reasonable, under explanation that further information would have had to have been made available in order to take that step. The case conference decision itself was reasonable standing the information that was then to hand. It was a matter of judgment, and the court ought to hesitate to dictate what conclusion should have been reached in the circumstances.

[589] But in any event, SPOA submitted, it was speculative to suggest that William's death might have been avoided had he remained on TTM, or been placed back on TTM in the light of the additional information. There was no lively possibility of this. In order to entirely obviate any risk to William, the harsh environment of a Safer Cell, with removal of personal items including clothing, would have been required. There would have been significant downsides to this for William's mental well-being. In any event suicidal ideation can arise suddenly, triggered by any number of factors, and is difficult if not impossible to predict. Even if William had been maintained on 30 minute observations in a standard cell, he would still have had ample time and opportunity to complete suicide. Observations could mitigate against the risk, but not eliminate it entirely.

[590] As to defects in any system of working, SPOA again accepted that the fractured nature of various record-keeping systems led to problems in William's case. These revolved around the information he brought in with him as opposed to record-keeping within the hall. Given William's short admission, it would have been difficult to staff to obtain records swiftly even had they been requested. But they had William's social worker's mobile number, therefore there was no systemic defect which prevented them from obtaining further information from this source. But while additional information would have prompted additional consultation with William, it was a leap to suggest that these specific details would have definitively altered his pathway. Even if these systemic kinks had been ironed out, therefore, it could not be said that this would have resulted in William's death being avoided.

[591] As to recommendations in William's case, SPOA submitted that these were a matter for the court. However staff should have been made aware of William's previous and recent attempts suicide so as to allow them to make the most informed decision possible. That was so even though it was submitted that William's death may not in any event have been avoided even if the flow of information into Polmont had been better, or better utilised.

FVHB

[592] FVHB confined its submissions to those issues relevant to health service provision within Polmont, and in particular the actions of health service staff in their interactions with Katie and William.

[593] As regards Katie, FVHB submitted that the Crown's criticisms of Nurse Macfarlane's RRA on 7 March 2018 were ill-founded. He addressed all the issues that were required by TTM in relation to a RRA. TTM required him to "determine if the individual has previously attempted suicide or self-harm or if they currently have any thoughts of suicide or self-harm". It was submitted that Nurse Macfarlane did this, and that he was not required to then note it on the form. Insofar as the form required him to "summarise responses", he explained that he summarised those factors which he considered to be of importance in relation to Katie.

[594] FVHB also rejected the Crown's submission that Nurse Macfarlane had taken the wrong approach to Katie's RRA. It was submitted that he undertook a comprehensive and detailed risk assessment of Katie in line with TTM. Insofar as his assessment was

in less depth, because it was following a transfer rather than a first admission, this was because on transfer some investigations - such as urine screening - would not necessarily be required. Furthermore, Nurse Macfarlane properly drew the distinction between a RRA, under TTM, and a full mental health assessment following a referral to the mental health team. None of the expert witnesses were critical of his approach to the RRA. There was no suggestion that his assessment, that Katie was at no apparent risk of suicide, was incorrect. Given that no member of prison staff placed any subsequent reliance on Nurse Macfarlane's RRA, it could not found a reasonable precaution, factually or temporally, beyond a remote possibility.

[595] As regards Joanne Brogan, FVHB submitted that the Crown's submission that her involvement with Katie was merely "informal, often amounting to empathising" was incorrect. This criticism did not reflect Nurse Brogan's whole evidence, nor the expert evidence. Nurse Brogan had been asked to speak to Katie at the invitation of Officer Morrison, and because it was known that she too had suffered from alopecia. It was true therefore that her contact was not based on a formal mental health referral or assessment. But that did not mean that her contact with Katie was "informal". Indeed no interaction with a patient by a healthcare professional, making decisions in relation to them and writing entries on their VISION record, could be regarded as informal.

[596] It was accepted, indeed submitted, that Nurse Brogan did provide support to Katie in an empathetic way. She aimed to give Katie hope for the future in terms of recovering from alopecia. Katie found that helpful. During their sessions she had discussed coping mechanisms, even if further planned relaxation and self-esteem

techniques had not commenced by the time of Katie's death. She proactively researched treatments for alopecia, and investigated the possibility of obtaining a wig for Katie. She advocated on Katie's behalf to facilitate her getting the wig which Linda Allan had purchased privately. She sought to ensure that Katie was receiving treatment from Dr Collier so that she could obtain an NHS wig on prescription following liberation.

[597] FVHB further rejected the Crown's criticism that no one had contacted Katie's family to obtain further information about her mental or physical health. Nurse Brogan did discuss Katie's medical history with her, and had access to her VISION records. There was no evidence to suggest further information was available which ought to have been obtained from Katie's family, and there was no specification of what that might have been. In any event Nurse Brogan did have direct contact with Katie's mother in relation to obtaining a wig for Katie and expediting its receipt into Polmont.

[598] Insofar as the Crown sought to highlight that Nurse Brogan did not carry out any formal mental health assessment or review of Katie, FVHB submitted that there was no basis to suggest that such an assessment was necessary. Katie was never formally referred to mental health services in Polmont, nor did she ever self-refer. Nurse Brogan was aware that Katie's alopecia was impacting negatively on her mental well-being (as distinct from mental illness) and took steps to help her with this. Nurse Brogan was an experienced mental health nurse, but at no time during their interactions did she have any concerns that Katie was exhibiting signs of mental illness or was at risk of suicide or self-harm.

[599] Had she been, Nurse Brogan would have put Katie on TTM, as she had done with other patients many times before. Rather, she found Katie to be open, resilient, capable and engaging. She did not report bullying or weight loss. She regularly discussed and displayed protective factors and future planning. It was not correct to suggest that no assessment of Katie's mental health was undertaken by Nurse Brogan. Nurse Brogan employed her skills as a mental health nurse to support Katie during her time in custody. None of the experts were critical of her interactions with Katie, indeed quite the contrary. What she did was "worthwhile and important", "appropriate, measured and proportionate."

[600] FVHB also rejected any criticism of Dr Fiona Collier. She had specialist medical skills in relation to alopecia. Her evidence was that the aetiology of this condition was not well understood. While it is sometimes attributed to stress, the evidence base for such a causal link is lacking. It did not follow that Katie's alopecia was accepted to be stress-related, indeed Dr Collier's evidence was that Katie herself did not attribute it to stress.

[601] Furthermore, Dr Collier's treatment of Katie with Dermovate steroid lotion was appropriate. Steroid injections, such as Katie had previously received, were rarely used, and were not available within the prison setting. Dr Collier herself had never undertaken the procedure. Having seen Katie, she arranged to review her in 8 weeks time, and this was much earlier than the 3 to 4 months waiting time for an NHS appointment in the community. Although Katie later expressed to Linda Allan her

dissatisfaction with Dr Collier, she was not upset, distressed or argumentative about her treatment plan to Dr Collier herself.

[602] FVHB submitted that Dr Collier was well aware of the devastating effect that alopecia can have on self-esteem and image in young people. Her evidence was that she believed, from the VISION records, that Katie was receiving support from the mental health team. The Crown's submission that Dr Collier was proceeding on a false assumption in this regard was rejected. Dr Collier's evidence was that the mental health team in Polmont were trained in risk assessment, were experts in the field mental health and that Katie had been thus assessed by an expert because Nurse Brogan was supporting her. In any event, had Dr Collier noted any signs of suicidality when she met with Katie, she would have initiated TTM.

[603] Nurse Louise Liddle did not give evidence to the inquiry. Her name features in the VISION records for Katie. In particular she arranged for Katie to be prescribed Zerobase cream in relation to the eczema which she developed while in Polmont.

[604] Insofar as the Crown sought to suggest criticism in that no community medical records were ever requested for Katie, FVHB submitted that they did not contain any information that had any bearing on her death. Katie disclosed her previous history of self-harming and alopecia; the records would not have disclosed any information beyond that.

[605] Although the Crown suggested that it would have been helpful for SPS staff to have known about Katie's history of self-harming, FVHB submitted that there was no evidential basis for any proposition that, had they done so, it would have made any

difference to her death. That was because the evidence, and in particular the expert evidence, was that self-harm is common in young women, and within a prison setting it is prolific. Where, as in Katie's case, there had been an isolated incident of self-harm while she was a teenager, and no concerns about recent self-harm, this would not suggest current suicidality, would not of itself prompt further detailed inquiry, and would not weigh heavily in assessing risk of suicide.

[606] As to the Crown's submission that, with hindsight, a full mental health assessment of Katie ought to have been undertaken prior to 3 June 2018, FVHB submitted that the evidence, and in particular the weight of expert evidence did not support this. The evidence was that it was genuinely difficult to say whether a full assessment should have been carried out, and this could be argued either way. The decision not to undertake such an assessment fell within the realms of clinical judgement based on Nurse Brogan's state of knowledge.

[607] In any event, even if Katie had been subject to such an assessment, it could not be said to be a lively possibility that her death would have been avoided. Even if a full, formal mental health assessment had been carried out, it was unlikely that Katie would have disclosed any further information than she in fact did. Although she might have been assessed and recommended for counselling and psychological support, work of that nature was already being implemented by Nurse Brogan. There was no suggestion of what Nurse Brogan ought to have done in this regard which she did not in fact do.

[608] Accordingly FVHB submitted that there were no reasonable precautions, individually or collectively, by which Katie's death might realistically have been

avoided. The expert evidence was overwhelmingly to the effect that Katie's suicide was likely impulsive, unplanned and unpredictable. In the run-up to the material time there was no indicator of such thoughts being on her mind. None of the factors relied on by the Crown contributed to Katie's death. The evidence did not establish that Katie's presentation at the time of her death justified further review of her mental health, nor that even if such a review had occurred, that any intervention would have gone beyond what was already being provided, or changed the outcome.

[609] As regards William, FVHB addressed the dispute that had arisen as to whether Tara Duthie told Nurse Leitch at the lunchtime staff meeting on 5 October 2018 what William had said to her earlier that morning. The Crown's submissions that Ms Duthie's evidence on this point should be accepted were disputed by FVHB. Ms Duthie's evidence was inconsistent and implausible. Nurse Leitch's evidence should be preferred.

[610] FVHB noted Nurse Leitch's acceptance that with hindsight he should have contacted social work to get more information, both before and after the case conference. FVHB noted that the expert evidence could not say whether William remaining on TTM observations would have prevented his death by suicide, but accepted that it would have reduced the risk. FVHB agreed in the light of this that seeking more information about William would have been a reasonable precaution that might have resulted in his death being avoided.

[611] In relation to section 26(1)(b) of the 2016 Act, FVHB confined its submissions to those requiring action on its part. In particular it submitted that it had taken steps

to improve the systems which it operated in Polmont since the deaths of William and Katie. These steps had been reviewed in the course of ERoMH, and the expert evidence available to the inquiry suggested that the FVHB systems were much improved as a result.

[612] Although not directly the subject of any proposed Crown recommendation, FVHB submitted that it had implemented a new process for obtaining patients' medical records and other relevant information where needed. When it is, FVHB communicates with organisations who hold information in order to obtain it. For non-urgent cases, within 24 hours, a mental health nurse will contact the relevant organisation to obtain the required information. A timeframe of 10 days is given for relevant information to be provided. When the information comes into Polmont it is passed onto the team leader, the deputy leader, the mental health team and the mental health nurse upon whose caseload the patient is on. Where information is required more urgently mental health staff can accelerate the process verbally, the default position being that patients are protected pending receipt.

[613] As regards the Crown's proposed Recommendation 13, FVHB submitted that the ISP was already place between SPS and the NHS, and the basis on which information can be shared is clearly set out therein. Staff are trained in the principles underlying the ISP, and understand that they are able to share confidential information with SPS staff without patient consent where there is a risk to the patient. Further, as explained in evidence, the ISP is supplemented by "healthcare markers" by which dedicated forms are prepared by health care staff and put onto PR2. These markers alert SPS staff to

specific healthcare issues giving rise to risk, for example if a patient is diabetic or asthmatic. FVHB agreed that further training of health care staff would be useful to ensure a clear understanding of what information can be shared, and when.

[614] As regards the Crown's proposed Recommendation 14, FVHB submitted that as regards the failure to immediately pass on Mr Doyle's mental health referral in relation to William on the afternoon of 5 October 2018, its system was updated almost immediately. The evidence before the inquiry was that a "single point of contact" system had been developed whereby any concerns which came into the mental health team would be sent to the health care manager, the deputy team leaders and the mental health care team, to ensure that relevant information received was identified and passed on. Furthermore the Care Partner system has been implemented at Polmont which provides standardised templates with a view to ensuring that information is available to those who require it.

[615] As regards the Crown's proposed Recommendation 15, FVHB submitted that it had taken steps to address the issues identified within the DIPLARs regarding clinical notetaking. This included specifically addressing the subject with new staff during induction, undertaking monthly audits of notetaking, and speaking to staff or an individual basis where issues were identified (including Nurse Brogan), preparing improvement plans, and developing a competency framework as part of ongoing clinical supervision. Expert evidence available to the inquiry suggested that these changes had been useful. FVHB agreed with the Crown's proposed recommendation that further training should be provided to staff in relation to this matter.

SPS

[616] By way of preliminary observation, SPS recognised that there were lessons to be learned from Katie and William's deaths and submitted that it was committed to learning those lessons. Questions of whether either of them should have been sent to Polmont were irrelevant, as this did not change the responsibility which SPS had for them. But that the prison environment was not appropriate for children under the age of 18 was now recognised and reflected in 2024 Act.

[617] SPS confined its submissions to issues involving the actions of SPS staff and its policies and procedures, and offered no substantive comment on the actions or policies of other participants. However it paid tribute to Linda and Stuart Allan, and acknowledged that their determination to ensure that the lessons of Katie's death were understood and acted upon had resulted in areas for improvement being identified.

[618] As regards William, SPS took no issue with the basic Crown narrative of events, and made no specific submissions on the factual disputes as regards the precise nature of information relayed to and by officers, healthcare workers, and third sector partners. These disputes did not detract from the systemic issues which allowed a breakdown in communication which compromised William's care. A consistent theme of the factual and expert evidence was that it would have been valuable for officers and health care professionals to have been provided with more information about William's history and the community, past attempts at self-harm and suicide, impulsivity and potential triggers. Such information existed but there was no effective mechanism in place to share it.

[619] SPS submitted that the decision to place William on TTM following the RRA on 4 October 2018 was plainly correct. On the other hand, the decision to remove William from TTM following the case conference the following day was plainly wrong. Each of the members of the case conference accepted that, with hindsight, the outcome of it would have been different if those present had been in possession of more information in relation to William. In the absence of that information, his presentation and self-declaration that he had no suicidal intent was given too much weight. In any event whether due to his inherent characteristics, or the absence of information which ought to have been requested, the decision to remove William from TTM on the morning of 5 October 2018 was not tenable.

[620] SPS accepted that the evidence indicated criticisms of the case conference procedure relating to its duration and record-keeping, and that these were learning points. However it submitted that the critical factor which could have made a difference to the outcome of the case conference was the availability of relevant information about William's history. Given the gap in the available information, and history of social work involvement, risk of suicidality, and involvement with mental health services, William should not have been removed from TTM absent a clear reason to do so.

[621] Furthermore, SPS submitted that the evidence also left little room for doubt that William's risk ought to have been reassessed following receipt of information provided by his social worker and Includem worker on the morning of 5 October 2018. The preponderance of evidence indicated that such a reassessment would have resulted

in William being put back on TTM. On any view, there was a series of missed opportunities in this regard.

[622] Even if William had been reassessed and reinstated on TTM on 5 October 2018, the evidence did not permit the conclusion that he would not have died by suicide on some future date. However the risk of him doing so at the time when he did could reasonably have been reduced by his being on TTM. In other words, SPS accepted that William's death on the night of 6 October 2018 was reasonably preventable.

[623] SPS also accepted that the risk to William was compounded by his physical environment. SPS specifically accepted that bunk beds were and are a known ligature anchor point risk. It accepted that William should not have initially been placed in a cell on his own with a bunkbed when subject to TTM. SPS, as a direct response to the evidence led in the inquiry, had now removed all 74 bunk beds from accommodation within Polmont used by children and young persons. It recognised and acknowledged that the inquiry would be concerned that this step had not been identified earlier.

[624] SPS therefore submitted that following precautions could reasonably have been taken which might realistically have resulted in William's death being avoided:

1) At the case conference on 5 October 2018 William should have been retained on TTM pending receipt of further information from external social work agencies.

2) William's risk of suicide should have been reassessed, and TTM policy measures reinstated following receipt of information from external social worker and third sector charity worker during 5 October 2018.

3) William ought not to have been placed in a single occupancy cell with a bunk bed.

[625] SPS submitted further that there were the following defects in a system of working which contributed to William's death:

1) There was a systemic inter-agency failure in relation to information sharing with SPS in respect of a young person who was remanded straight from court.

2) Systems within Polmont for sharing urgent information received from external agencies were defective.

[626] Beyond this, SPS offered the following comments on the Crown's submissions on reasonable precautions in relation to William:

1) It was not reasonable to expect the staff conducting the RRA for William on 4 October 2018 to have called for further records. The RRA was conducted out with working hours, and its outcome was the initiation of TTM and a case conference within 24 hours. It should have been for that case conference to decide what if any further external records should be requested.

2) It would have been a reasonable precaution for the case conference to have considered inviting William's social worker. Whether he could have in fact have attended, is not known. But TTM requires the consideration be given to this.

3) There was no proper basis in the evidence for finding that putting a transitional care plan in place would have been a reasonable precaution for William - what it might have included was not explored. But in any event the point was moot, because the evidence made clear that William should never have been removed from TTM.

4) SPS did not accept the Crown submission that TTM was defective on the basis of overreliance on self-reporting. TTM assessments should take account of self-report, but also non-verbal cues and clues and information obtained from other sources. In any event TTM is a suicide prevention policy, primarily aimed at identifying and managing prisoners in acute distress. It is not for the managing and supporting of a vulnerable prisoner more generally. Criticising the TTM strategy for including self-report, yet lacking more detail in respect of background information, risks conflating these two matters.

[627] As regards Katie, SPS acknowledged that her death must have brought devastation on family and friends, particularly given that she was so close to release. But in the present inquiry the issues in relation to her were (i) whether she should have been subject to TTM on the night of 3 June 2018, and (ii) her physical environment and the extent to which ligature risk ought to have been managed within it given that she was not subject to TTM.

[628] SPS submitted that there was no evidence to challenge to the conclusions of the RRAs, on 5 and 7 March 2018, that Katie presented as being at "no apparent risk"

of suicide. The issue was therefore whether something should have changed the assessment of her suicide risk, such that she would have been subject to TTM on 3 June 2018. The constellation of factors relied on by the Crown could not, however, properly be considered in isolation from the evidence about Katie's experience in Polmont.

[629] There was evidence in the form of her written correspondence, transcripts of numerous telephone calls, as well as evidence from family members, prison officers, health care staff, the prison and university chaplains, and her fellow prisoner Megan Sandeman. Katie was described by all who encountered her as intelligent, articulate and personable. She was trusted with a pass job which allowed her to be out of her cell for the maximum permitted time. She took opportunities to participate in educational opportunities, youth workgroups, fitness, and recreational activities. Continued contact with her university was facilitated, allowing her to continue education with a view to returning to her degree course on release. She formed friendships with other prisoners.

[630] Next, the evidence was that Katie was well-liked by prison staff, and that officers went out of their way to help during her time in Polmont. She had a good relationship with those officers who had the closest contact with her. There was no evidence that she was frightened of them or felt unable to approach them. They were of the view that Katie should not have been in prison at all, and were alive to the general vulnerability it gave rise to. They treated her with kindness and went out of their way to care for her.

[631] SPS submitted that the criticism made of body searching of Katie was ill-founded. She was subject to two random post visit body searches on 21 March 2018 and 13 April

2018. These were performed in accordance with SPS policy and procedures. Expert evidence indicated that body searching was a necessary part of a prison regime and that it was used appropriately in Katie's case.

[632] SPS submitted that as regards bullying of Katie, the evidence established only that there were two incidents of bullying behaviour, in April 2018 and on 3 June 2018. The latter incident, it was accepted, would undoubtedly have been distressing for her; she was subjected to cruel verbal abuse from the ringleaders of the fight in the hall on that day. However it was submitted that there was no evidence that Katie was subjected to abuse or threats throughout her time in Polmont. That proposition was not properly supported by the documentary, oral or expert evidence.

[633] At no point during her time in Polmont did Katie reveal or exhibit thoughts of self-harm or suicide to anyone, either within or without the prison. Had she done so, the evidence was that staff would have immediately put her on TTM. Although she may at times have been feeling low, down, upset, distressed or distressed, this did not mean that she was at risk of suicide or self-harm. She did disclose her feelings to others on occasions, but there was no indication of emotional disturbance disproportionate to her situation. The clear and consistent evidence was that there was nothing in Katie's presentation which caused concern that she was at risk of suicide or self-harm.

[634] As to Katie's physical presentation, SPS submitted that the cause of the recurrence of her alopecia while in Polmont was unknown. But it was clear that it caused her distress. From 19 March 2018 at the latest she was under the care of FVHB staff in relation to this condition. Katie disclosed it to prison officers and they took

appropriate steps by seeking support for her from Nurse Brogan, a trained and experienced mental health nurse who herself had experienced alopecia. Accordingly the fact that Katie suffered from alopecia did not warrant initiation of the TTM strategy in respect of her.

[635] Katie had a history of eczema, and disclosed this to clinical staff. She received treatment for it. It was not disclosed to prison officers for reasons of confidentiality. But there was no evidence that eczema would be a cause for concern that a prisoner was at risk of self-harm or suicide. There was evidence that eczema was common in prison.

[636] Katie lost 7kg in weight whilst in Polmont. This weight loss was discovered at post-mortem examination. There could have been a number of reasons for it, not least the change of diet in prison. There was no evidence that it was evident to any staff working in Polmont. There was no evidence that it was an indicator of suicidal ideation or thoughts of self-harm, requiring Katie to be put on TTM.

[637] As to Katie's history of self-harm, SPS submitted that it consisted of a single incident disclosed to her GP on 1 June 2015. It was linked to a specific set of circumstances at that time. It was not accompanied by suicidal ideation. Katie disclosed this history on admission to custody. Recovery of her community medical records would not have shed further light on this, and accordingly criticisms directed towards any failure to recover them were misplaced. The expert evidence was that an historic incident of self-harm nearly 3 years prior to custody, while relevant, would not have had significant weight in assessing Katie's risk of suicide in Polmont. Some 25% of

young people in the community between 16 and 25 years of age have some kind of history of self-harm.

[638] SPS noted that it was a matter of agreement that Katie self-harmed on the night of 3 June 2018, but submitted that there was no basis for any finding that she self-harmed at any other time while she was in Polmont. No one who interacted with her during this time observed evidence of self-harm. Self-harm by cutting was a known risk within Blair House, and officers were watching for it. Had there been evidence of Katie self-harming it would not have been ignored. That officers were not aware of her self-harm history did not compromise her care. On the contrary it would have made any evidence of self-harm by her more conspicuous; she would have been placed on TTM.

[639] In relation to Katie's court appearance on 29 May 2018, SPS disputed the Crown's contention that, absent a requirement for TTM to be instigated, no action would have been taken by the officer conducting the RRA on that day. It submitted, on the contrary, that the evidence suggested that had Katie been upset at the time, but did not meet the TTM threshold, she would have been referred to a mental health nurse in the reception area.

[640] As to the events of 3 June 2018, SPS acknowledged that they were distressing for Katie. While the broad outline of events was not contentious, there was a lack of clarity about what information was relayed to Officers Scott Wilson and Tart by Officer Doherty. It was suggested that this was explicable by the passage of time. But in any event Officers Scott Wilson and Tart did discuss with Katie the concerns

raised by Linda Allan, and Katie herself disclosed the nature of her concerns, namely the shouting and verbal abuse she had received from the ringleaders of the fight. Officer Scott Wilson's evidence was that Katie was told that these individuals had been put out of circulation pending disciplinary procedures. The possibility of moving halls was discussed, and Katie agreed to think about it.

[641] SPS acknowledged that a concern form should have been completed on 3 June 2018 in the light of Linda Allan's report. Beyond that it was submitted that in all other respects SPS officers acted appropriately. Mrs Allan's concern was relayed to hall officers and acted upon. Officers Scott Wilson or Tart assessed Katie in the light of the events of the day, and neither were concerned that she was at risk of suicide or self-harm. Katie's behaviour gave no indication that she was. She was forward planning, arranging a visit with her father for the following afternoon, putting out her laundry for collection, and making a requisition for cosmetics. She appeared settled when her cell was locked up. Her presentation when checked later in the evening gave no cause for concern.

[642] In all the circumstances, it was submitted that there was no evidence which would permit the conclusion Katie presented as being at risk of suicide on the evening of 3 June 2018. There was no evidence that Katie should have been placed on TTM at this time.

[643] That conclusion was consistent with the evidence from the four clinical experts who provided evidence for the inquiry. This supported the conclusion Katie's act of suicide was likely a relatively impulsive act and that it could not have been easily

predicted. She did not have known or obvious mental health challenges, but rather more subtle issues of well-being which did not, by the time of her death, cross the threshold of requiring a reassessment of her risk of suicide. Even if Katie had been reassessed, it was unclear that she would have been provided with any further support beyond that which was in fact provided. And even if additional support had been provided it was not possible to say that the outcome would have been different.

[644] In relation to ligature prevention in Katie's case, SPS submitted that reduction of ligature risk was a part of the protective measures available under TTM, including use of Safer Cells, removal of ligature items, and regular observations. But on 3 June 2018 Katie was not subject to such measures, and there was no evidence that she ought to have been.

[645] However SPS acknowledged that the rectangular door stop, placed at the height it was, was an obvious ligature anchor point, requiring no innovation for use for this purpose. It accepted that replacement of rectangular door stops with stops with sloping tops, as used elsewhere in the prison estate, would reduce ligature risk. It submitted that the removal of any remaining rectangular door stops such as the one in Katie's cell was now underway. But it was impossible to know what Katie would have done if the door stop had not been present. She was not in a ligature free environment and might have utilised another ligature point to the same effect.

[646] In the light of all this, SPS submitted that there were no reasonable precautions by which Katie's death might realistically have been avoided in terms of section 26(1)(a)(e), and no systemic defects which contributed to her death in terms of

section 26(1)(a)(f). The Crown's contentions to the contrary were rejected. As regards section 26(1)(a)(g), SPS submitted that the inquiry should find, as a fact relevant to the circumstances of the death, that where door stops are required on shower/toilet cubicle doors, door stops should not be designed or positioned in such a way as to present a ligature point.

[647] Turning to the question of ligature prevention more generally, SPS acknowledged that it should be addressed. It recognised that the evidence indicated that ligature deaths account for the overwhelming majority of suicides in the prison estate, mostly by prisoners who were not then on TTM. Accordingly SPS recognised that there was a live question for the inquiry about the routine reduction of ligature anchor points, and the availability of items which might be used as ligatures, in standard cells.

[648] SPS submitted that there were competing factors in ligature prevention, as detailed in the letter from its former chief executive to the Cabinet Secretary dated February 2019. Although it was seen primarily as an Estates issue, it did feature at policy level as well, including the NSPMG. And within TTM, care planning must consider whether to put a prisoner into a Safer Cell, designed to reduce ligature risk as far as possible to mitigate an identified, imminent risk of suicide. Decisions also have to be made about use of potential ligature items, for example clothing, belts, shoelaces and bedding. Anti-ligature clothing and bedding was available in high suicide risk cases.

[649] But protective measures could have a detrimental effect. That was why TTM required and provided for individualised assessment. There was a balance to be struck

between the comfort that a prisoner might derive from remaining in a normalised environment with ongoing access to their own possessions, and that prisoner's safety. Where there was an immediate concern about risk to life, the priority was preservation of life, by use of more intensive protective measures. But otherwise, care had to be taken not to worsen the situation.

[650] Where prisoners are not currently assessed at risk, and therefore not on TTM, there are no specific suicide prevention measures. However the design of standard cells continues to evolve, and ligature anchor points minimised. There is an ongoing convergence between the design of Safer Cells and the design of a standard cell. The extent which that was possible depended on the age and building fabric of the prison as well as the design and layout of individual cells. But SPS accepted that in relation to new build facilities, such as HMP Grampian, standard cells and Safer Cells already appear to be, to the untrained eye, of similar design.

[651] As to ligature items, the data produced by SPS showed that bedding was by far the most frequently used item. This was followed, at some distance, by shoelaces, clothing and belts. Where an individual was on TTM, a decision should be made about what items they should be permitted to have access to. Where prisoners were not on TTM, and in terms of the Prison Rules, the concern was that by removing everyday items the aim of achieving normality was compromised. Accordingly it was submitted that there was no sound policy reason for blanket removal of such items from all prisoners. Again, reliance was placed on the reasoning in former Chief Executive's letter to the Cabinet Secretary of February 2019.

[652] SPS again reverted to this letter in the context of the LAP Review. There was a need to maintain normality in relation to standard accommodation. The substantial estimated cost of making all accommodation in the SPS estate ligature free was a factor. There were other means to mitigate suicide risk, including TTM. The focus should therefore be on the creation of more and improved Safer Cells for those identified as being at risk.

[653] But it was acknowledged that improvement of the design of the physical estate was "left behind" after ERoMH, particularly in relation to standard cell environment and the development of the audit toolkit recommended by Gordon McKean. As a result of the evidence heard in the inquiry SPS submitted that it had taken steps to include ligature prevention as part of the ongoing TTM review and would review the development of ligature assessment criteria specifically for use within the prison estate.

[654] As to the possible use of signs of life technology in the context of suicide prevention, SPS acknowledged that it might have a part to play, and submitted that this was under active consideration. However the technology was at a relatively early stage of development, and required to be refined for use in prisons. Challenges existed in relation to its use given the existing infrastructure. Issues of privacy would arise. Revision of the Prison Rules would likely be required. Budgetary constraints would inevitably be a factor in the extent to which such technology could be introduced.

[655] In turning to the question of recommendations under section 26(1)(b), SPS expressly did not restrict its submissions to matters potentially linked to Katie and William's deaths. It accepted that a broader view should be taken from the lessons

which could be learned from the inquiry, in terms of policy, procedure and practice more widely. It was submitted that this was already under active consideration at the highest levels within SPS. It acknowledged that the inquiry had revealed aspects of its systems and processes which could have been improved, and it was committed to learning the lessons of these two deaths.

[656] The following general points were made:

1) TTM was a suicide prevention policy, not a policy designed to provide for well-being, mental health care, or to keep a record of an individual's journey through the prison estate. Insofar as TTM seeks to capture concerns, they are concerns related to suicide or self-harm only.

2) In considering what to expect from prison officers it should be remembered that they are not mental health professionals, and should not be held to that standard. While officers are alert for suicide risks, they are not qualified to address mental health issues more generally.

3) Although it might be said that all prisoners are vulnerable in the sense of being at increased risk of suicide, there were good reasons to not impose blanket suicide prevention measures, and to maintain the threshold approach currently found in TTM. Preserving normality was critical to prisoner wellbeing. And any interference with a prisoner's residual liberties had to be proportionate.

4) SPS acknowledged the consistent evidence of a disconnect between the envisaged use of concern forms under TTM and their use in practice.

On a practical level, officers did interact with prisoners, assess risk, and implement the policy. But the lack of documentary record risked an information gap in a prisoner's record, particularly for those officers not familiar with that prisoner. Training and GMA instruction had not been effective to address the disconnect. There were multiple places where non-threshold TTM concerns might also be recorded - PR2, TT, or intelligence logs. Officers did not know where to record concerns, and there was no single repository for them. In the light of all this, SPS considered that there was scope for a more effective way of recording concerns in a consistent and accessible way, for example, regular reporting for young people, and would consider and address this.

5) The inquiry had cast doubt on the utility of the current method of reporting concerns under the TT anti-bullying policy. Practical concerns were not always appropriately recorded. SPS proposed to review this issue.

6) The more information that is provided about an individual coming into Polmont, the better - for example, from social work or third sector organisations. But there was a gap as regards consistent provision of such information where a young person was remanded or sent straight from court to Polmont without any existing history of detention. Given this, SPS welcomed the suggestions, in particular, that there should be (i) a standardised package of information accompanying young people entering Polmont - whether physically or electronically - including the warrant,

CJSWR, bail reports, ISMS reports, letters from social workers and COPFS; and (ii) a central portal for uploading of concerns from external agencies to ensure they are received by the prison at a central location.

7) Consideration should be given to specifying criteria which must be considered before a young person is removed from TTM. A very clear reason should ordinarily be needed to remove a young person from TTM before obtaining social work input. There were practical challenges in obtaining social work records and an initial process for verbal input might be more appropriate. Flexibility was desirable.

8) An individual does not forfeit their right to medical confidentiality by virtue of detention. Exceptions may be made in limited circumstances, as set out in the ISP, but they must be clearly justified. SPS respected the professional duties of healthcare providers, and the understandable desire that prisoners would not want prison officers to have ready access to their medical information. The only change which might be considered would be how best to provide NHS staff with access to information about individual concerns, for example bullying.

9) SPS acknowledged that there was value in reviewing the TTM forms relating to the RRA and case conferences to ensure that all relevant information was obtained and properly recorded. Revised forms might include incorporation of checklists, aide memoirs, and the recording of potential trigger points for distress and levels of impulsivity for future

reference. Expert input into this was appropriate. New forms might be tailored for young prisoners.

10) Storage of TTM forms should be reviewed to make them more accessible to those who need to review them, for example RRA forms. Electronic storage of forms was being considered.

11) Notwithstanding the recommendation in ERoMH, SPS did not consider it appropriate to create a distinct and bespoke TTM policy for young people. That did not preclude other measures tailored to the specific needs of young people being implemented.

12) The categorisation of risk in TTM was neither binary nor necessarily inflexible, albeit that in practice its use is more rigid than intended. An assessment of "no apparent risk" does not indicate no risk, and it did not necessarily follow that no action is taken - referral to the mental health team is an option. If a prisoner is assessed as being at risk a range of options are available. If removed from TTM, a transitional care plan for young people is now mandatory. However the evidence to the inquiry indicated that, in practice, TTM measures are used more mechanistically than intended - for example the view that 15 minute observations automatically required the use of Safer Cell. Further specific training was required. But overall, SPS submitted that it remained important to the clarity and practical efficacy of the policy to have a clear threshold for an "at risk" categorisation, with the flexibility following in the tailoring of available measures.

13) As to assessment of risk, SPS submitted that there were three aspects: direct questioning and verbal response, non-verbal cues and clues, and information obtained from other sources. SPS submitted that both SPS and NHS staff were alive to the need to look for non-verbal cues and clues, and not just relying on self-report. But in reviewing TTM consideration would be given to ways to ensure that risk assessments did not rely too heavily on self-report and presentation where other sources of relevant information were available.

14) SPS would give consideration, in the review of TTM, to mandating annual refresher training. Consideration would also be given as to how changes to TTM were disseminated.

15) SPS acknowledged that there was a need to improve the way in which it learned from deaths in custody including collating and distributing FAI determinations. One improvement could be requiring SPS HQ to play a more central role in ensuring that recommendations were implemented.

[657] Against this background SPS produced a helpful tabular response to the Crown's proposed recommendations. In summary SPS accepted all of these recommendations either in full, or subject to caveats and qualifications arising from the foregoing submissions.

(G) STATUTORY FINDINGS - DISCUSSION AND DETERMINATION

Introduction - the main issues in the inquiry

[658] Katie and William were both young prisoners who died by suicide through self-ligature while detained in Polmont in 2018. It appeared to the Crown that these similarities made a single inquiry appropriate, for the statutory purposes of establishing the circumstances of the deaths, and considering what steps (if any) might be taken to prevent other deaths in similar circumstances. The main issues initially identified for consideration were the effectiveness of the TTM suicide prevention strategy in relation to young people, the information gathering and sharing systems relevant to this strategy within Polmont, and the decisions and decision-making processes by which it was - or was not - applied to Katie and William.

[659] But although there were similarities in their cases when looked at broadly, Katie and William's situations were quite different. Katie was not considered to be at risk of suicide when she was admitted to Polmont, nor at any time during the 3 month period that she was detained there. Therefore the main focus in her case was on whether her circumstances and/or presentation should have led to such a risk being recognised prior to her death, thus triggering the TTM process and the use of protective measures in respect of her. In turn this required consideration of the adequacy and operation of the systems for obtaining, recording and sharing information relevant to her risk of suicide, and the decision-making in relation to this.

[660] William, on the other hand, was placed on TTM on admission to Polmont, but was then removed from it shortly afterwards. He was not placed back on TTM despite

further information then being received which suggested that this should have been done and/or that the earlier decision to remove him from TTM had been wrong. Therefore the main focus in his case was on the decision to remove him from TTM, the failure to put him back on it thereafter, the information on which the decision-making was based, and the processes which were followed.

[661] Underlying these issues is the proposition that had Katie been put on TTM on the night of 3 to 4 June 2018, and had William not been removed from it prior to the night of 6 to 7 October 2018, there was a realistic possibility that their deaths might have been avoided. Alone of the participants SPOA disputed this conclusion, but it seems to me to be unavoidable. Had they been on TTM at these times, it is likely that they would have been, at the very least, subject to regular checks and observations within their cells, in particular overnight. The time available to them to die by suicide without being observed would therefore have been materially reduced. That does not mean that their deaths would necessarily have been avoided, or even that they would probably have been avoided. But I have no hesitation in accepting that there was at least a realistic possibility that they might have been.

[662] Underlying this conclusion, in turn, is the statistical evidence which suggests that only a relatively small minority of prisoners who die by suicide in Polmont - and indeed elsewhere in the Scottish prison estate - do so while subject to TTM (or its predecessor A2C). The (admittedly incomplete) data available suggests that those who do die by suicide tend to fall into two categories: those like Katie, who had never been placed on TTM, and (more commonly) those like William, who had earlier been

removed from it. This raised questions for the inquiry as to whether TTM, whether in theory or in practice, was sufficiently attuned to initially identifying all those young prisoners not initially assessed as being at risk of suicide, and to continuing to protect those who had previously been identified as being at risk where that risk was assessed as no longer being present. Put another way, it raised the question of whether the threshold for TTM intervention - or continuing intervention - was too low, as a matter of policy and/or practice.

[663] But no system of person-centred prison suicide risk assessment will be perfect. No matter how good the strategy in theory, and how good its implementation in practice, some attempts to die by suicide will not be predictable, and so will not be predicted. One response to this sad fact might be to propose that all young prisoners should automatically be subject to TTM while they are detained in Polmont. No participant to the inquiry suggested this although as noted, coming close to it, William Brown Senior submitted that SPS should consider monitoring all young offenders on a two hourly basis as a matter of course. But to subject a prisoner to TTM observations is to infringe, to some degree, their residual liberty and privacy within the prison, and to do this in relation to every young prisoner throughout their time in custody would be disproportionate - and may also be counterproductive. An alternative approach is to make the physical environment of Polmont safer for all young prisoners detained there, such that whether or not they are subject to TTM their ability to die by suicide, should they be minded to try to do so, is materially restricted. This became the other main issue in the inquiry.

[664] The starting point was again the statistical evidence. The glaringly obvious fact to be drawn from it is that, over many years, the overwhelming majority of suicides in Scottish prisons - at least 90% - are by self-ligature. That being so, it is also - in my view - obvious that any suicide prevention policy should seek to directly address and materially reduce the opportunities for prisoners to self-ligature. In order to do this it is first necessary to recognise that for a person with intent to self-ligature three things are required: (i) a ligature point, (ii) a ligature item, and (iii) time alone without being found. As Joanne Caffrey, an expert in safer custody issues, graphically put it in her evidence, this is the "ligature triangle". Removing even one aspect of it can significantly reduce the opportunity for a prisoner to die by self-ligature. The more aspects that can be removed, the less the likelihood that it will occur. While the third aspect takes the focus back to regular contacts and observations, and hence to person centred assessment and prediction of risk, the first two invite a quite different focus: firstly on the prisoner's physical environment, and secondly on the nature of any items to which they are permitted access to while in custody.

[665] In considering these aspects, the statistical evidence is yet again the starting point. It makes apparent that almost all self-ligatures are by prisoners while they are in their cells. That is unsurprising, as a cell offers the privacy to self-ligature unobserved. So an obvious approach, in seeking to address the first side of the ligature triangle, would seem to be to try to make all prison cells safe (or at least safer) by identifying and removing ligature anchor points (or at least, those obvious points which require little or no ingenuity or adaptation for use). In relation to some anchor ligature points this is

relatively straightforward; in relation to others there are substantial difficulties and costs. This issue was therefore the subject of much evidence during the inquiry - which included evidence as to the reasons why SPS had not taken action to address it previously.

[666] As to the second side of the triangle, the statistical evidence indicates that the most common item used as a ligature in suicide in Scottish prisons is bedding materials such as sheets, which have been cut or torn into strips for this purpose. Such items featured in around 51% of cases, including William's. The second most common item used is shoelaces (in around 17% of cases) and the third is a belt (in around 10% of cases, including Katie's). These three items therefore feature in almost 70% of all prison suicides - possibly more, as the data is incomplete. So an obvious approach, in trying to address this side of the ligature triangle, might seem to be to supply prisoners with bedding which cannot easily be cut or ripped to form a ligature, and to deny (or at least restrict) prisoners' access to shoelaces and belts. These issues too are not straightforward. They are the subject of provisions of the Prison Rules. Evidence was led in relation to them in the inquiry, including evidence in relation to previous consideration given by NSPMG to restricting or prohibiting the use of belts by prisoner.

Timing and causes of Katie and William's deaths

[667] The findings to be made under sections 26(2)(a) - (d) of the 2016 Act in relation to the timing and causes of Katie and William's deaths were agreed by all participants

and were not controversial. Accordingly I will make the following findings in terms of these subsections, and no further comment is required in relation to them:

In terms of section 26(2)(a) (when and where the deaths occurred):

a. **Katie Allan, date of birth 25 April 1997, died in in cell 1/33, Blair House, Polmont, sometime between 2010 hours on 3 June 2018 and 0550 hours on 4 June 2018, her life being pronounced extinct at 0610 hours on 4 June 2018;**

b. **William Brown, date of birth 20 October 2001, died in cell 2/45, Monro Hall, Polmont, sometime between 2055 hours on 6 October 2018 and 0740 hours on 7 October 2018, his life being pronounced extinct at 0755 hours on 7 October 2018.**

In terms of section 26(2)(b) (when and where any accident resulting in the deaths occurred):

a. **Katie's death was self-inflicted, and not the result of any accident.**

b. **William's death was self-inflicted, and not the result of any accident.**

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

a. **The cause of Katie's death was hanging.**

b. **The cause of William's death was hanging.**

In terms of section 26(2)(d) (the cause or causes of any accident resulting in death):

a. Katie's death was self-inflicted, and not the result of any accident.

b. William's death was self-inflicted, and not the result of any accident.

Reasonable precautions by which Katie's death might realistically have been avoided - section 26(2)(e)

[668] Katie was a young woman from a positive background who should have had a positive future ahead of her. Her death was a tragedy, which will have been devastating for her family and friends.

[669] It is pertinent to the issues in this inquiry to note, however, that this devastation will have been compounded by Katie's death being so unexpected. The simple fact is that none of the many people who gave evidence in relation to their contact with Katie while she was in Polmont thought that she was at risk of suicide. This included members of her own family, the prison officers, healthcare staff, the chaplains, and her fellow prisoner, Megan Sandeman. Indeed, a theme which emerged from the witnesses' evidence was to the effect that Katie was the last person whom they would have expected to take her own life. She was seen - no doubt correctly - as intelligent, articulate, and personable. She was well liked and respected. She appeared resilient and brave in the face of the difficulties which she faced. While the witnesses to fact may have misremembered details, given the passage of time and the emotional context of the inquiry, I considered that they were all doing their best to tell the truth in this regard.

[670] It is worth noting in this context that the evidence showed in particular that Katie developed good relationships with members of staff within Polmont. She came to like and trust her personal officers, Scott Wilson and Heather Morrison. Officer Morrison, knowing that Nurse Joanne Brogan had previously had alopecia, asked her "as a favour" to provide support to Katie. Nurse Brogan did so, even though Katie was not formally on her mental health caseload. Officer Jennifer Wilson, conscious of Katie's distress at her hair loss, brought in bandanas for her to wear, even though strictly speaking she should not have done so. While the informality of these actions was - in effect - criticised as being at variance with TTM policy, the point for present purposes is that they show that prison staff went out of their way to try to be kind and supportive to Katie.

[671] That all the witnesses who gave evidence about their contact with Katie did not consider her to be at risk of suicide is unsurprising, given that Katie's verbal and non-verbal presentation did not give them cause to think otherwise. This is apparent not only from the oral testimony of witnesses as to how she presented and what she said, but also from her own words. These can be found in what she wrote, for example in her Positive Futures Plan of 3 April 2018, and what she said, for example in the many telephone calls to friends and family, the transcripts of which were produced. It can also be seen in evidence of the way that she engaged positively with her university studies, as well as with the prison youth group, and in her job on the pass. While Katie faced significant challenges while in Polmont, and was undoubtedly caused upset and distress

by them on occasion, at no point prior to 3 June 2018 did she say or do anything to suggest that she was suicidal, or had thoughts of otherwise harming herself.

[672] That remained the position until very shortly before her death. Prior to being locked in her cell on the evening of 3 June 2018 Katie was making plans for the future. She asked Officer Tart to book Stuart Allan in for a visit the following day. She put out her laundry for collection and ordered some cosmetics. And once in her cell she wrote three letters - to Linda Allan, to her grandmother, and to a friend. Katie's letter to her mother was regretful and apologetic in relation to the visit earlier that day. But otherwise these letters were, in summary, generally positive in tone and content, and in parts chatty and upbeat. They were forward looking. They are of a piece with other evidence of Katie's presentation whilst in Polmont: that she hated being in prison, was hurt by the verbal cruelty of some of the other prisoners, but was determined to put a brave face on matters, and get through to release, a release which she had good reason to expect would have taken place via HDC only around 4 weeks later.

[673] At some point that evening her mental and emotional state must have deteriorated drastically. The post-mortem evidence shows that she self-harmed by cutting herself. And she formed the intention to end her life with sufficient pre-meditation to write a suicide note to her parents. This is the note that no parent would ever want to have to read. But for the purposes of this inquiry it has to be recognised that it is the first piece of evidence to come to light indicating that Katie had suicidal thoughts or feelings. To pile tragedy on tragedy, this evidence in the end shows that Katie was one of the "silent ones" that she and her mother had discussed

on the telephone less than 2 weeks earlier; one of those individuals who, when contemplating suicide, do not tell anyone about it prior to acting.

[674] From all this it is clear, and as ultimately recognised to one extent or another by all participants to the inquiry, that Katie's decision to take her own life was a spontaneous and impulsive one, made late in the evening of 3 June 2018 or early the following morning. That was also the unanimous view of the expert witnesses who gave oral evidence: Dr Martin Culshaw, a consultant forensic psychiatrist with extensive experience of working in Scottish prisons; Dr Mayura Deshpande, a consultant forensic psychiatrist with extensive experience of working in forensic mental health settings in England and Wales; and Professor Graham Towl, a professor of forensic psychology and expert in prison suicide. As Professor Towl put it, in the circumstances it is comparatively straightforward to see how staff would not have picked up Katie's inflated risk of suicide on the evening of 3 June 2018. She likely took her own life as a result of personal sense of failure, low self-esteem, and crucially, not seeing a way out of challenging circumstances - even following her imminent release.

[675] But notwithstanding all this, the Crown submitted that there were precautions which could reasonably have been taken by which Katie's death might realistically have been avoided. This submission was adopted by Katie's next of kin. There were two main strands to it. The first related to events and incidents adversely affecting Katie while in Polmont, and to the recording, collation and responses to them by SPS and FVHB staff. The second related to the ligature anchor point which Katie used to complete suicide.

[676] In relation to the first strand, and as noted above, the Crown conceded that while there was no single factor which could be singled out as a reasonable precaution by which the death might realistically have been avoided. But it submitted that there were a constellation of precautions which, if taken together, might have done so.

[677] First, the Crown pointed to the RRA carried out by Nurse Macfarlane at Polmont on 7 March 2018. This was criticised as not being as comprehensive as was required by TTM, in particular because it was carried out following Katie's transfer from Cornton Vale, not her first admission to custody. Nurse Macfarlane was also criticised for not including on the RRA form the information that Katie had self-harmed in 2015.

[678] I do not accept the first criticism. Nurse Macfarlane was a very experienced mental health nurse, trained and experienced in risk assessment under A2C and TTM. I accept his evidence that he reviewed the VISION notes made by Nurse McKirdy at Cornton Vale 3 days earlier, and so was aware of Katie's history of self-harm, alopecia, and eczema. He spent 15 minutes assessing Katie, asked her about her medical history, questioned her about self-harm and suicidality, and considered her non-verbal presentation. That was what TTM required him to do: the RRA is not, as FVHB submitted, a full mental health assessment, such as might take an hour or more. It is in effect a screening tool, directed solely and specifically at assessing whether there is a risk of suicide.

[679] In the circumstances, I consider that the manner and content of Nurse Macfarlane's RRA assessment of Katie was at least adequate in terms of TTM. Whether TTM ought, as a matter of policy, to require a more comprehensive RRA is

another matter. But for present purposes it is important to note that Nurse Macfarlane's conclusion following his RRA of Katie, that she was then at no apparent risk of suicide, was not challenged by any participant to the inquiry. The Crown therefore did not submit that, had Nurse Macfarlane carried out a more comprehensive assessment, he would have reached a different conclusion, and so made Katie subject to TTM. Given that, I am unable to see how a more comprehensive assessment could be a reasonable precaution by which her death might have been avoided, either alone or as part of the constellation of factors relied on by the Crown.

[680] As to the second criticism, I accept that Nurse Macfarlane could reasonably have noted on the RRA form that Katie had a history of self-harm, and noted the details of it. The RRA form expressly directed the assessor to determine if the prisoner has previously attempted self-harm and to summarise their responses. I accept Nurse Macfarlane's evidence that he was aware that Katie had self-harmed from her previous disclosure to Nurse McKirdy as shown on the VISION record, and that he discussed this with her. But although he noted that Katie strongly denied thoughts of self-harm, he did not record that she had previously done so. The prompt on the RRA form could be more clearly focussed, perhaps, but on a reasonable reading of it this information should have been recorded.

[681] Because it was not, and SPS staff did not have access to VISION, there was no accessible record for the prison officers directly responsible for her care that Katie had previously self-harmed. That information, although relevant to ongoing assessment of her risk of suicide while in Polmont, was therefore not available to the prison staff

most directly responsible for carrying it out. It would therefore have been a reasonable precaution for Nurse Macfarlane to have specifically recorded it on the RRA form. Now there was no evidence that any member of SPS staff ever did in fact look at Nurse Macfarlane's RRA form when assessing Katie's suicide risk during her time in Polmont. In practical terms they were disincentivised to do so, insofar as it was held in paper form only, in a file, in an office, located 5 to 10 minutes' walk away from the hall. But it can still be said that it might have been a reasonable precaution for them to have gone and looked at it. So Nurse Macfarlane's failure to record Katie's history of self-harm on the RRA form remains relevant.

[682] However it is important to note that Katie's "history of self-harm", amounted to a single incident for which she attended at her GP on 1 June 2015. She had cut herself, but the record of that attendance describes her wound as "very superficial", and linked her actions to doubts about her sexuality and the anxiety caused by that. It appeared to be a one-off incident linked to a specific set of circumstances, had occurred 3 years prior to Katie entering Polmont, and was not accompanied by suicidal ideation. Although it was suggested at points in the inquiry that Katie's community GP records should have been recovered on her admission to Polmont, this is all that they would have shown in relation to this matter.

[683] Accordingly while Katie's self-harm in 2015 was relevant to assessment of her suicide risk in 2018, it was unlikely to have been regarded as having significant weight from a clinical point of view. There was evidence, which I accepted, that self-harm is distressingly common among young people, with perhaps around a quarter of 16 to

25 year old women having some experience of it. As in Katie's case, in 2015, it is not necessarily accompanied by suicidal ideation. But it can still be said that had there been awareness of this incident of self-harm, it might at least have made prison officers in 2018 more alive to looking out for any repeat of it while Katie was in Polmont.

[684] That is given focus by the fact that, as identified at post-mortem, Katie clearly did self-harm by cutting herself the night that she died. She very likely used the piece of metal that was found on her desk in her cell. Dr Culshaw, who has considerable experience of working with women in prisons, suggested that this may have been a final and unsuccessful attempt by Katie to relieve her stress. But plainly this act of self-harm came too late for it to be noticed by staff and/or assessed in the context of preventing Katie's suicide.

[685] There were other marks found on Katie post-mortem, and these too appear compatible with self-harm. But, as was agreed in the second joint minute, it is not possible to put a definitive timescale on when they were inflicted. It is possible that they were inflicted by Katie while she was in Polmont, given that they were not identified and recorded when Katie was physically examined on admission. But it was agreed that these marks were faint, and it is possible that they may have been missed. There are no photographs of them from which this might have been assessed in the inquiry.

[686] Overall, the likelihood is that these marks were not self-inflicted while Katie was in Polmont. That is because all of the witnesses who interacted with Katie said that they had not observed any evidence that she was self-harming prior to 3 June 2018. In

particular, Megan Sandeman, Katie's friend and fellow prisoner, was not aware of any. Nor did prison officers, even though given the prevalence of self-harming by young women in Blair House they were watching out for such behaviour. The evidence did not suggest that Katie was, for example, consistently wearing long sleeved clothes, which might have suggested that she was trying to cover up self-harm marks. And as Officer Morrison said, and I accept, had she seen evidence of self-harm on Katie she would have acted on it, and put her on TTM. The fact that she was not aware of Katie's self-harming behaviour in 2015 would, if anything, have heightened Officer Morrison's concerns, had she thought that Katie had now started self-harming for the first time.

[687] Accordingly, while it can be said that it would have been a reasonable precaution for Nurse Macfarlane to have recorded Katie's disclosed self-harm from 2015 on the RRA so as to make it available to SPS staff, the significance of that for assessment of Katie's suicide risk, prior to 3 June 2018, is likely to have been relatively small. That is so, in particular, given that the balance of evidence suggests that she did not further self-harm in Polmont until very shortly before her death.

[688] The second precaution identified by the Crown was that staff should have completed concern forms in respect of Katie in accordance with TTM strategy. The evidence of the failure to do so by prison officers was so widespread as to be properly seen as a systemic issue, about which more will need to be said later. But for present purposes it is apparent that concern forms could or should have been completed, but were not, (a) on 21 March 2018, following Katie's distress at being strip searched; (b) on 8 April 2018 relative to her observed distress on that day; (c) on 12 April 2018, relative to

the report of bullying recorded in the intelligence log; (d) on 27 April 2018, 1 May 2018, 4 May 2018 and 22 May 2018 relative to her observed distress due to her alopecia; (e) on 21 May 2018 relative to her reporting another prisoner's plans for suicide; (f) on 29 May 2018 following the hearing at which Katie's appeal was abandoned; and (g) on 3 June 2018 relative to reports of bullying. To have done so would have been a reasonable precaution, as the information relative to Katie's distress on those dates would have been available in a standardised form, collated in a single place, and which would thereafter have been available to any prison officer carrying out ongoing assessment of her risk of suicide.

[689] Some further comment is appropriate in relation to the failure by officers to complete a concern form on 3 June 2018. On that afternoon Officer Marie-Claire Doherty was on duty in the reception area, assisting with visits. She observed that Katie was distressed during her visit from Linda Allan. Mrs Allan told her that Katie had said that she was terrified of some other prisoners in the hall and had been threatened. In terms of TTM that should have triggered the completion of a concern form by Officer Doherty. Instead, she undertook to pass on what Mrs Allan had said. She then went - out of her way - to Blair House, and spoke to Officers Scott Wilson and Tart. She said that she told them what Mrs Allan had said, that they told her that they knew something was going on, and that they would speak Katie about it. However Officer Doherty did not complete a concern form, or otherwise record what she had heard and seen.

[690] Officer Scott Wilson's evidence about what Officer Doherty had said was rather different. He said that he was aware that Katie was distressed after returning to the

hall following the visit. But he said that all Officer Doherty told him was that Katie had "had a difficult visit", and that no mention was made of her being terrified or having been threatened. That version of events was supported by Officer Tart. There is therefore a conflict of evidence. The principal point, for present purposes, is that if Officer Doherty had completed a concern form, as she should have done, this conflict would not have arisen. Relying on a verbal exchange of information, as was done, risked - even on an innocent construction of the evidence - that information may have been mis-heard or misunderstood. On a less innocent construction, one or more of these officers was not telling the truth.

[691] For what it is worth, I tend to favour Officer Doherty's account, although I accept the possibility that Officers Scott Wilson and Tart may have misremembered all of what was said. It seems unlikely that Officer Doherty would have gone out of her way to go to Blair House just to say that Katie had "had a difficult visit". But it is apparent that Officers Scott Wilson and Tart were aware of the fight earlier that day, and also that Katie had then been the subject of some verbal abuse and threats by one or more of those involved. And their interactions with Katie after she returned to the hall were appropriate. Seeing that she was distressed they spoke briefly to her, left her to have a cup of tea and recompose herself, and then returned later in the afternoon to speak privately with her to discuss what had happened.

[692] I think it likely that in this discussion Katie may have underplayed her concerns about the abuse directed towards her by the other prisoners, and that Officer Scott Wilson may have underestimated Katie's concerns in the face of it. In

oral evidence he presented as personable and outgoing, and it is easy to see why Katie might have liked him. But at times he appeared to be somewhat overconfident in his own abilities, and in particular in his consequent belief about Katie's willingness to be open with him. I accept that he was sufficiently concerned about her to suggest moving her to another hall, even though she was physically safe from the other prisoners who had abused her, given that at that time they had been removed from association. This too rather supports Officer Doherty's account of the information which she says she passed on.

[693] It was not submitted that it would have been a reasonable precaution for Officer Scott Wilson to have moved Katie to another hall on the afternoon 3 June 2018. The main reason for that must presumably be the evidence that she herself did not want such a move at that time. Likely material to that - as it had been when the issue of a move had arisen on 25 April 2018 when she turned 21 years of age - was that Katie did not want to lose Officer Scott Wilson as her personal officer. Looked at from a TTM perspective, it might be noted, her good relationship with him would be seen as a protective factor. But he too did not, as he should have done, complete a concern form, and so a contemporaneous record of events from him was not available.

[694] The third of the constellation of precautions relied on by the Crown was that information that Katie's alopecia was affecting her mental health, and that she had previously self-harmed, should have been shared between FVHB and SPS staff and systems. It was submitted that this was information that could have been shared under the ISP.

[695] As regards Katie's history of having self-harmed in 2015, as already noted, this was recorded on VISION and so accessible to FVHB staff, but was not recorded on the RRA of 7 March 2018 by Nurse Macfarlane, as it could and should have been. Nurse Brogan was aware of it, and so was Dr Collier. They consulted VISION when providing healthcare services to Katie and saw Nurse McKirdy's entry of 5 March 2018. It is likely that Nurse Liddle will have seen it too. But there is no evidence that Katie ever disclosed previous self-harm to a prison officer, and there is no evidence that any of them - including in particular her personal officers - were aware of it. As already noted, it may be that relatively little weight would have been attached to this matter, but the point at this stage is that it was at least relevant to ongoing suicide risk assessment, and so should, and in terms of the ISP could and should have been shared with SPS.

[696] As regards the information that Katie's alopecia was adversely affecting her mental health, it is true that there are entries on VISION to this effect. In particular there are entries of 27 April 2018 by Nurse Brogan, and of 22 May 2018 by Nurse Liddle. And there is no doubt that Katie's alopecia significantly impacted on her mental health, in the sense of causing her distress, and undermining her self-esteem and ability to cope.

[697] But that said, Katie interacted with Nurse Joanne Brogan on a number of occasions from 27 April 2018 onwards. Katie appears to have liked and trusted her. Nurse Brogan was an experienced mental health nurse, trained in TTM. She had personal experience of the effects of alopecia. The supports that she provided to Katie were appropriate, and were criticised more for their informality than their substance. Had she thought Katie to be at risk of suicide she would have put her on TTM. Had she

thought that a full mental assessment of Katie was necessary or appropriate, she would have instigated this. As she did not, the VISION entries regarding Katie's mental health should be understood in the sense of her mental and emotional well-being, rather than as a diagnosis of a recognisable mental disorder or illness requiring formal intervention and treatment. And as SPS submitted, it does not follow that because a person is upset, distressed or depressed, that they are necessarily at increased risk of suicide.

[698] This being so, it is apparent that the adverse impact of her alopecia on Katie's mental health and well-being was known to and recognised by at least some SPS staff. They did not require the information known to FVHB staff to be formally shared under the ISP in order for them to be made aware of it. Katie's hair loss was increasingly evident to everyone who came into contact with her after mid-March 2018. Perhaps predictably it was the female officers who most appreciated the extent to which it affected Katie's well-being. Officer Morrison was sufficiently concerned to arrange for Nurse Brogan to see her and provide support. Officer Jenifer Wilson was aware that after Katie's hair loss became more evident she struggled to come to the visiting room and come into contact with male prisoners, and that her alopecia had "rocked her self confidence". Officer Scott Wilson was aware - because Katie told him - that her hair loss was down to stress, but I do not think that he really appreciated the full extent of the emotional impact on her.

[699] Accordingly while the information available to health care staff regarding the adverse mental effect of hair loss on Katie was a matter which could have been formally shared with SPS staff, I am unpersuaded that this could be properly described as a

distinct precaution. Rather, as already stated, this is a matter which could on more than one occasion have been the subject of a TTM concern form completed by the health care staff involved. The ISP would not have precluded this. It would have placed the matter formally onto Katie's record, and in a manner that would have been accessible to SPS staff for the purpose of carrying out ongoing suicide risk assessment. To this extent this third precaution suggested by the Crown can be seen as a further aspect of the second.

[700] The fourth precaution pointed to by the Crown was that the intelligence that Katie had been subjected to bullying should have been shared, at least, with her personal officers.

[701] As SPS submitted, prior to 3 June 2018 there was only one record of an incident in which Katie was bullied. That is the entry in the SPS intelligence log of 12 April 2018. This states that a named prisoner was bullying Katie for her tobacco. It is graded E21. This grading meant that the intelligence assessment was (i) that the information giving rise to the entry was untested and should be treated with caution, (ii) that it was known to the source (presumably another prisoner) but not to the officer reporting it, and (iii) that the information was common knowledge in the prison and that there was no risk to any individual in handling it.

[702] The intelligence log was accessible to the FLM of Blair House, who did not give evidence to the inquiry. But in terms of security clearance it was not accessible by the residential officers, and in particular by Katie's personal officers Scott Wilson and Morrison. As they were unaware of the intelligence, and as bullying is a relevant factor in relation to ongoing assessment of suicide risk under TTM, and as Katie's personal

officers were those best placed to carry out such assessment given the frequency of their contact with Katie, the sharing of this intelligence with them can be said to be a reasonable precaution. But again, the manner in which such sharing is envisaged under TTM is by use of a concern form. In other words, the officer who received the intelligence regarding Katie on 12 April 2018 should both have reported it to the intelligence unit, and completed a concern form, which would then have made it accessible to Katie's personal officers.

[703] The Crown and Katie's next of kin submitted that this issue was of significance because Katie was bullied throughout her time in Polmont. The main source of evidence for this was that of the late Reverend Stuart MacQuarrie, the former Glasgow University Chaplain, whose statement was read into the evidence. Although his statement was not precise about dates it seems that he first came to meet Katie in early April 2018. He said that she told him that a couple of other prisoners had been bullying her and shouting at her. At a later meeting, which I took to be around early May 2018, he stated that Katie told him that the bullying and abuse was continuing. He said that there were two prisoners who would scream at her and threaten her. They would call her a "baldy bastard" and would sneer at her appearance and try to make her an outcast from the other prisoners. But Reverend MacQuarrie stated that Katie did not want to report these prisoners as it "would not do any good and would probably make matters worse". She said that "she could bear it".

[704] SPS submitted that there was a conflict of evidence here. It pointed out that Reverend Donald Scott, the Polmont chaplain, gave oral evidence that there was only

one occasion when Reverend MacQuarrie met with Katie when he was not also present. He said that both from these meetings, and from his more frequent informal contact with Katie in the hall, that he was unaware of any complaints of bullying aimed at her personally. SPS submitted that Reverend Scott's evidence was more reliable and should be preferred.

[705] Mention must also be made again of Megan Sandeman's evidence. She was asked how Katie fitted into the hall initially, and said that she "got on OK", that everyone was nice to her, and that no-one targeted her "at first" - that is, for the first month or two. She was asked whether Katie was bullied for tobacco in April and she said that she could not remember. But she said that some prisoners would try to take tobacco and stamps from Katie as she always had enough money to buy them, and was seen as a soft touch. She was asked whether Katie was being bullied at the time of her death, and she said that on that weekend she was, with some prisoners shouting some horrible things at her - "but not before that".

[706] I think it likely that Katie was subjected to bullying behaviour on a number of occasions while in Polmont. She was obviously from a different demographic than the other prisoners in the hall. Without putting too fine a point on it, she would have stood out in every way, and so would have been an obvious target for bullies from the outset. But the balance of evidence suggests to me that any bullying likely started at a relatively low level. It is easy to picture her giving tobacco to others in an attempt to fit in, only then to find them repeatedly coming back for more, and verbally abusing her if she

then refused. As her hair loss increased through April and May 2018, this would have provided another reason for her to stand out, as well as a source for hurtful comments.

[707] But it was only on the weekend of her death, following the fight in the hall, that the bullying became more pronounced and serious. Katie was subjected to some vile abuse and threats on that day. That it affected her is clear from Linda Allan's evidence and indeed what Katie wrote that night. It might have been submitted - although it was not - that there was a basis for Officer Scott Wilson, even on his own evidence, to have completed a SBR under the TT anti bullying strategy. But a significant part of the difficulty, as it was in relation to TTM in this connection, is that the evidence shows that Katie did not want to report bullying to prison officers. She thought that it would do no good, and might only make matters worse. She thought, until the end, that she could deal with it, "keep her head down", as Linda Allan put it, and get through to release.

[708] Tragically she was wrong about that, but, as already noted, I think that she likely underplayed her concerns to Officer Scott Wilson on the evening of 3 June 2018 - put a brave face on - and I do not consider that his response at that time was unreasonable. He knew that Katie was physically safe from those who had abused her, as they had been removed from association and were locked in their cells. He knew that they had been moved to the end of the hall, which while not preventing them from shouting abuse, at least meant that it would be less audible to Katie. And he was willing to secure Katie's transfer to another hall - and took steps to prepare for this - should she wish to do so. It is apparent, in particular from Katie's letter to her mother that evening, that Officer Scott Wilson planned to review matters with her the following morning.

[709] So, as stated, it would have been a reasonable precaution for the information giving rise to the intelligence log entry of 12 April 2018 to have been shared with residential officers. In terms of TTM it could and should have been the subject of a concern form. But - relative to the events of 3 June 2018 - it related to an incident of low level bullying which Katie herself did not wish to report and thought that she could cope with. It is unlikely that knowledge of this incident would have made any significant difference to the actions taken by officers in the light of the more serious abuse which Katie suffered on 3 June 2018.

[710] The fifth precaution relied on by the Crown was that SPS and FVHB staff should have been familiar with the list of cues and clues and triggers set out in TTM guidance and training, and should have understood the significance of assessing and recording such factors as they arose, for example relationship difficulties, court appearances, expressions of guilt and low self-esteem.

[711] I am unclear exactly what was being suggested here, and in what specific instances it was being suggested that staff were *not* familiar with the cues and clues and triggers in TTM. While different staff who had contact with Katie had received different levels of training on TTM - given, for example, whether they had previously been trained on A2C - all claimed awareness of the cues, clues and triggers. Indeed a more common complaint in the inquiry was that staff were over-reliant on the cues and clues, rather than investigating and taking proper account of background information. But I take it that the general complaint was that staff were not sufficiently trained on

TTM, and that - once again - there was a failure to record, and so assess under TTM, information in relation to Katie's sense of guilt and low self-esteem.

[712] The Crown submission seems to relate to three matters, Officer's McIntyre's PR2 entry of 8 April 2018, Katie's distress at having to withdraw her appeal on 29 May 2018, and difficulties in her relationship with Nick Belton. As to recording of the first two of these matters, again these come back to the concern form. In terms of TTM both could or should have been the subject of such forms. Officer McIntyre did record her concern in the narrative section of PR2, so it was at least available and readily accessible to other officers thereafter - even if they did not in fact look at it. Officer Goodsir said that she had no recollection of Katie's appeal hearing on 29 May 2018, and the RRA form - assuming one was completed - was missing. But Linda Allan's evidence was that Katie was stressed and upset by the abandonment of her appeal, and I accept that this would have been likely and that a concern form could have been completed by Officer Goodsir. Her position seemed to be, in common with the other officers, that if she had had significant concerns she would have initiated TTM, not filled in a concern form.

[713] As to the third matter, the evidence was not entirely clear. Nick Belton, I was told, was not willing to engage with the inquiry. There were some indications which suggested that Katie's relationship with him may not have been in a particularly healthy state, perhaps even before she came into Polmont. As the presence of an ongoing relationship could be a protective factor, in terms of TTM, and the subsequent

loss of it a risk factor, it is reasonable to say that this is a matter which might have been explored with Katie on admission, and monitored thereafter.

[714] But in any event the bulk of the available evidence about their relationship in the days prior to 3 June 2018 was that it was still extant. When Katie wrote to Mr Belton on 30 May 2018 she did so in positive terms which did not suggest or refer to difficulties in the relationship. The last available transcript of a call between them (Crown Production 9, call 46) appears friendly in content and tone. Katie expressed her affection for Mr Belton and that she was looking forward to his forthcoming visit on 1 June 2018. At that visit it seems that Mr Belton made derogatory remarks about Katie's having shaved her hair, and her appearance. And there is a post-mortem intelligence log entry referring to an abusive telephone call between Katie and Mr Belton, and the relationship ending, but it is unclear exactly when this was, and in any event it was graded as unreliable. What is clear is that Mr Belton emailed Katie on 2 June 2018, and although reference was made to the visit the previous day, the tone and content of his email were chatty and affectionate.

[715] So ultimately it was unclear to me exactly what the state of Katie's relationship with Mr Belton was, either when she was sentenced, or as at 3 June 2018. The preponderance of evidence is that the relationship was still extant at the time of Katie's death, and that there had not been such a disagreement or falling out between them as would likely have been regarded as significant from a TTM perspective. Accordingly even if prison staff had monitored Katie's relationship as a protective/risk factor for

suicide prevention purposes, the evidence does not establish that as at 3 June 2018 it would have been seen as significant one way or the other.

[716] The sixth precaution identified by the Crown was that Katie's weight loss whilst in Polmont should have been noticed and monitored, given her particular vulnerabilities.

[717] Katie was weighed by Nurse Macfarlane as part of his clinical examination of her on admission to Polmont on 7 March 2018. She weighed 65kg. This examination was routine, and separate from the RRA. She was next weighed post-mortem, and had lost 7kg in 12 weeks.

[718] Two things are being suggested. First, that Katie's weight loss should have been noticed. The difficulty with that is that there was no evidence to support it. The only witness who appeared to be aware of Katie's weight loss was Reverend Scott, and that was because Katie told him. However it did not give him cause for concern, in particular because she joked about how the "prison food was good for her diet". There was some other evidence to this effect, that is, that the prison diet could cause weight loss. But in any event I am not prepared to infer that prison staff ought have noticed an incremental weight loss such as that which Katie experienced, or that it would have been a reasonable precaution for them to have noticed it.

[719] The second suggestion is that Katie's weight should have been monitored. But while Katie had vulnerabilities, she was far from alone in that. Indeed the tenor of some of the evidence was that appeared significantly less vulnerable than other prisoners. The proposition therefore comes to be, in effect, that it would be a reasonable precaution

in the context of suicide prevention to routinely and periodically weigh all young prisoners in Polmont, even where they had not sustained weight loss sufficient to be noticeable to staff. There was no direct evidence that weight loss in itself was an indicator of suicidal ideation or thought of self-harm. But "self neglect or not eating" is one of the non-verbal cues and clues in TTM guidance. As weight loss might point towards either of those things, the proposition can at least be seen as a precaution.

[720] But I do not consider that it is a reasonable precaution in this context. If a prisoner is noticed to be self-neglecting or not eating then having their weight checked might be reasonable. But routine weighing of every prisoner for the purpose of suicide prevention - at some unidentified frequency or interval of time - is not justified by the evidence in this inquiry.

[721] In any event, the Crown submission came to be that had all of these six precautions been taken, it was "not unrealistic to suggest" that Katie's death might have been avoided. Prisons officers would have realised that Katie was not - as they thought - being open with them, and was not disclosing any thoughts of self-harm or suicide. They would more accurately have assessed her risk, and put in place "adequate supports and safeguards", which "could have included counselling" (as suggested by Professor Towl), or a more structured version of what was already being provided (as suggested by Dr Deshpande). The failure to take all the suggested precautions meant that the officers did not have all the necessary information to properly assess Katie's risk of suicide on 3 June 2018, and so viewed these events "through the wrong lens"

(as suggested by Mr Nick Cameron, former prison Governor, who gave expert evidence from this perspective about the management of Katie's case).

[722] I can accept, for the reasons just outlined, that most (although not all) of the actions suggested by the Crown might, in principle, be seen as reasonable precautions in the context of suicide prevention. The overarching submission is really that it would have been a reasonable precaution to have recorded and preserved all information relevant to Katie's risk of suicide - as that is defined by TTM - such that it was available for and accessible by prison officers prior to, or at least by, the afternoon and evening of 3 June 2018. But this merely begs the further question, which is, had this overarching reasonable precaution been taken, might that realistically have resulting in Katie's death being avoided, and if so, how?

[723] I do not consider that it is sufficient to answer that question to say that the officers would have looked at matters "though a different lens". The real question is whether prior to or on the evening of 3 June 2018 there was a realistic possibility that the officers would, in the light of all the relevant information, have assessed Katie as being at risk of suicide and therefore put her on TTM. Neither the Crown nor Katie's next of kin made this submission. I consider that they were correct not to do so, but that this is fatal to the argument under this chapter.

[724] As SPS submit - and in the light of the foregoing analysis I agree - the evidence of everything that happened to Katie in Polmont, considering both protective and risk factors, would not have supported such a submission, had it been made. And further it would have flown in the face of the expert evidence led at the inquiry.

[725] Dr Culshaw concluded that Katie's suicide was likely an impulsive act that could not easily have been predicted. A fuller mental health assessment at some point might have revealed an increased risk but that would not necessarily have indicated that she required TTM to manage it. It might rather have suggested she would be benefit from additional general support, but of the same nature that was already being provided, and that Nurse Brogan planned to further provide on return from sickness leave. Even if further intervention had been offered it would not have resulted in a different outcome.

[726] Dr Deshpande also thought that Katie's suicide was impulsive and could not have been foreseen. There were a range of protective measures in place in Polmont, and Katie engaged with them. Had all the information relevant to Katie's suicide risk been known, had the dots been joined, there would have been a discussion about additional structured support. But it was not possible to say that it would have changed the outcome.

[727] Professor Towl considered that, with hindsight, an awareness of all the factors relevant to Katie's risk of suicide ought to have given rise to a review or assessment of her mental health. But any deterioration in her mental health was likely to have been incremental, and he was unable to say whether such a review should have taken place prior to 3 June 2018.

[728] Accordingly I am unable to accept the Crown's submission, on this branch of its argument, that there were precautions, individually or collectively, which could reasonably have been taken, and had they been taken, might realistically have resulted

in Katie's death being avoided. Even if all the information relevant to her risk of suicide had been recorded and collated and been readily available to and considered by prison officers on the evening of 3 June 2018, and standing the protective factors as well as the risk factors, it has not been established that there was a realistic possibility that Katie would have been identified as being at risk of suicide, and so placed on TTM. To hold otherwise would be to engage in speculation or wishful thinking, rather than drawing reasonable inferences properly grounded in the evidence. It is therefore not appropriate to make a finding under section 26(2)(e) of the 2016 Act in relation to this matter.

[729] The second, distinct ground on which the Crown sought a finding under section 26(2)(e), again adopted by Katie's next of kin, was in relation to the rectangular metal toilet cubicle door stop which Katie used for self-ligature. It was submitted that removal of this obvious ligature anchor point was a precaution which could reasonably have been taken. It would have been inexpensive and straightforward. Had it been, Katie would have been unable to use it for self-ligature. This might realistically have resulted in Katie's death being avoided as it would have made it more difficult to Katie to take her own life.

[730] In response, SPS acknowledged that the door stop, located at the height that it was, was an obvious ligature anchor point. But it submitted that it was impossible to know what Katie would have done if the rectangular door stop was not present - she was not in a ligature free environment and might well have used another ligature point to the same effect. But SPS accepted that replacement of such rectangular door stops with a sloping, anti-ligature design would reduce the ligature risk. It submitted that

this work was now underway. A finding in relation to this matter should be made under section 26(2)(g) of the 2016 Act, not 26(2)(e).

[731] As I have found, the evidence established that rectangular metal toilet cubicle door stops, such as that which Katie used as a ligature anchor point, were installed in the cells of Blair House in around 2009. By no later than 2012 these rectangular stops were recognised by SPS to be a potential ligature anchor point. This can clearly be inferred from that fact that in subsequent new prisons, for example HMP Low Moss (which opened in 2012) and HMP Grampian (which opened in 2014), cell cubicle doors were fitted not with rectangular stops but with sloped, anti-ligature stops - an example can be seen in the photograph at page 2 of SPS Production 22.

[732] However notwithstanding its recognition of the ligature anchor point risk associated with the rectangular toilet door stops, SPS did not take steps to remove them from the cells in Blair House and replace them with anti-ligature stops. The evidence of Gordon McKean, which I accept, is that this could have been done quickly and cheaply. It did not require substantial capital investment.

[733] As the evidence also established, there was a circular hook fitting on the wall of Katie's cell. This can be seen in photograph 8 of Crown Production 3. This is an anti-ligature hook, designed so that it can take the weight of an item of clothing, but not the weight of a human body. Along with many others across the SPS estate, this hook was installed in around 2012. It was located a few centimetres from the rectangular toilet door stop. Accordingly it follows that action was taken by SPS to install an anti-ligature hook in Katie's cell in 2012, but no action was taken at the same time or

subsequently to remove a recognised potential ligature anchor point - the rectangular door stop - located right next to it.

[734] This is all a matter of great concern, and in respect of which no good explanation has been provided. SPS knew for many years prior to Katie's death that more than 90% of suicides in Scottish prisons were by self-ligature. It knew that most suicides were by prisoners who were not on A2C/TTM, and so would be accommodated in standard cells such as cell 1/33 in Blair House. It knew of the need to minimise the use of cell fittings which presented obvious ligature points, that is, which presented particular risks because they required no ingenuity or adaptation for use to self-ligature. In relation to the rectangular door stops in Blair House, removal and replacement with an anti-ligature design could have been carried out without significant difficulty or expense. And it could and should have been done well before 2018.

[735] SPS seek to resist a finding under section 26(2)(e) of the 2016 Act, in effect, on the ground that Katie might have died by suicide from a different ligature point had the rectangular door stop not been present. That is of course true. But section 26(2)(e), as explained above, refers to precautions by which "the" death might realistically have been avoided. This means the death which actually occurred, not a death which might have occurred had the actual death not occurred.

[736] In Katie's case the death for the purpose of section 26(2)(e) of the 2016 Act was suicide by self-ligature from the rectangular door stop in cell 1/33 on 3 June 2018. It would have been a reasonable precaution to have removed and replaced that door stop with an anti-ligature stop prior to this date, standing the known risk that it presented

and the ease with which it could have been removed. Had this been done, the death which Katie suffered could not and would not have occurred. It is no answer to this for SPS to point out - and in effect seek to rely on - its failure to identify and remove other ligature anchor points from Katie's cell. A finding under this subsection is therefore appropriate.

[737] Accordingly I will make the following finding under section 26(2)(e) in relation to Katie's death:

> **Finding 1: Katie could reasonably have been accommodated in a cell without a rectangular metal toilet cubicle door stop, located at more than 1.7m above floor level, which was readily capable of being used as a ligature anchor point without ingenuity or adaptation.**

Systemic defects contributing to Katie's death - section 26(2)(f)

[738] As the Crown submitted there was no system in place in SPS prior to Katie's death to regularly audit the physical environment of her cell - or any other cell in Polmont - for the presence of ligature anchor points. Nor was there a system to remove such ligature anchor points as had been identified by such an audit.

[739] The absence of a system of ligature point audit was spoken to by Gordon McKean. As noted, it was only at the end of 2018 that he was tasked with carrying out such an audit at Polmont and he was not aware of one having been done by SPS before. Indeed, he had to fashion his own methodology to carry out an audit, based on his coincidental awareness of the use of MTK in the secure health sector. Had

there been an audit prior Katie's death, it would have identified - as Mr McKean's audit did - that the rectangular metal toilet cubicle door stops in Blair House constituted a high risk ligature point. Had there been a system to act on such an audit, it would have secured the removal and replacement of these door stops with anti-ligature alternatives. This could have been done quickly and cheaply, as already noted.

[740] The presence of the rectangular metal door stop in Katie cell provided her with an obvious ligature anchor point which she was able to use at her time of crisis without ingenuity or adaptation. The failure to have in place systems to carry out a ligature point audit and to act on that audit by removing the door stop therefore contributed to Katie's death. A finding under section 26(2)(f) of the 2016 Act is therefore appropriate in relation to this matter.

[741] I do not accept the remainder of the Crown's submission in relation to proposed findings under this sub-section. That is because I do not accept that any of the matters referred to, and which is capable of being characterized as a systemic defect, has been shown to have contributed to Katie's death. The necessary causal connection is absent.

[742] Accordingly I will make the following finding under section 26(2)(f) in relation to Katie's death:

> **Finding 1: There was no system in place within SPS to (i) regularly audit the physical environment of Katie's cell for the presence of ligature anchor points, and (ii) to remove such ligature anchor points as had been identified by the audit.**

Other facts relevant to the circumstances of Katie's death - section 26(2)(g)

[743] The following matters, although not giving rise to reasonable precautions by which Katie's death might realistically have been avoided, or constituting systemic defects which contributed to her death, are nevertheless relevant to the circumstances of it, and so appropriate for findings under section 26(2)(g) of the 2016 Act.

[744] First, the documentation relative to the RRA carried out at Cornton Vale on 5 March 2018 was lost. In any event the RRA form would not have been accessible by SPS staff at Polmont following Katie's transfer there on 7 March 2018. Accordingly the information contained in this RRA documentation was not available to SPS staff (and in particular Katie's personal officers) to inform ongoing suicide risk assessment of Katie while she was in Polmont.

[745] I accept that it is likely that a RRA was carried out by Nurse McKirdy at Cornton Vale on 5 March 2018. The completed form should have been filed in paper form. For reasons unknown it was lost. And in any event, even if it had not, it would not have accompanied Katie to Polmont and so would not be available to prison staff there. The relevance of this is to highlight the advantages of recording RRA forms electronically. That should prevent them from going missing, make them more readily accessible by prison officers, and enable them, in effect, to travel with the prisoner on transfer, and so also to be available for ongoing risk assessment by officers in the receiving prison.

[746] The following finding is therefore appropriate:

Finding 1: The documentation relative to the TTM RRA carried out at Cornton Vale on 5 March 2018 was lost. In any event it would not have been

accessible by SPS staff at Polmont following Katie's transfer there on 7 March 2018. Accordingly the information contained in this RRA documentation was not available to SPS staff (and in particular Katie's personal officers) to inform ongoing suicide risk assessment of Katie while she was in Polmont.

[747] Second, Katie's history of self-harm was not recorded on the RRA documentation completed by Alan Macfarlane, the mental health nurse who assessed her following transfer to Polmont on 7 March 2018. Nor was it brought to the attention of SPS staff by FVHB staff while she was in Polmont. Accordingly this information was not available to SPS staff (and in particular Katie's personal officers) to inform ongoing suicide risk assessment of Katie while she was in Polmont.

[748] As already discussed, Nurse Macfarlane should have recorded on the RRA form of 7 March 2018 that Katie had self-harmed in 2015. The wording of the form, in the circumstances, prompted him to record this. It was relevant information for ongoing suicide risk assessment in relation to Katie, and the failure to record it on the RRA meant that it was not accessible to SPS staff in Polmont. There is a need to redesign the RRA forms, to include clearer prompts and checklists, and therefore to better to ensure that all relevant and available information in relation to a prisoner's risk of suicide is captured and recorded at admission, better enabling the RRA to serve as a reference document for ongoing risk assessment.

[749] I will therefore make the following finding:

Finding 2: Katie's history of self-harm was not recorded on the RRA documentation completed by Alan Macfarlane, the mental health nurse

who assessed her following transfer to Polmont on 7 March 2018. Nor was it brought to the attention of SPS staff by FVHB staff while she was in Polmont. Accordingly this information was not available to SPS staff (and in particular Katie's personal officers) to inform ongoing suicide risk assessment of Katie while she was in Polmont.

[750] Third, entries recorded on the VISION healthcare system by Joanne Brogan on 27 April 2018, 23 May 2018, 26 May 2019 and 29 May 2018 were factually inaccurate insofar as they suggested that Katie was being formally assessed and reviewed by the FVHB mental health team at Polmont. These inaccuracies were due in part to the need to select drop down options when inserting entries. They led Dr Fiona Collier, in particular, to assume that Katie was receiving formal assessment and ongoing support for her mental health by FVHB when in fact Nurse Brogan was not providing support on this basis.

[751] Again, while Nurse Brogan's entries on VISION were misleading in relation to recording the informality of her involvement with Katie, I accepted that they did not affect the substance of it. Nurse Brogan did provide support to Katie. She was alive to the adverse impact that Katie's alopecia was having on her, but did not consider that she was at risk of suicide. Even had the VISION entries been more accurate the outcome would not have been different. But in another case it might be, and the finding is appropriate in order to reflect the need for accurate clinical note taking and training in connection with that, both for Nurse Brogan and the mental health nurses in Polmont generally.

[752] I will therefore make the following finding:

Finding 3: Entries recorded on the VISION healthcare system by Nurse Joanne Brogan on 27 April 2018, 23 May 2018, 26 May 2019 and 29 May 2018 were factually inaccurate insofar as they suggested that Katie was being formally assessed and reviewed by the FVHB mental health team at Polmont. These inaccuracies were due in part to the need to select drop down options when inserting entries. They led Dr Fiona Collier, in particular, to assume that Katie was receiving formal assessment and ongoing support for her mental health by FVHB when in fact Nurse Brogan was not providing support on this basis.

[753] Fourth, there was a systemic failure by SPS staff in Polmont to use concern forms in accordance with TTM. Accordingly no concern forms were completed in respect of Katie while she was in Polmont, notwithstanding multiple occasions when they could or should have been completed had the policy been followed. In particular such forms could or should have been completed in particular (a) on 21 March 2018, following Katie's distress at being strip searched; (b) on 8 April 2018 relative to her observed distress on that day; (c) on 12 April 2018, relative to the report of bullying recorded in the intelligence log; (d) on 27 April 2018, 1 May 2018, 4 May 2018 and 22 May 2018 relative to her observed distress due to her alopecia; (e) on 21 May 2018 relative to her reporting another prisoner's plans for suicide; (f) on 29 May 2018 following the hearing at which Katie's appeal was abandoned; and (g) on 3 June 2018 relative to reports of bullying. Accordingly the information giving rise to these concerns was not recorded as

required by TTM, and was not available to SPS staff (and in particular Katie's personal officers) to inform ongoing suicide risk assessment of Katie.

[754] Concern forms are, for the reasons detailed in the findings set out above, an integral and critical aspect of TTM. Yet the clear picture from the evidence of the prison officers is that they are rarely if ever used in relation to internal concerns. That was the position in 2018, and it remains the position. As the Crown submitted, the evidence illustrated at best a fundamental misunderstanding of the purpose and importance of concern forms by SPS staff, and at worst a complete disregard for them. Even the Deputy Governor of Polmont, Natalie Beale, suggested (incorrectly) that use of an internal concern form was good practice rather than mandatory in terms of TTM, and that its role in keeping a record for the purposes of ongoing risk assessment was not of primary importance (when it is). Senior management were either unaware of the scale of problem, and/or have been unable to take action to rectify it. In these circumstances it is appropriate to describe this as a systemic defect and to make a finding under this subsection, even if in the circumstances of Katie's case it has not been established on the evidence that completion of the forms would have changed the outcome.

[755] The following finding is therefore appropriate in relation to this matter:

> **Finding 4: There was a systemic failure by SPS staff in Polmont to use concern forms in accordance with TTM. Accordingly no concern forms were completed in respect of Katie while she was in Polmont, notwithstanding multiple occasions when they could or should have been completed. In particular such forms could or should have been completed (a) on 21 March**

2018, following Katie's distress at being body (strip) searched; (b) on 8 April 2018 relative to her observed distress on that day; (c) on 12 April 2018, relative to the report of bullying recorded in the intelligence log; (d) on 27 April 2018, 1 May 2018, 4 May 2018 and 22 May 2018 relative to her observed distress due to her alopecia; (e) on 21 May 2018 relative to her reporting another prisoner's plans for suicide; (f) on 29 May 2018 following the hearing at which Katie's appeal was abandoned; and (g) on 3 June 2018 relative to reports of bullying. Accordingly the information giving rise to these concerns was not recorded as required by TTM, and was not available to SPS staff (and in particular Katie's personal officers) to inform ongoing suicide risk assessment of Katie.

[756] Fifth, and as a result of all of the foregoing matters, there was no single, readily accessible source of all the information relevant to Katie's risk of suicide which was available to SPS staff in Polmont. There was therefore no system by which a proper, ongoing/dynamic assessment of her risk of suicide could be carried out, standing that such a system must enable the assessor to take account of all relevant history in relation to a prisoner and assess changes in their dynamic risk and protective factors, as well as their self-report and non-verbal presentation.

[757] I do not accept the Crown submission that TTM is, in principle, unduly static and incapable of providing a dynamic assessment of the risk of a prisoner's suicide. I will return to this when considering of recommendations under section 26(1)(b). But TTM relies on accurate recording of all information relevant to suicide risk, collation of that information in standardised form in a single repository, and ensuring that it is

readily accessible by prison staff. If it is, then any officer who has cause for concern regarding a prisoner in distress should be quickly and easily able to access their TTM records. They should then be able to assess the significance or otherwise of the concern, and the prisoner's verbal and non-verbal presentation in response to it, in the light of all the known historical risk factors, and any changes over time in relation to their risk and protective factors. That is what dynamic risk assessment requires. But what Katie's case shows clearly is that the failure to record, collate and make readily accessible all the relevant information means that officers' ongoing assessment was, in practice, based on the prisoner's verbal and non-verbal presentation at a given time.

[758] I will therefore make the following finding:

> **Finding 5: As a result of all of the foregoing matters, there was no single, readily accessible source of all the information relevant to Katie's risk of suicide which was available to SPS staff in Polmont. There was therefore no system by which a proper, ongoing/dynamic assessment of her risk of suicide could be carried out, standing that such a system must enable the assessor to take account of all relevant history in relation to a prisoner, and assess changes in their risk and protective factors, as well as their self-report and non-verbal presentation.**

[759] Sixth, the DIPLAR conducted in relation to Katie's death failed to consider or make recommendations in relation to the ligature anchor point, and ligature, which she had used to die by suicide.

[760] That ligature issues did not feature in Katie's DIPLAR is an extraordinary and concerning omission. As already discussed, there was an obvious issue regarding the need to remove the rectangular door stops in Blair House, and questions as to why that had not been done before. That it was wholly omitted illustrates the apparent failure to acknowledge that when more than 90% of prisoner suicides are by self-ligature, and most are by prisoners not subject to TTM, that anti-ligature measures must be central to suicide prevention strategy. They are not just 'a matter for the estates department'. The circumstances in which a prisoner is able to self-ligature must be audited and reviewed in the DIPLAR, both as regards the ligature point and the ligature used, so as to learn how it happened, and what action to take to try to prevent it happening again.

[761] Accordingly I will make the following finding in relation to this matter:

Finding 6: The DIPLAR conducted in relation to Katie's death failed to consider or make recommendations in relation to the ligature anchor point, and the ligature, which she had used to die by suicide.

[762] The Crown also submitted that Katie's GP records should have been requested and that a finding in relation to this should be made under section 26(2)(g). But this seems to me to be of peripheral relevance to Katie's death. There was evidence about the difficulties and delays of obtaining GP records for prisoners. But even had Katie's records been requested and obtained, they would not have disclosed anything material in relation to her pre-existing medical conditions, and so relevant to her suicide risk, beyond that which she had already disclosed to FVHB staff while in custody. No formal finding is necessary or appropriate in relation to this matter in this case.

[763] Finally, the Crown submitted that a section 26(2)(g) finding should be made in relation to what was said to be an inconsistent approach to PR2 narrative entries in relation to prisoners. It is true that there was evidence of inconsistency in this area, but it is really beside the point in this inquiry where the real issue is in relation to TTM of the failure to use the concern form process. It might be argued that the narrative section of PR2 could or should be used to record concerns regarding a prisoner's risk of suicide, or that more generally or - as appears at one time to have happened at Cornton Vale - that personal officers should provide weekly narratives in relation to any matters bearing on each of their prisoner's wellbeing. But as matters stand, it is not so much the use or non-use of the PR2 narrative which was relevant to Katie's death, but the non-use of concern forms as a crucial component of TTM suicide prevention strategy. Accordingly I have made no section 26(2)(g) finding in relation to this matter.

Reasonable precautions by which William's death might realistically have been avoided - section 26(2)(e)

[764] William's background, and his prospects for the future, could hardly have been more different from Katie's. As is apparent from the findings set out above, his short life was lived almost entirely in the care system, with a succession of foster families, then in secure accommodation. It was characterised from an early age by abuse of alcohol and controlled drugs, violence, and significant mental health difficulties. Had he not died when he did, he might have died by suicide at a later time, or found himself trapped in the revolving door of offending and imprisonment. Yet more than one witness spoke

positively of him, and that he was intelligent and capable of personal charm. His death, no less than Katie's, was a tragedy, which will have been devastating for those who knew and loved him.

[765] William's death resulted from a catalogue of individual and collective failures by prison and healthcare staff in Polmont. Almost all of those who interacted with him were at fault to some extent.

[766] Looked at broadly, and as SPS pithily submitted, the decision to put William on TTM following the RRA on 4 October 2018 was plainly correct, and the decision to remove him from TTM following the case conference on 5 October 2018 was plainly wrong. Thereafter the failure to reassess him and put him back on TTM later that day was also plainly wrong. Had he still been subject to TTM on the night of 6 to 7 October 2018, as he should have been, there is at least a realistic possibility that his death might have been avoided.

[767] William arrived in Polmont as a 16 year old child entering custody for the first time. He was accompanied by three pieces of paper: (i) the PER, which made clear that he had been treated by G4S as at risk of suicide or self-harm; (ii) the PF fax, which stated that he was considered to be a suicide risk and should be dealt with accordingly; and (iii) the VPN, which made apparent that William was regarded as vulnerable by social services and, by implication, that he might be suicidal in custody. There was little by way of specific information in these documents, but given his young age and that he was about to start his first period in custody, what was contained within them was

sufficient to make it clear that William could not sensibly have been regarded as being at "no apparent risk" of suicide on admission, and so not placed on TTM.

[768] But the documents also made it clear that there was further information known to others which was likely to be relevant to assessment of William's suicide risk. On what basis had the PF and G4S deemed William to be a suicide risk? Why did William say to Catriona Eaglesham that he was not "currently" suicidal, but "did not know how he would be" when locked up? Even if for some reason little weight were to be given to the brief contents of these documents, it was obvious that no decision should be made that William was at "no apparent risk" of suicide for TTM purposes without first obtaining further information about him. And as Ms Eaglesham had provided William's social worker's name and telephone number, there was an easy means to do so.

[769] Further information relevant to William's suicide risk was also available in Kenneth Miller's ISMS bail supervision report. This noted that William was subject to child care legislation, and was the subject of a compulsory supervision order. It noted he was a looked after child and previously spent time in secure accommodation. It noted that he suffered from mental health problems, was extremely isolated in the community, and had intensive support from Includem. In principle there seems no reason why Mr Millar's report could not also have accompanied William to Polmont, but it did not, and so the information contained in it was not available to prison staff.

[770] To his credit, officer Christopher McAinsh, who carried out the first part of the RRA on 4 October 2018, immediately recognised that William should be made subject

to TTM. What is concerning is the manner in which and basis on which he did so. He appeared to pay little regard to the available documentation, which he regarded as routine and generic and therefore of little weight. He did not appear to see it as essential to obtain further background information, albeit that as his assessment was being carried out outwith office hours that might not then have been readily available. He regarded William's verbal and non-verbal presentation as more important in assessing his suicide risk, even though in the absence of background information about him he had no means to critically assess whether it was credible or reliable. But again, to be fair, Officer McAinsh obtained from William that he had a history of self-harm and suicidal ideation, that he might feel suicidal now that he was in custody, and that he had a history of mental ill-health. It is therefore all the more surprising that his reason for making William subject to TTM was not his apparently high suicide risk, but "to make him feel secure and safe to make him feel ok and to reassure him".

[771] Nurse Brian Leitch's approach to RRA assessment of William was similarly surprising. It is apparent from Nurse Leitch's evidence, and indeed from what he recorded on the RRA form and on VISION, that he too obtained information from William which on the face of it indicated that he could not sensibly be regarded as being at "no apparent risk" of suicide. This included information that he had thoughts of self-harm, a history of self-harm/suicide attempts, and a history of psychiatric disorder, anxiety and depression. But Nurse Leitch too placed little weight on the PF fax, PER or VPR. And he too appeared willing to take at face value, and in the absence of background information against which to test it, William's self-reported denial of

current suicidal thoughts. So like Officer McAinsh, Nurse Leitch saw the principal reason for TTM as being to "reassure" William on his first night in prison, rather than because he was at risk of suicide. But it can at least be said that the right decision was made at this stage, if for the wrong reasons.

[772] By chance, rather than design, Nurse Leitch was on duty the following morning, and so was assigned to conduct William's pre-case conference assessment and then participate in the case conference itself. As regards the former, he did not take a detailed history, given his previous involvement. But he ticked the relevant boxes on the pre-case conference form confirming that William had a history of self-harm or suicide attempts, a history or diagnosis of mental health issues, a history of drug or alcohol misuse and an expression of suicidal intent or ideas. On the face of it this was obviously incompatible with a conclusion that William was at "no apparent risk" of suicide. But Nurse Leitch placed greater reliance on William's improved verbal and non-verbal presentation from the night before, and saw no need to obtain background information to place this in context or against which to critically assess it. He now accepts that he should have done so, and that he was at fault in this regard.

[773] The case conference which followed was conducted in a manner can be criticised in a number of respects. It was brief, almost to the point of superficiality. Nurse Leitch recorded it on the contemporary documents as lasting only 5 minutes. I took that as the best evidence on the matter of timing, in preference to the 10 or 15 minutes suggested by the witnesses in oral evidence to the inquiry. In any event, Officers Dowell and Cameron had not read all the documentation which had accompanied William to

Polmont. Officer Dowell had not read the Nurse Leitch's pre-case conference report. These officers in effect deferred to Nurse Leitch's assessment that William was not at risk of suicide, even though all three members of the conference were equally responsible for the decision.

[774] What happened at the case conference, in summary, was that William was spoken to and asked whether he was currently suicidal. William put on a brave face and said that he was not. There was no properly detailed inquiry into his previous suicide attempts, for example how many times he had attempted to kill himself, how recently, and by what means (that is, whether in a planned or impulsive manner). Given his presentation, and Nurse Leitch's perception that it was much improved from the previous evening, William's self-report was taken at face value and accepted. There was no proper discussion in relation to his history of mental health or drug and alcohol issues. Contrary to TTM guidance, no consideration was given to contacting William's social worker, his Includem worker, or his family, and so obtaining background information relevant to his suicide risk, and/or the credibility or reliability of William's self-report.

[775] But even leaving aside procedural criticisms of how the case conference was conducted, the position is that even on the material before it the decision to remove William from TTM was plainly wrong. I reject the arguments to the contrary advanced by Nurse Leitch and SPOA. Professor Towl gave helpful evidence about this, drawn from his expertise and extensive experience in relation to prison suicide, which I accepted. He said that even on the information available to the case conference William

was presenting at a "very high risk" of suicide at that time. He said that based on the content of the PF fax, PER and VPR, and William's inherent characteristics (his young age, that it was his first time in custody). Even the nature of William's offence 2 days before suggested a high level of impulsivity and risk.

[776] Professor Towl placed considerable emphasis on what he said was strong empirical evidence, recognised internationally well before 2018, that the first few days in prison were associated with an increased risk of suicide. Such was the strength of that evidence that, operating the precautionary principle, William should never have been taken off TTM at the time when he was, which was only around 14 hours after he had been admitted to Polmont. Although Nurse Leitch was entitled to make a clinical judgment, Professor Towl did not accept that this could ever override the evidence of high risk with which William presented. Self-report and non-verbal presentation should not have been allowed to take precedence over the data. The only real question requiring the exercise of judgment was between "high risk" and "very high risk", not between "at risk" and "no apparent risk".

[777] Further and in any event, it was also plainly wrong for the case conference to take William off TTM without having sought background information about him relative to his risk of suicide. It was clear that such information existed and, given that Mark MacDonald's telephone number had been provided on the VPR, it was obvious how to obtain it. Nurse Leitch expressly accepted to the inquiry that he was at fault for not contacting Mr MacDonald. He expressly accepted that had he done so the decision of the case conference could and should have been different, and that William's death

might realistically have been avoided. He expressed deep regret for this. The impact on him of William's death appears to have been considerable, both personally and professionally.

[778] Nurse Leitch's acceptance of fault in this regard is properly made. As Professor Towl put it, given the various "red flags" with which William presented, there was an obvious and urgent need to obtain background information about him. As he also pointed out, the value of the TTM requirement to hold a case conference within 24 hours was to check whether all the relevant information about a prisoner was available, and if not, to take steps to obtain it. It should not be, he said, for the purpose of removing a prisoner from TTM who was recognised to be at risk on admission. Indeed, for Professor Towl, even respecting the need for individual assessment, there were good arguments for an absolute rule that for at least the first 24 hours in custody all prisoners should be subject to TTM.

[779] Two other factors were relevant to assessment of William's risk at the time of the case conference. The first was the recognised empirical evidence that prisoners often do not wish to be subject to TTM and will therefore often deny suicidality or fail to disclose matters relevant to it. William's self-report and improved non-verbal presentation should therefore not have been simply accepted at face value in the absence of background information to support it. The second is that this case conference was taking place on a Friday, and that removing William from TTM would mean that he would with 24 hours of entering Polmont be subjected to the relatively impoverished weekend regime. In short, he would spend much of the period between Friday

afternoon and Monday morning alone, locked in his cell. The increased isolation and lack of structured activities during this period was liable to increase the risk of suicidality.

[780] In the light of all this it is clear that it would have been a reasonable precaution for the case conference not to have removed William from TTM and continued to make him subject to 30 minute observations until at least Monday 8 October 2018. Meantime background information could have been sought for the purpose of a further case conference on that date, and would likely in have been available in any event given the need to also then hold a WSA review. The decision of the case conference to remove William from TTM on 5 October 2018 was, in the circumstances, a culpable error of judgment, for which all three members of the conference were equally responsible.

[781] I will therefore make the following finding under section 26(2)(e):

Finding 1: William could reasonably have continued to be subject to contact/observations in accordance with TTM following the case conference held at around 0945 hours on 5 October 2018.

[782] Officer Robert Baird became aware of the decision of the case conference very soon afterwards. He had been intending to participate in it himself. He had read William's TTM documentation from the previous night and had interacted with him when carrying out observations that morning. He said, and I accept, that his clear view was that William would not be removed from TTM by the case conference, particularly on a Friday, given the approaching and relatively impoverished weekend regime. He also said that he was shocked when he heard that it had done so. But it is a central

feature of TTM that all members of staff are equally responsible, and equally entitled to institute it in respect of a prisoner if they consider them to be at risk of suicide. Officer Baird did consider that there was such a risk, yet did not put William back on TTM.

[783] As Officer Baird said, and I have no reason to doubt it, he knew and respected both Officer Dowell and Nurse Leitch, and was conscious of their long experience working in Polmont. And it is perhaps easy to see why he might be reluctant to immediately reverse the decision of a three-person case conference which should, after all, have obtained more information about William than he had himself. William Brown Senior submitted that Officer Baird's reluctance to do so was an aspect of a hierarchical system within Polmont where staff were either not willing to question someone superior, or were happy to rely on their decision without question. Without overstating it in the present context, there may be some force in this. With hindsight it is clear that the case conference made the wrong decision, and had Officer Baird decided to reverse it and put William back on TTM as he thought he should have, that would have been the right decision. While all institutions have hierarchies which it is necessary to respect, it is inherent to TTM that decisions to initiate it in respect of a prisoner should not be subject to them, either in theory or in practice. Accordingly while I am reluctant to be overly critical of Officer Baird at this stage, his decision not to act on the basis of his own opinion and put William back on TTM was an error on his part.

[784] However more criticism is due to Officer Baird in relation to what happened thereafter. While there was some confusion in the evidence, what I ultimately accepted

happened was that around 1030 hours William's social worker, Mark MacDonald, telephoned Andrew Doyle, a social worker working within Polmont and detailed his concerns regarding William. Mr Doyle then telephoned Officer Baird about 1100 hours and passed these on. They were that William had a history of low mood, self-harm, recent suicidal ideation and impulsiveness, but would be "putting on a brave face", that is, seeking to conceal these matters.

[785] Accordingly Officer Baird now had information that had not been available to the case conference earlier that morning. In particular he had information that indicated not only that William had a history of suicidal ideation and self-harm, but also that there may have been a *recent* suicide attempt. It also indicated not only that there was an empirical *possibility* that William might conceal suicidal ideation, but also evidence from someone who knew him to suggest that he would likely do so. Even leaving aside the detail, Officer Baird also now had information that William's social worker was so concerned about his suicide risk that he felt the need to proactively make contact with Polmont and relay his concerns.

[786] Given all this, it is clear that Officer Baird should at this stage have put William back on TTM. He was wrong to think that he had been given no new information. As Professor Towl put it, it was "crystal clear" that William should have been put back on TTM in the light of the information from Mark MacDonald. The failure to do so was "breathtaking". As Professor Towl asked, rhetorically, "what else does one need to know?" It is proper to record that Officer Baird, in his evidence to the inquiry, did not seek to shy away from this. He described himself as having been "criminally negligent",

and after a lifetime's work in the prison service left shortly after William's death, apparently racked with guilt. I have some sympathy for him. He struck me as a decent and committed prison officer, who made a bad mistake, which contributed to a tragic outcome. Of course, had the case conference earlier made the decision which it should have, it is not a mistake which he should ever have been put in a position to make.

[787] Officer Ross Cormack took over from Officer Baird at around 1230 hours that day. Officer Baird had been attempting to contact Stephen Cain at Includem in order to obtain William's mother's telephone number for him. Due to missed calls, Mr Cain did not phone back until Officer Baird had gone off shift. Accordingly Mr Cain spoke to Officer Cormack instead. He relayed further information about William's suicide risk, that he was likely to be both willing and able to not disclose suicidal thoughts, and that he had "real concerns" for William in Polmont in relation to this.

[788] Again, this was information which was new, and which had not been before the case conference earlier that morning. Again, even leaving aside the detail of what Mr Cain said, the position was that an Includem support worker, with experience of regular and frequent contact with William over the period of more than a year, was so concerned about his suicide risk as to proactively make that known to prison staff. Professor Towl's observations in relation to the information received earlier by Officer Baird from Mark MacDonald are equally apt in relation to the information now received by Officer Cormack. It is clear that Officer Cormack should have put William back on TTM in the light of it. He was no less at fault in this respect than Officer Baird, although unlike him showed little awareness of this in his evidence to the inquiry.

[789] It is then necessary to consider what happened - or rather did not happen - to the information received by Andrew Doyle from Mark MacDonald. Mr Doyle, who acted appropriately, made a formal referral to the FVHB mental health team at around 1130 hours, following his telephone call to Officer Baird. This emailed referral contained the information which had been passed to Officer Baird, together with the information received from him that William had been taken off TTM that morning. It was received by an administrator in the FVHB mental health team - presumably located in the Polmont health centre. It required urgent attention by a member of healthcare staff. Had that happened, and for the reasons already indicated, it should have led to William being reassessed and placed back on TTM. Instead, it was printed out and left in a tray, and not collected or acted on prior to William's death.

[790] The circumstances which led to this failure are confusing and unclear to me, and were not explored in evidence with those most directly involved. The administrator who received and printed out Mr Doyle's referral was not called as a witness. Nor was the health centre manager who was on duty at the time. Rosemary Duffy, the FVHB health care manager for Polmont in 2018, did give evidence, and accepted that the referral should have been passed to a member of the mental health team immediately. However I remain unclear as to exactly what system was supposed to have been in place in relation to a referral such as was made in respect of William, and whether that system was defective, or was not operated by one or more individuals as it should have been.

[791] In particular, as will be discussed shortly, there was evidence that there was a hand over meeting at the health centre at around 1300 hours that afternoon, and that a

number of staff, including clinical staff, were present. Was any of them responsible for checking the in-tray in which William's referral lay? If so, who, and why did they not do so? If not, why not? Did the fault lie with the administrator who put the referral into a tray rather than straight into the hand of a mental health nurse? In the absence of clear answers to these questions I am left to conclude that there was a collective and culpable failure by the health care team at Polmont to ensure that the referral was considered and acted on promptly - by reassessing William and in all likelihood putting him back on TTM. This failure, no less than the failures by Officers Baird and Cormack, contributed to William's death.

[792] Tara Duthie was a prison healthcare addition worker employed by a charity operating within Polmont. She had a routine admission meeting with William at around 0830 hours on 5 October 2018, that, is, shortly prior to the case conference. In the course of that meeting William disclosed to Ms Duthie that he had been suicidal at the time of his offence two days before, and that although not currently feeling suicidal he would not tell anyone even if he was.

[793] This was consistent with the information later received from Mark MacDonald and Stephen Cain, and Ms Duthie recognised that it was relevant and concerning. However following her meeting with William she saw that he was on TTM, and so she took no action in relation to it. She must be criticised for that. She would have known that William would be the subject of a case conference that day, and that she had information which was of relevance to its decision-making. She should at least have passed it on, for example to Officer Dowell. She should not have assumed, as in effect

she did, that she did not need to do so because William would not be taken off TTM on a Friday.

[794] Thereafter a sharp factual dispute arises. Ms Duthie said that she attended the handover meeting in the health centre at around 1300 hours that afternoon. She said that Nurse Leitch and between 16 and 18 other members of staff were present. She said that he told her what William had said to her earlier that morning, and he told her that William had been removed from TTM. Ms Duthie said that the health centre manager heard and acknowledged this. She said that she was surprised by what had happened, but did not question it. By contrast Nurse Leitch gave evidence that Ms Duthie did not pass on information about William's disclosures at the handover meeting. His recollection was that the information was first passed on to the health centre manager in his presence the following Monday, 8 October 2018, after William had died. The Crown invited the inquiry to prefer the evidence of Ms Duthie over Nurse Leitch. FVHB invited it to take the opposite view.

[795] In my view FVHB's submissions on this matter are to be preferred. The Crown suggested that if Ms Duthie's evidence were untrue, there would have been no reason for her to make a retrospective entry in William's VISION record following his death. However her own evidence was that she did not do this voluntarily on 8 October 2018, but rather at the instruction of the health centre manager. That was also Nurse Leitch's evidence, who was also present on the Monday. But the entry which Ms Duthie then made makes no reference to her having passed the information to Nurse Leitch at the handover meeting on 5 October 2018, nor that she was then made aware that William

had been taken off TTM. Nor does her entry make any reference as to why, in the light of all this, she herself did not take further steps, such as completing a concern form, or indeed putting William back on TTM. If Ms Duthie's evidence about the Friday handover meeting were true and accurate, I would have expected at least some reference to be made to it in her VISION entry.

[796] Nurse Leitch's evidence regarding the handover meeting appears to me more plausible. His position before the inquiry was to accept with hindsight that he should have sought more information about William before removing him from TTM at the case conference. He candidly accepted that there was fault on his part in this regard. Given this position, it is perhaps hard to see why he would lie about not receiving the information about William from Ms Duthie at the handover meeting. But as FVHB also point out, it is also not plausible to suggest that in a room full of healthcare professionals, some of all of whom would have received training on suicide prevention, that not one of them would have heard or further inquired about the information which Ms Duthie received from William if she had indeed disclosed it at this point.

[797] What this comes to is that Ms Duthie came to know by around 1300 hours on Friday 5 October 2018 that William had been removed from TTM by the case conference, contrary to her earlier expectation. She knew that she had information which was indicative that William was at risk of suicide, and which may not have been before the case conference. She was as entitled to put William back on TTM as any other member of staff with direct access to prisoners. She should have done so or, at the very least, should have formally recorded the information which she possessed in a concern form

and passed it to the hall manager immediately. Had she put William back on TTM, there is a realistic possibility that his death would have been avoided.

[798] In the light of the foregoing, the Crown proposed a number of findings be made under section 26(2)(e) of the 2016 Act, many of which focussed on staff failures to follow TTM procedure. However I preferred the approach of SPS in its submissions. SPS expressly took no issue with the Crown's narrative of events, and accepted that learning points arose in particular from criticisms of the case conference procedure - as they also do from the criticisms of the RRA, and pre-case conference procedures. But ultimately, the failures in procedure are secondary for present purposes. That is because, as matters of substance, the RRA decision to place William on TTM was plainly correct, and the case conference decision to remove William from TTM was plainly wrong, as were the subsequent failures by multiple members of staff to reinstate him on TTM in the light of the further information received. It is on these matters that it is appropriate to focus findings under this subsection, rather than speculating on whether, had proper procedures been followed, different substantive decisions would have been made.

[799] Accordingly I will make the following finding under section 26(2)(e) in relation to this matter:

> **Finding 2: William could reasonably have been reassessed under TTM after the said case conference, and contact/observations reinstated, in the light of information received by prison, healthcare, and social work staff in Polmont during the morning of 5 October 2018, being information received from William himself, his external social worker, and his Includem support worker.**

[800] The Crown also submitted that a finding under section 26(2)(e) should be made in relation to the failure of the case conference to put in place a transitional plan for William after he was removed from TTM. I disagree, again for the reasons advanced by SPS. The basic point remains, which is that William should not have been removed from TTM by the case conference, therefore the question of a transitional care plan, and what it might have contained, is moot. There was also no evidence as to what such a plan might have contained. But in reality that is because the only transitional care plan by which the death might realistically have been avoided was one which was indistinguishable from maintaining William on TTM, which underlines the academic nature of the point.

[801] But there is a further matter. Where a prisoner is placed on TTM, the care plan should include a decision whether to accommodate the prisoner within a Safer Cell rather than a standard cell. As noted above, and as a matter of TTM policy, Safer Cells are only to be used in exceptional circumstances, where such a cell is believed to be the only safe option available. Beyond that, TTM does not expressly require the member of staff drawing up the care plan to consider the environmental safety - in terms of suicide prevention - of any standard cell to which the prisoner might be allocated.

[802] In William's case the care plan following his being placed on TTM did not specify a Safer Cell, and no consideration was given to which standard cell he should be accommodated in, nor any issue of the safety of that cell. William was therefore allocated to standard cell 2/45 in Monro Hall by the hall manager. William was

accommodated in this cell by himself. It had a double bunk bed in it. William used the metal frame of this bed to self-ligature around 48 hours later.

[803] As the evidence showed, double bunk beds were and are an obvious ligature anchor point. When placed in single occupancy cells they are readily available for use by prisoners to self-ligature, particularly where those prisoners are not subject to observations. SPS, in common with the prison service in England and Wales, knew this long before 2018. In particular, but only by way of example, a young prisoner named Jordan Barron had died by self-ligature from a double bunk bed in Monro Hall in July 2014. Indeed Nurse Leitch had given evidence at the FAI into Mr Barron's death, and the sheriff's determination had been considered by the NSPMG at its meeting of 7 December 2016[22].

[804] Given this, it would have been a reasonable precaution to have removed double bunk beds from use in relation to all single occupancy cells for young prisoners in Polmont prior to 2018. This could have been done relatively cheaply and easily, and did not require substantial capital expenditure. Had this precaution been taken, William could not have been accommodated in a cell with a double bunk bed at the time when he was, and so would have been unable to self-ligature as he did on the night of 6 - 7 October 2018.

[805] Alternatively, and in any event, it would have been a reasonable precaution not to have allocated William to a single occupancy cell containing a double bunk bed in

[22] *Determination of the inquiry into the death of Jordan Barron* [2016] FAI 9.

the particular circumstances of his case. He had been placed on TTM following the RRA, and - if perhaps for the wrong reasons - he was therefore a prisoner assessed as being at risk of suicide. There was no suggestion that alternative single occupancy cells without a double bunk bed were not available for him in Monro Hall. Put another way, even if double bunk beds had not been removed from all single occupancy cells, it would still have been a reasonable precaution not to accommodate a prisoner subject to TTM in such a cell.

[806] By either route, it would have been a reasonable precaution in terms of section 26(2)(e) of the 2016 Act not to have accommodated William, alone, in a cell with a double bunk bed. Had he not been so accommodated, the death would not have occurred. For the same reasons as in Katie's case, the possibility that he might have found another ligature anchor point to use on the night of 6 to 7 October 2018 is no bar to a finding under this subsection. That is implicitly accepted in William's case by SPS, who did not oppose such a finding.

[807] Accordingly the following finding under section 26(2)(e) is appropriate:

> **Finding 3: William could reasonably have not been accommodated alone in a cell with a double bunk bed, which was readily capable of being used as a ligature anchor point without ingenuity or adaptation.**

Systemic defects contributing to William's death - section 26(2)(f)

[808] As already noted in relation to Katie's case, there was no system in place in SPS prior to William's death to regularly audit the physical environment of his cell - or any

other cell in Polmont - for the presence of ligature anchor points. Nor was there a system to remove such ligature anchor points as had been identified by such an audit.

[809] This systemic defect contributed to William's death, for essentially the same reasons as it contributed to Katie's death. However the defect is even more glaring in William's case, given that not only were double bunk beds a recognised potential ligature anchor point, but as noted at least one other young prisoner in Monro Hall had actually used such a bunk bed to complete self-ligature prior to 2018. Any reasonable system of audit would have identified this, and would surely have called for the end to the use of double bunk beds in single occupancy cells for young prisoners in Polmont prior to William's death.

[810] A finding under section 26(2)(f) is therefore appropriate in relation to this matter, as follows:

> **Finding 1: There was no system in place within SPS to (i) regularly audit the physical environment of William's cell for the presence of ligature anchor points, and (ii) to remove such ligature anchor points as had been identified by the audit.**

[811] Where a young person is transferred from secure accommodation to Polmont there is a specific process and SOP which provides for transfer of background information relevant to suicide risk. However there is no such system in relation to a young prisoner, such as William, who was remanded directly from court. The absence of such a system is particularly acute where, as with William, the prisoner has not previously been detained, and so will have no PR2 prison record.

[812] William was accompanied to Polmont by the PF Fax, the PER and the VPR, which contained information relevant to his risk of suicide.

1) If there was a system in place in relation to sending of the PF fax I was not made aware of it. It was suggested by Officer McAinsh that it was a generic letter the like of which he saw regularly. There may be guidance to PFDs in court in relation to creating and sending it to a receiving prison in appropriate cases. If so, I do not know whether any guidance is national or confined to Glasgow Sheriff Court.

2) The PER is expressly recognised within TTM. Staff conducting the RRA on admission must, in terms of the policy, ensure that they have seen it. They are directed, if no PER is presented, to require the escort personnel to either provide it or provide a written statement of concerns, and an explanation of why there is no PER - which should then be reported to SPS HQ. To that extent there is therefore a system in place in relation to provision of this document.

3) As to the VPR, this is a pro forma, and the terms of it suggest that court social workers in Glasgow are required by HSCP to complete it in appropriate cases and ensure that it is sent to the receiving prison. Whether a similar system exists in social work departments elsewhere in Scotland I do not know.

[813] There was other information which was readily available on 4 October 2018 but was not sent to Polmont with William. Kenneth Miller's ISMS bail report, provided for

the court, was considerably more detailed as regards William's background and issues relevant to his suicide risk. There seems to have been no good reason why this too could not have accompanied him to Polmont and so been available for TTM risk assessment during the critical first hours of custody.

[814] Mark MacDonald had a relatively up to date Child's Plan in respect of William, as he was a looked after child. This provided a narrative of William's background and history and details of his history of self-harming behaviour and suicidal ideation. This too was not sent to Polmont in time for the TTM decision-making of 4 and 5 October 2018. As I understood the position there was no requirement on the social work department to make it available until the WSA review, which would not have taken place until at least 72 hours after William's admission. But again, there seems to be no good reason why in principle it could not have been sent immediately.

[815] In the absence of a system requiring such background information to be provided to Polmont at the time of William's admission, SPS was dependant on whatever information was in fact provided to it. But there were systemic shortcomings in relation to this too. Mark MacDonald telephoned Andrew Doyle, a social worker based in Polmont. Andrew Doyle telephoned Monro Hall and spoke to Officer Baird. Stephen Cain of Includem phoned Monro Hall and spoke to Officer Cormack. This reflected a lack of a proper system whereby external agencies could relay concerns and share information with Polmont relevant to the suicide risk of a young prisoner, and to do so via a central point of contact within the prison.

[816] Had there been a system whereby this background information had been made available at the time of William's admission - or at least by the time of the case conference on 5 October 2018 - a different decision would likely have been reached, and William would have remained on TTM. Nurse Leitch accepted as much in his evidence to the inquiry. He and his colleagues were, as has been said, at fault for not requesting background information, but the absence of a system whereby it was provided at the earliest stage at least contributed to the faulty decision-making, and so to William's death.

[817] A finding under section 26(2)(f) is therefore appropriate in relation to this matter, as follows:

> **Finding 2: The system for sharing information with SPS by external agencies relevant to a risk of suicide in respect of young prisoners remanded or sentenced straight from court (rather than transferred from secure accommodation) was defective, such that available information relevant to William's risk of suicide did not accompany him to Polmont, and was not otherwise readily available to prison staff following his admission.**

[818] Further issues arise in relation to systems within Polmont for sharing and acting on the information that was received from Mark MacDonald and Stephen Cain - and indeed from William himself - on 5 October 2018.

[819] In the first place the Crown submitted, as it had in Katie's case, that there had been a systemic failure by staff to use the TTM concern form system. It submitted that

the failure to utilise this system in relation to information received into the prison on 5 October 2018 contributed to William's death.

[820] As noted, Officer Baird received information - indirectly - from Mark MacDonald, Officer Cormack received information from Stephen Cain, and Tara Duthie received information from William himself. The information which each of them received ought to have resulted in them putting William back on TTM. However even though they did not do so, nor did any of them complete a concern form as they otherwise should have done in terms of TTM policy and guidance. Had they completed concern forms, they would have required to give them to the FLM in Monro Hall, that is, either Officer Dowell or whoever took over from him as manager at the end of his shift.

[821] Accordingly by early afternoon on 5 October 2018 the FLM would have had, in a standardised form, three separate pieces of information, none of which had been available to the case conference earlier, and all of which pointed towards William being at risk of suicide. Had that happened, or in other words, had these three pieces of information been effectively shared via the concern form system, it is likely that William would have been put back on TTM. Put another way, even if each individual piece of information had not been sufficient to persuade the recipient to put William back on TTM, collectively they would likely have done so.

[822] I accept, for the reasons already discussed in relation to Katie's case, that the failure of staff in Polmont to use the TTM concern forms was and is so widespread as to be properly characterised as systemic. That Officers Baird and Cormack, and

Tara Duthie, did not complete such forms on 5 October 2018 can properly be seen as both illustrative and representative of this failure.

[823] Accordingly a finding section 26(2)(f) is appropriate in relation to this matter, as follows:

> **Finding 3: The system within SPS at Polmont for sharing information received from external agencies relevant to a risk of suicide in respect of young prisoners was defective, such that information communicated to SPS officers in Polmont which was relevant to William's risk of suicide was not effectively shared or acted upon.**

[824] The second issue which arises in relation to information sharing concerns the failure by FVHB staff to timeously act on the formal mental health referral made by Andrew Doyle in the late morning of 5 October 2018. As noted, this emailed referral was simply printed out by a member of administrative staff in the health centre and left in a tray until after William's death, more than 36 hours later. The Crown submitted that there was no mechanism in place to ensure that it was passed directly to a mental health practitioner, and timeously actioned in an appropriate manner.

[825] Somewhat surprisingly, FVHB did not make any written submissions on the circumstances of the failure to act on Andrew Doyle's referral. It confined its submissions to changes which it said had been made to its systems almost immediately following William's death. Implicit in this is a concession by FVHB that there was indeed a systemic defect in its processes for receiving and actioning urgent mental health referrals. As already noted that does not preclude the possibility of individual

failures as well, but the absence of evidence from those directly involved means that this cannot be assessed nor findings made thereon.

[826] In any event the failure of FVHB to act timeously on Andrew Doyle's referral was unacceptable and incomprehensible. On any reading the referral required immediate attention by a mental health practitioner. Had it been passed directly to such a practitioner and timeously acted upon, it is likely that William would have been placed back on TTM on 5 October 2018. Therefore accepting that the failure to pass on the referral was due to a defect in FVHB's system for doing so carries the consequence that this defect contributed to William's death.

[827] Accordingly a finding under section 26(2)(f) is appropriate in relation to this matter, as follows:

> **Finding 4: The system for actioning mental health referrals to FVHB mental health team at Polmont was defective, in that the emailed referral made in respect of William by social worker Andrew Doyle at around 1130 hours on 5 October 2018 was printed out and placed in a filing tray by an administrator, but not actioned by healthcare staff until 8 October 2018, by which time William was dead.**

[828] The Crown submitted that there was a systemic defect within TTM in that it did not provide guidance to staff as to when or how background information in relation to a prisoner such as William could or should be obtained. Allied to this was a submission that TTM was further defective in placing overreliance on self-reporting and insufficient emphasis on ingathering and assessing background information.

[829] As SPS submitted, TTM itself does not confine assessment to matters of self-report by the prisoner. Part 1 of the TTM guidance, in relation to assessment, draws specific attention to a number of historical risk factors, such as a history of mental health issues or deliberate self-harm. It also provides that anyone carrying out assessments under TTM must take into account background factors such as relationships with family and friends, previous trauma or abuse, and social factors such as employment and housing. It expressly provides that it is important that an assessment includes appropriate information from the individual "and other relevant parties who may have been involved in previous care" - see Crown Production 57, page 2460. And the TTM training materials teach staff that the sources of information in relation to assessment include not just the person in prison, but also "past records", and "any other concerned party (family/friends/social work)" - Crown Production 58, page 2551 and 60, page 2637.

[830] But as the name of the policy itself suggests, the main emphasis in the TTM policy and guidance is on encouraging prisoners to talk to staff, and so create the circumstances in which both a verbal and non-verbal cues and clues can be detected. The very difficulties that were shown to exist in relation to transmission of background material, such as health and social work records and information, adds to the risk of an in-built bias towards assessment which is over-reliant on verbal and non-verbal presentation.

[831] That was the view of Dr Deshpande in her evidence to the inquiry, and also of Professor Towl. He did not suggest that TTM did not consider obtaining background information about a prison in order to risk assess them, but that a "significant

limitation" of TTM as presently framed in both the policy and the training materials was "the unduly heavy weight placed upon self-report based data". Nick Cameron, speaking from an operational perspective, also saw TTM as being over-reliant on self-report, and as in effect not doing enough to prevent a prisoner's self-report that they are not suicidal being taken at face value, rather than just taken into account.

[832] There is therefore some force in the Crown submissions on this point as a matter of generality. They gain further strength in the circumstance of the present case given that there was virtually nothing by way of background information available to those assessing William on 4 and 5 October 2018 and, as already stated, defective systems for obtaining and sharing such information as did exist and/or was provided by others. Allied to that was the critical importance of William's first few hours and days in custody during which, as Professor Towl explained, the statistical evidence clearly pointed to a significantly heightened risk of suicide.

[833] What this all points to, in my view, is a broader defect in TTM as it was applied to William. That is that TTM should have been framed so as to mandate, in effect, a strong presumption that he should have been placed and maintained on TTM following admission in the absence of, and pending receipt of, information relevant to his risk of suicide from other parties who might have been involved in his care, in particular family and friends, social work services, mental health services, and/or third sector agencies. Such a policy presumption should have been arisen, in particular, because of his young age, that he was entering custody for the first time, that the PER, VPR and PF fax indicated a risk of suicide, and there was an absence of background information about

him sufficient to enable proper, critical assessment of his self-report and presentation from independent sources of evidence. Had TTM so provided, William could not have been removed from TTM by the case conference on 5 October 2018.

[834] The failure of TTM to so provide therefore contributed to his death, and a section 26(2)(f) finding is therefore appropriate, as follows:

> **Finding 5: The system for assessing the risk of suicide under TTM was defective in that it failed to require that William continue to be subject to TTM observations on 5 October 2018 in the absence of, and pending receipt of, information relevant to his risk of suicide from other parties who might have been involved in his care, in particular his family, social work services, mental health services, and/or third sector agencies.**

Other facts relevant to the circumstances of William's death - section 26(2)(g)

[835] It is under section 26(2)(g) of the 2016 Act that it is appropriate to formally record a number of the procedural concerns in relation to the RRA and case conference processes identified by the Crown in relation to its submissions under section 26(2)(e).

[836] Nurse Leitch, in carrying out the pre-case conference assessment of William on 5 October 2018, did not attempt to contact his social worker Mark MacDonald, even though his name and telephone number was known to him from the VPR. Plainly he should have done so, as he now accepts. Thus I find that:

> **Finding 1: Brian Leitch, the mental health nurse carrying out the pre-case conference assessment of William on 5 October 2018, did not attempt to contact**

his social worker, even though his name and telephone number was known to him from a VPR produced by HSCP and which had accompanied William to Polmont.

[837] Even assuming that the repeated, dangerous and spontaneous nature of William's previous suicidal and/or self-harming behaviour was discussed and disclosed to Nurse Leitch at the pre-case conference, this information was not recorded in the pre-case conference documentation, and so not available in writing for the other members of the case conference. It is far from clear that the prison officers were properly aware of some or all of these matters. The following finding is therefore appropriate:

Finding 2: Even assuming that the repeated, dangerous and spontaneous nature of William's previous suicidal and/or self-harming behaviour was discussed and disclosed to Nurse Leitch at the pre-case conference on 5 October 2018, this information was not recorded in the pre-case conference documentation, and so not available in writing for the other members of the case conference itself.

[838] The case conference carried out on 5 October 2018 was not carried out properly in accordance with TTM: (i) not all the members of the case conference had read all the available paperwork; (ii) the prison officers overly deferred to Nurse Leitch's views, even though each was individually responsible for the decision; (iii) undue weight was placed on William's self-report and presentation in the absence of background information; (iv) no consideration was given to inviting William's social worker to

participate; (v) the case conference lasted only around 5 minutes, which was not long enough to properly explore the suicide risk which William presented.

[839] I will therefore make the following finding under section 26(2)(g):

> **Finding 3: The case conference carried out on 5 October 2018 was not carried out properly in accordance with TTM: (i) not all the members of the case conference had read all the available paperwork; (ii) the prison officers in attendance, John Dowell and Natalie Cameron, overly deferred to Brian Leitch's views as mental health nurse, even though each of them was individually responsible for the decision; (iii) undue weight was placed on William's self-report and presentation in the absence of background information; (iv) no consideration was given to inviting William's social worker to participate; and (v) the case conference lasted only around 5 minutes, which was not long enough to properly explore the suicide risk which William presented.**

[840] Additionally, the DIPLAR conducted in relation to William's death failed to consider or make recommendations in relation to the ligature anchor point and ligature used by him to complete suicide. The points made in relation to the DIPLAR following Katie's death are also applicable here. If anything the omission is even more concerning given that William was not the first young prisoner to die by self-ligature from a double bunk bed while in a cell in Monro Hall. I will therefore make the following finding:

Finding 4: The DIPLAR conducted in relation to William's death failed to consider or make recommendations in relation to the ligature anchor point, and the ligature, used by him to die by suicide.

(H) RECOMMENDATIONS - DISCUSSION AND DETERMINATION

Introduction

[841] The Crown proposed some 20 recommendations under section 26(1)(b) of the 2016 Act. These were adopted by Katie and William's next of kin, who proposed a total of 11 more. None of the Crown's recommendations were opposed by Nurse Leitch. SPOA submitted that no recommendations were required in respect of Katie's death and took a neutral stance in relation to recommendations in respect of William's death. Only three of the Crown's proposed recommendations related to FVHB. None of these were opposed by FVHB, although it was keen to stress that action had already been taken in respect of them. SPS accepted six of the Crown's recommendations in the terms proposed, and gave a qualified response to all the others. However SPS accepted that the process of this inquiry had revealed aspects of its systems and processes which could be improved, and submitted that it was committed to learning the lessons from Katie and William's deaths.

Ligature anchor point reduction

[842] If only one positive result were to come out of this inquiry, it should be a greater recognition by SPS of the importance of ligature prevention as an essential aspect of

suicide prevention policy, and a commitment by it to take concrete and practical steps to address it more directly. Its submissions to the inquiry give cause to hope that this might occur. But in any event it is appropriate to put this issue front and centre of the inquiry's recommendations.

[843] It remains a matter of some astonishment to me that, although the safer custody expert Joanne Caffrey was on the Crown witness list from an early stage, the issue of ligature prevention was not initially identified as one of the key issues for the inquiry. As I have already said, the glaringly obvious fact is that more than 90% of suicides in prison in Scotland, over many years, have been by self-ligature. This is not a reason not to have a person-centred suicide prevention policy, that is, a policy which aims to predict when a prisoner is at risk of suicide, and to then take action to protect against and ameliorate identified risks. But as most prisoners who die by suicide do so when that policy has failed for one reason or another to predict their risk, a broader approach is required. The question becomes not just "how best to predict if a prisoner will attempt to die by suicide?" but also "how best to prevent prisoners from dying by self-ligature?" And the first part of the answer, in simple terms, is by making all prison cells safer, that is, making them - as far as reasonably practicable - ligature anchor point free.

[844] Historically, that has not been the approach taken by SPS. Rather, its recognition of ligature anchor point risk in prison suicide has been given effect through the concept of Safer Cells. These cells, found in every establishment, have long been designed to be as far as possible ligature anchor point free. But in the first place, they are cells for

prisoners who have already been predicted to be at risk of suicide, and so provide no assistance to preventing suicide in relation to those who have not. And in the second place, in designing Safer Cells to be ligature anchor point free what in the past was typically created was a harsh and austere cell environment, quite inappropriate for either medium or long term occupancy. Indeed stopping the perceived overuse of such cells under A2C was, as noted, one of the key aims of TTM.

[845] But SPS has been aware for some time now of the desirability of making all standard cells safer. Where new prisons have been built in Scotland in recent years, specifically HMP Low Moss in 2012 and HMP Grampian in 2014, effort has been put into designing standard cells which are significantly more ligature anchor point safe, that is, safer not only than the cells in the Victorian estate, but also those in prisons refurbished in the 10 year period beforehand. The plans for the cells in the proposed new HMP Glasgow, intended to replace HMP Barlinnie, are similarly being designed with anti-ligature point safety in mind.

[846] All this was apparent from the valuable evidence of Gordon McKean to the inquiry, and the productions lodged by SPS relative to it. Put shortly, in new build prisons standard cells have been made safer from a ligature point perspective, while at the same time Safer Cells have been made less austere. So if it is recognised that it is appropriate to make standard cells in the new estate safer from a ligature anchor point perspective, why not in the existing estate too? The main though largely unspoken answer, I assume, is the cost of doing so.

[847] In the wake of Katie and William's deaths, Gordon McKean was, as detailed above, asked by then SPS Chief Executive to produce an estimate of the costs of bringing all cells in the SPS estate up to the ligature free standard of Safer Cells. His report, Crown Production 90, suggests a cost of around £5,000 per cell in the new estate, around £24,000 per cell in the refurbished estate (which includes Polmont), and around £35,000 per cell in the old (Victorian) estate. Together with additional costs in relation to cells in segregation units, the total cost across the entire Scottish prison estate was estimated at around £155 million. These figures were produced in 2019, and will have risen substantially since then, due in particular to inflation and the cost of materials. Faced with this cost it is perhaps easy to see why the then Cabinet Secretary for Justice in 2019 was persuaded by the Chief Executive to continue with SPS's historical, Safer Cell centred, approach.

[848] I have set out in some detail the history of Mr McKean's involvement with anti-ligature point issues in Polmont from 2018. It makes for sorry reading. It seems that, following Katie and William's deaths, the Cabinet Secretary for Justice was initially keen to investigate and pursue making the prison estate - or at least Polmont - ligature anchor point safer. Mr McKean received from the Chief Executive, indirectly, what was on the face of it an impossible brief, to carry out a ligature point audit of the whole SPS estate. This was a highly complex task never before carried out in Scotland, for which SPS had no methodology, and for which Mr McKean had no particular qualifications. He was given a week to do it. A cynic might be forgiven for thinking that he was being set up to fail. But by chance he had become aware of MTK through his contacts with the

secure mental health sector, recognised the potential to adapt it for SPS use, and through considerable industry and skill, produced the LAP Review.

[849] For a representative sample of cells within Polmont, and in some detail, the LAP Review identified and risk scored those ligature anchor points which were due to the inherent design of fixtures and fittings, and those that were due to disrepair or unauthorised adaptation. Crudely put, it suggested that the cells in which Katie and William had been accommodated fell to be graded as being at the highest ligature anchor point risk. Put another way, they presented a level of risk which, if found within the secure health care sector under MTK, would call for remediation as a matter of course. In any event, the rectangular metal door stops, such as that in Katie's cell, and the metal framed bunk beds, such as that in William's cell, were both identified as high-risk ligature points.

[850] Mr McKean submitted his report to SPS HQ by early December 2018. The Chief Executive then wrote to the Cabinet Secretary for Justice. In very short summary, he in effect suggested that it was too expensive to remove or replace those ligature points which were due to inherent design, and that those that were due to disrepair or adaptation could be dealt with in the course of routine maintenance. The LAP Review would therefore simply inform the use of Safer Cells. This of course, completely defeated the central point of the LAP Review, which was to audit standard cells and take action to make them safer. And it also failed to recognise that some ligature points arising from design - for example the rectangular metal door stops in Blair House

and the metal framed bunk beds in Monro Hall - did not require significant capital investment to rectify.

[851] Mr McKean was not invited to address the Chief Executive in relation to his work on the LAP Review. Rather he was invited to attend a 'Safer Spaces group' meeting in January 2019 - a group tasked, in effect, with pursuing the Safer Cells review, about which Mr McKean knew nothing. Nonetheless he presented the LAP Review to the meeting and set out a list of detailed proposals arising from it. These included measures to directly address ligature points arising from disrepair and adaptation. He also proposed developing a ligature assessment toolkit along MTK lines, and setting up a group, perhaps as a subgroup of NSPMG, to focus on anti-ligature policy. He recognised correctly that it was necessary to ensure that it was seen as an operational issue, and not just a matter for the estates department. He specifically proposed that double bunk beds be removed from single cells in Polmont. However none of Mr McKean's proposals was acted on, and he was not asked back to the Safer Spaces group.

[852] It was against this background that Mr McKean was asked for his costings report by the SPS Chief Executive. But it is important to note that Mr McKean had not proposed in the LAP Review that all standard cells be - in effect - turned into Safer Cells. What he was suggesting was a more realistic programme aimed at reduction of ligature anchor point risk, not its elimination to a Safer Cell standard. Accordingly Mr McKean was asked to provide costings for works that went well beyond what he was actually proposing, and would inevitably be much more expensive. He was not

aware that SPS Chief Executive had in effect already decided - subject to the approval of the Cabinet Secretary - that the proposals in the LAP Review would not be acted upon.

[853] It is into that context that the then Chief Executive wrote to the Cabinet Secretary on 15 February 2019, now SPS Production 71. In its submission to the inquiry SPS submitted that this letter explains why ligature prevention policy is not a black and white issue and requires the balancing of competing factors. While in general terms that is true, I consider that this document misrepresented the import of the LAP Review, and the competing factors which it was trying to balance. In effect, the letter posited a false choice between on the one hand bringing all cells up to Safer Cell standard at huge cost, thereby creating a restrictive, sterile for all prisoners, or on the other providing more and better Safer Cells, trying to improve TTM to predict when prisoners should be in them, and otherwise and so far as possible seeking to normalise the prison environment for young people. So framed, it is perhaps unsurprising that the Cabinet Secretary approved the Chief Executive's proposal that the latter approach be taken.

[854] The LAP Review was therefore, in effect, buried - or as SPS euphemistically submitted, "left behind". No attempt was made to develop the prototype audit toolkit that Mr McKean had created, let alone to carry out the phased programme of removal and replacement of inherent ligature points identified by it. No attempt was made to incorporate anti-ligature issues into SPS suicide prevention policy as he had suggested. Indeed Stephen Coyle, the Chair of the NSPMG between 2020 and 2022, was not even aware of the LAP Review until it was drawn to his attention in 2024 as a result of this

inquiry. And the rectangular metal door stops in Blair House, and the double bunk beds in Monro Hall, remained where they had been at the time of Katie and William's deaths.

[855] Following the conclusion of the hearing of evidence in this inquiry, in a Note of 19 February 2024, senior counsel for SPS advised that in the light of the evidence which had to that point been led it had removed all 74 bunk beds from accommodation within Polmont into which any children or young persons might be placed. That is obviously welcome. In its submissions to the inquiry in June 2024, SPS acknowledged that the court would be concerned why this step had not been identified earlier. But as the above narrative shows, that is not correct. This step *had* been identified much earlier; the concern is that although it was identified, nothing was done about it. It could and should have been. The narrative shows - if anything - that a positive decision was taken not to do so.

[856] The Crown's proposed recommendation to the inquiry, in relation to bunk beds, was that they should be removed from all prisons which have adopted a policy of single cell occupancy, and that no prisoner should be placed in a cell on a single occupancy basis with bunk beds. SPS's response to this was qualified. It submitted that no prisons currently had a policy of single cell occupancy. SPS aspired to single cell occupancy, but this was dependent on the size of the prison population. And for operational reasons - that is, because the prison population changes daily, or even during the day - it was not practical to ensure that no prisoner was ever placed in a cell on a single occupancy basis.

[857] I have taken these submissions into account in formulating a recommendation on this point. In terms of the 2016 Act, my recommendations must be confined to those

aimed at preventing deaths in "similar circumstances" to those of Katie and William. Those circumstances are the deaths of young prisoners, by suicide, in Polmont. While any recommendation I make may have wider ramifications across the prison estate, I therefore cannot make a recommendation in the broad terms stated by the Crown. As for the operational issues raised by SPS, I do not see how they can now arise in Polmont, given that I was told that all bunk beds for young prisoners have been removed. In all the circumstances an unequivocal recommendation in relation to young prisoners in Polmont is therefore appropriate:

> **Recommendation 1: Double bunk beds should be removed from all cells in any wing or hall within Polmont in which young prisoners are accommodated. SPS must take all necessary measures to ensure that no young prisoner is in future accommodated on a single occupancy basis in a cell in which there is a double bunk bed.**

[858] During the hearing of evidence in January 2024 I asked, by reference to photographs of her cell, for clarification of the ligature anchor point which Katie had used. There was confusion about this. Some witnesses seemed to suggest that it was the item attached to the cell wall near to the metal door stop, but that was later identified as an anti-ligature coat hook fitting. Counsel for SPS helpfully clarified the matter in their above mentioned Note of 19 February 2024. Following the procedural hearing on 21 February 2024 I directed that further photographs be taken of the door stop in Katie's cell. I also directed that evidence be provided as to whether, since Katie's death, any

consideration had been given to removal of this fixture, and what if any action had been taken in this regard.

[859] The evidence later produced in response to these directions showed that at some point between 2018 and March 2024 the rectangular metal door stop had been removed from cell 1/33 in Blair House. It had not been replaced with any other fitting. However rectangular door stops identical to those used as a ligature anchor point by Katie, and identified in the LAP Review in 2018, were still present in a number of other cells in Blair House.

[860] In its written submissions to the inquiry SPS acknowledged, correctly, that the rectangular metal door stop in Katie's cell had been an obvious and accessible ligature point, which required no innovation for use. It accepted that replacement of it with one with a sloping top, anti-ligature design, already used elsewhere in the prison estate, would reduce the ligature risk in the cells where they were located. Accordingly removal of any remaining rectangular door stops, such as those used by Katie to self-ligature, was underway.

[861] Again, that is welcome. But the above comments in relation to the failure to remove bunk beds from single occupancy cells for young people prior to 2018 and since are also apposite in relation to the rectangular door stops. They were identified as a potential ligature point no later than 2012, because by then sloping, anti-ligature doors stops were being installed in new build cells. They were identified as an actual ligature point no later than Katie's death in June 2018. And they were identified again in the LAP Review - even though Mr McKean was unaware of the circumstances of Katie's

death. At some point since then, at a time and for reasons unknown, the door stop in Katie's cell was removed, but those in other cells in Blair House were not. They could and should have been.

[862] In the circumstances the following recommendation is appropriate:

Recommendation 2: All door stops of the type identified in the book of photographs which forms Crown Production 92 (photographs 95 - 112), and which are of the same or equivalent design as the door stop used as a ligature anchor point by Katie, should be removed from all cells in Polmont and replaced with sloping door stops (such as that identified in the photograph in SPS Production 22/2), or an equivalent anti-ligature design.

[863] The Crown proposed that the inquiry recommend that SPS develop and make use of a ligature audit toolkit, to provide ongoing review of ligature anchor point risks in standards cells, the feasibility of these, and prioritisation of work based on the risk posed. SPS agreed with this in principle, but submitted that this would require to be bespoke and capable of being adapted for different prisons given their different age and infrastructures. Again, I am constrained to confine my recommendations on this point to Polmont. But I cannot avoid commenting that while different establishments may well require different responses to such an audit given their differing ages and infrastructure, there can be no good reason for a difference in safety standards within the audit tool. A metal framed double bunk bed in Barlinnie is no less a high-risk ligature anchor point than it is in Polmont.

[864] But to return to the issue of the cost of making standard cells safer, while not trying to turn them into Safer Cells. Although my recommendations must be limited to the accommodation for young prisoners at Polmont, SPS will I hope look to address the issue across the wider estate. The costs in relation young prisoners' accommodation at Polmont may be manageable, if still substantial. The costs across the whole estate will be much larger. How if at all should that affect the recommendations from this inquiry?

[865] Some guidance comes from the helpful evidence of Joanne Caffrey in relation to her experience in Cumbria Police at the time of the passing of the Manslaughter and Corporate Homicide Act 2007. She said, in summary, that senior managers were concerned that they might be prosecuted under this legislation for deaths by suicide in police custody, and so conducted a ligature anchor point audit of all the force's police cells. The cost of rectifying all the problems was found to be substantial. But rather than do nothing, management made a long-term plan to deal with the problem as resources permitted, and carried it though over a number of years, prioritising dealing with the worst cases first. To paraphrase a comment that Nick Cameron made one point in his evidence, making these kind of difficult choices, and carrying through with them, are what real prison leadership is often all about.

[866] I agree in general terms with the submission for SPS that the requirement of realism in an inquiry such as this requires that recommendations are capable of being given practical effect. But this limitation should not be overstated nor taken too far. It is not untypical that a recommendation from an inquiry such as this involves substantial expense by the person or body to whom it is directed. The court is not blind to the fact

that money for public services is limited, and that allocation of resources by public bodies may well require political and policy trade-offs which the court is not in a position to properly assess, let alone make.

[867] This does not mean that the cost of implementing a recommendation - even at an apparently high cost - is therefore a trump card by which a participant can resist the making of a section 26 recommendation. A recommendation from an inquiry is, after all, just that, a recommendation, and ultimately it will be for the participant concerned to decide whether to accept it or not. Where the participant is a devolved public body such as SPS, that decision will in the final analysis be a policy one, for which it will ultimately be answerable to the Scottish Ministers, who in turn will be answerable to the Scottish Parliament. But even if such a body does accept a recommendation from a FAI, that does not meant that there can be no flexibility in how it does so. Typically, and as in the present case, where what is recommended involves a high cost, what is required is for the person or body concerned to show leadership, make a plan for implementation, set priorities, decide a timescale, work out a budget, and make a start.

[868] In the light of the evidence led in this inquiry, and the foregoing observations, I therefore make the following further recommendation under this heading:

Recommendation 3: SPS should take steps to make standard cells at Polmont safer by identifying and removing, as far as reasonably practicable, ligature anchor points present in such cells. In that regard it should:

1) Develop a standardised toolkit for auditing cells for the presence of ligature anchor points. This toolkit should, in particular, (i) identify

both obvious and potential ligature anchor points; (ii) specify whether such points are inherent to the design of fixtures or fittings within the cell, or due to modification of, or damage to, such fixtures and fittings; (iii) provide a system of grading the level of risk in relation to each identified ligature anchor point (for example, by reference to the ease/level of ingenuity required to use it for self-ligature), and so provide a system of grading the level of ligature anchor point risk in relation to the cell as a whole;

2) Use the foregoing toolkit to conduct an audit of potential anchor ligature points within all standard cells. This should result in the production of a report detailing all obvious and potential ligature anchor points within each cell, identifying whether they are inherent to the fixtures and fittings within the cell or are due to modification or disrepair, and provide a grading of the risk for each identified ligature anchor point and for the cell as a whole;

3) In the light of the foregoing audit:

a. As regards any ligature anchor points arising from damage to or modification of fixtures or fittings, (a) repair or replace same so as to remove or at least reduce the risk of ligature arising therefrom as soon as practicable; and thereafter (b) institute a policy of regular ongoing cell audit using the said toolkit so as to promptly

identify and repair or replace any further damage or modifications which have created further ligature anchor points;

b. As regards any ligature anchor points arising from the inherent nature of fixtures or fittings, (a) develop and publish a plan for their phased removal, replacement or modification, again so as to remove or at least reduce the risk of ligature arising therefrom; (b) specify a timeframe over which this plan is to be implemented having due regard to available resources; (c) commence implementation, for example, beginning with removal, replacement or modification of those fixtures and fittings graded as presenting the highest level of risk pursuant to the said toolkit; and (d) publish annual reports of progress in implementation of the said plan;

4) Ensure that proposed fittings and fixtures in any new build or refurbished cells are audited using the said toolkit at the planning stage, and that any fittings or fixtures graded as presenting an inherent and significant risk of being used as ligature anchor points are not included within such cells when built or refurbished.

Suicide prevention technology

[869] Like many people these days, I have a smart watch on my wrist. It is a clever piece of technology. Among other things, it contains a heart rate monitor, and sends this data to my phone via Bluetooth. As the evidence unfolded in the inquiry I

wondered whether such technology could have a part to play in suicide prevention in prisons. If a prisoner attempted self-ligature, their heart rate would drop. Could that not be monitored, and set off an alarm, thereby enabling intervention to safe life?

[870] I was therefore surprised when Anthony Martin, SPS Head of Operations and Public Protection, told the inquiry that such technology not only existed, but was already in use in secure hospital settings. Further evidence to the similar effect was later given by Dr Deshpande. However neither of these witnesses were in a position to give detailed evidence about the technology, or its application to prisons. In the light of this I directed that such evidence be produced, and a number of helpful witness statements were later obtained and lodged. These were entered into the evidence and I have set out my findings above in relation to what they contained.

[871] In retrospect, it is surprising that this issue was not earlier identified as one for the inquiry to consider. The evidence shows that this technology not only exists (known as "signs of life" technology), but is already being actively trialled in Scottish prisons, as it is by the prison services in Northern Ireland, England and Wales, and elsewhere. There are clearly both technical and operational issues to address, and the cost of supplying and installing the technology is not insignificant - particularly in the old estate. But the potential benefits for suicide prevention policy and practice are substantial, and obvious. On no sensible view could or should such technology replace a person-centred suicide prevention strategy, and nor is it a reason not to make cells safer from a ligature point perspective. But it might provide a powerful additional

tool in seeking to prevent prison suicides. I understood SPS to acknowledge this in its submissions to the inquiry.

[872] However the evidence shows that signs of life technology, and its possible adaptation for Scottish prisons, is still at a relatively early stage of development. I have detailed this in making findings on this issue. Therefore my recommendation in relation to it must necessarily be limited. I cannot recommend that SPS proceed to install signs of life technology in Polmont as matters presently stand. However SPS must continue to actively review and pilot the possible use of this technology, and seek to address the technical and operational issues arising therefrom. It should thereafter report on its findings in relation to this - it is not another matter that should get "left behind". I therefore make the following recommendation under this heading:

> **Recommendation 4: SPS should actively pilot and review use of in cell "signs of life" suicide prevention/monitoring technology in Polmont. SPS should not confine this pilot and review to Safer Cells but should also consider its use in standard cells. SPS should report the findings of this pilot and review, and any recommendations arising therefrom, to Scottish Ministers, within 12 months of the date of publication of this determination.**

Ligature items

[873] Katie used a belt as a ligature, in common with perhaps around nine or ten other prisoners who have died by suicide in a Scottish prison in recent years. It was the belt

for her dressing gown, which she had been permitted to retain and have use of in her cell. It required no adaptation or ingenuity for use as a ligature.

[874] Katie's next of kin submitted that the inquiry should recommend that given their ready availability as a potential ligature item, SPS should change its policy in relation to permitting prisoners to have and use belts. "Particularly vulnerable prisoners" should not be permitted to have them, it was said. By "particularly vulnerable" was meant first offenders, young offenders, those on remand or in the first weeks of sentence, and those with mental health problems.

[875] SPS submitted that there was no sound reason for a policy of blanket removal of belts from prisoners. To do so would compromise the aim of achieving normality. The Prison Rules permitted prisoners to retain personal property unless prohibited or unauthorised. Bedding was by far the most frequently used ligature items, not belts. Where prisoners were thought to be at risk of suicide and put on TTM, a case by case assessment would be made as to whether their use of belts should be restricted. The NSPMG had reviewed this issue in 2021 and approved the present policy. Joanne Caffrey's evidence in relation to restrictions on use of belts in police custody or mental health settings did not automatically translate to the prison environment and should be treated with caution.

[876] While there may be a question as to whether a belt is properly understood as a personal item in terms of rules 46 to 50, or also as an item of clothing in terms of rules 31 to 33, the Prison Rules do not confer an absolute right to a prisoner to have possession and use of a belt. It is an obvious potential ligature item, which unlike a bedsheet,

does not have to be altered or adapted for use as a ligature. And it is an item which is regularly used for this purpose. Belts can therefore be removed from a prisoner if they are assessed as being at risk of suicide. Indeed TTM care planning requires that consideration be given to doing so. What the Prison Rules create, in effect, is a presumption that all prisoners will be permitted to retain and use belts, a presumption which is rebutted if there is reason to suppose that to do so would be prejudicial to their health or safety. The Prison Rules not distinguish or make special provision for young prisoners in this regard.

[877] I am conscious that SPS policy in relation to prisoners' use of belts has been considered in another FAI recently[23]. In that case the sheriff was not asked to recommend that belts be routinely removed from all prisoners. But he was not persuaded that removing the belt of the deceased would have been a reasonable precaution by which his death might realistically have been avoided. His reasoning, accepting the position advanced by SPS witnesses, was that belts were a personal item, retention of which was conducive to seeking to "create a normal and therapeutic environment for prisoners". There was no "clear and proportionate reason" for removing them, given the number of other potential ligatures to which the prisoner would have had access. This, in effect, approved the reasoning of the NSPMG in its meeting of 19 August 2021, detailed above.

[23] *Inquiry into the death of Philip John Hutton* [2023] FAI 3, paragraphs 229 - 241.

[878] With respect to the sheriff, I am unable to agree with this reasoning. Even if it is a legitimate aim to try and create a "normal" environment for prisoners, the fact remains that prison is not "normal" - still less is it "therapeutic". Preserving life by reduction of suicide risk is however clearly a legitimate aim which can justify restrictions on a prisoner's possession and use of items which they might normally have if at liberty. There are numerous 'normal' items which a prisoner might have and use at home which they are not permitted to have when in prison on grounds of safety. Removing belts from prisoners would appear to be a relatively minor restriction, and I do not see how to do so would be destructive of such normality as the prison environment can have. It is far from abnormal for people to wear clothing outwith prison which does not have, or need, a belt.

[879] Furthermore, that other items may be available to prisoner for self-ligature does not seem to me to be an adequate justification for not removing belts from prisoners. Belts, unlike bedsheets, can readily and easily be used as a ligature without ingenuity or adaptation. If items other than belts are available to prisoners for self-ligature, that is an argument for taking steps to remove or reduce the risk arising from such items, not for failing to remove the risk arising from belts. Even if a risk of self-ligature cannot be eliminated altogether, this should not be used as an excuse to not at least reduce the risk by removing an item known to contribute to it. The perfect should not be made the enemy of the good.

[880] Further still, to argue that removal of belts should only be done by the TTM case conference on a case by case basis is to ignore the fact that most suicides by self-ligature

are by prisoners who are not subject to TTM, and so whose possession of a belt is not subject to regulation by a case conference. A policy of removal of belts from persons who are not subject to TTM would therefore be to supplement that policy, not to undermine it.

[881] Finally, the recommendation proposed by Katie's next of kin is not one that was considered by the NSPMG at its meeting on 19 August 2021. What is proposed is not removal of belts from all prisoners, but - in the context of the limits of this inquiry - that they be removed from all young prisoners in Polmont. That is plainly a more limited proposal than for removal of belts from all prisoners across the whole estate. And in my view it can and should be limited further, so as to not wholly remove case by case decision-making. This could be done by, in effect, reversing the presumption in present policy as regards this group of prisoners. In other words, SPS policy should move to a position whereby young prisoners in Polmont are not routinely permitted the possession and use of belts, but can be permitted to have them if it is determined that they are not a suicide risk, and that there are therapeutic reasons to do so.

[882] Accordingly I make the following recommendation:

> **Recommendation 5: SPS should review and revise its policy regarding permitting young prisoners to routinely have possession of items which are readily capable of being used as ligatures without ingenuity or adaptation, in particular belts and dressing gown cords. The new policy should contain a presumption, as regards young prisoners in Polmont, that they are not permitted to have possession of such items. That presumption should only**

be overcome in limited circumstances, for example where a healthcare professional has certified in writing that the prisoner is not at risk of suicide and that there is therapeutic reason for permitting them to have use of such items. The Prison Rules should be amended accordingly.

[883] William tore or ripped one of the bedsheets provided to him by SPS in his cell to fashion a ligature. More than 50 other prisoners have used a similar ligature item to die by suicide in Scotland in recent years. As just noted, the prevalence of the use of ripped bedsheets as a ligature has hitherto been used a justification for not seeking to restrict possession and use of belts and other personal items by prisoners. But as I have said, I think that this is to look at matters the wrong way round. What it should be is a spur to the importance of trying to find ways to prevent prisoners to cut or rip prison issue bedsheets into ligatures, or at least significantly restrict their ability to do so.

[884] In terms of rule 30 of the Prison Rules the Governor must provide sufficient bedding as necessary for the prisoner's warmth and health. There is no further specification as to the type or amenity of bedding that should be provided. There is no requirement to provide bedding of quality akin to that which might be found in a domestic setting, nor an institutional setting such as a hospital. However that appears to be the standard of bedsheet that is in fact provided in Polmont. It is clear that it is relatively easy to rip or cut and so form a ligature.

[885] What alternatives are there to the use of such standard bedsheets? As detailed above, prisoners assessed under TTM as being at a high risk of suicide can be issued with anti-ligature bedding materials, such as the duvet cover lodged as SPS

Production 38. These are heavy and inflexible, and unsuitable for anything but short-term use in acute cases of risk. I cannot imagine that they would be directed to be used other than in a Safer Cell, that is, where the prisoner is assessed at being at high risk of suicide. But as I understood Joanne Caffrey's evidence, there are intermediate products available on the market, that is, which provide greater rip resistance than domestic standard sheeting, but do not involve the loss of amenity of full, anti-ligature materials.

[886] But the evidence about this was limited, and I consider that I am unable to make a firm recommendation that SPS replace the bedsheets for all young persons in Polmont by a rip-resistant alternative. What I will recommend is that SPS commissions or carries out research into what alternatives are available, reports on this matter, and then considers whether to change its bedsheet policy for young persons at Polmont in the light of it. I recognise that questions of the cost of alternatives will have to be considered as part of this research. But the starting presumption must be that simply allowing the present situation to continue, with one young prisoner after another using ripped or cut SPS issued bedsheets to self-ligature, should not be an option.

> **Recommendation 6: SPS should undertake or commission a research project in relation to the availability and cost of alternative bedding materials for use in cells by young prisoners in Polmont. This should determine whether there are bedding materials available which, even if not certified as anti-ligature and inappropriate for use in standard cells (such as Crown Production 38) are nevertheless rip-resistant, to the extent that they are significantly less**

amenable to being cut or torn by a prisoner so as to form a ligature than are the bedding materials currently in use. SPS should publish the findings of this research project, and review its choice of bedding materials in standard cells at Polmont in the light of it.

Information sharing and recording

[887] The Crown recommended that a system should be established to ensure that all information and documentation available to the court when a prisoner is sentenced or remanded is passed with the prisoner to SPS. This did not happen in William's case. This proposed recommendation was supported by Katie and William's next of kin, by Nurse Brian Leitch, and - without qualification - by SPS.

[888] I agree with it. I also agree with the further submission by SPS that consideration might be given to creating a set of standardised paperwork - whether physically or electronically - for all young people coming into prison from the courts. Such standardised paperwork would include the warrant, any CJSWR, any bail reports, letters or reports from the prisoner's family, COPFS, social workers, third sector agencies, and/or healthcare providers. But in any event the aim should be to transmit sufficient information at the time of admission so to enable SPS to quickly identify suicide risk and protective factors in relation to the young prisoner. It should contain names and contact details of any persons involved in their care or treatment.

[889] It is appropriate to direct this recommendation to the Scottish Ministers for implementation, in particular as it will involve public bodies other than just SPS. For

the reasons already mentioned, my recommendation must be limited to the position of young prisoners coming to Polmont, but there may be good reason for the Scottish Ministers to consider a system which would apply to all persons sent to prison by the courts. However I will make a recommendation in the following terms:

> **Recommendation 7: Scottish Ministers should put in place a system to ensure that all written information and documentation available to a court at time of remanding a young person, or sentencing them to custody, is passed to SPS with that young person on admission, whether physically or electronically, such that it can be considered when carrying out the RRA on that person. This should include, in particular, any written information or documents provided to the court by the young person or their representative, by social work or third sector agencies (including any CJSWR), and by health care services (including any mental health assessments carried out relative to the person's fitness to appear in court).**

[890] In relation to William's case the inquiry highlighted difficulties and inconsistencies in the means by which information from external agencies might provide information relating to the risk of suicide of a prisoner in Polmont. As already noted, Mark MacDonald phoned a social worker based in Polmont, Andrew Doyle. Andrew Doyle phoned Officer Baird. Stephen Cain phoned Officer Cormack. There appears have been no recognised, central point of contact within Polmont to which those agencies involved with prisoners could transmit their concerns, and which would ensure that they were quickly passed on and acted upon.

[891] In the light of this William Brown Senior submitted that the inquiry should recommend that SPS consider introducing procedures to allow a more ready flow of information from the community. SPS should consider whether a secure portal could be created where social work, medical staff and third sector organisations could provide relevant reports and records in relation to a prisoner. SPS welcomed this suggestion.

[892] I agree that the suggestion is a good one, and I note that it is not said that there would in principle be any technical difficulty in creating a dedicated, secure point of contact for external agencies, and a portal for uploading concerns and documentation relevant to it. How precisely it might be done is not for me to prescribe further. But I recommend as follows:

> **Recommendation 8: SPS should introduce a secure electronic portal whereby social work, medical staff and third sector organisations can provide information relevant to a prisoner's suicide risk directly to Polmont, and a system whereby any such information received will be immediately drawn to the attention of the FLM or nightshift manager of the hall where the prisoner is located, and recorded in a form which is readily accessible by SPS staff having contact with the prisoner.**

[893] In a similar vein, TTM acknowledges the role that prisoners' families may play in providing information which may be relevant to a prisoner's risk of suicide. William's family would likely have had such information. The VPR indicated that they were too upset following William's remand to provide this to Catriona Eaglesham at Glasgow

Sheriff Court on 4 October 2018. The evidence shows that he was anxious to make contact with them the following morning.

[894] There was some evidence in the inquiry to suggest that SPS were in the process of setting up a dedicated telephone line for families by which they could alert Polmont to concerns in relation to a prisoner's risk of suicide. This is plainly a sensible and overdue measure. There was however a question mark over whether this had in fact been done. I therefore make the following recommendation:

> **Recommendation 9: SPS should provide a dedicated 24 hour telephone number by which family members can call into Polmont in order to notify a concern relevant to suicide risk which they may have in relation to a prisoner. This phone number should be readily accessible on the SPS website, along with guidance as to its purpose and use. Where such a concern is received, an electronic concern form should be completed immediately, sent to the FLM or nightshift manager of the hall where the prisoner is located, and recorded in a form which is readily accessible by SPS staff having contact with the prisoner.**

[895] The Crown proposed that the inquiry recommend that SPS guidance should be issued to ensure that intelligence received in relation to bullying of a prisoner should be shared where possible and in an appropriate format with those directly responsible for the care of the prisoner. SPS agreed with this proposed recommendation without qualification. So do I.

[896] It is apparent that information was received on 12 April 2018 that Katie had been bullied. This was recorded on an intelligence log. Her personal officers did not have

access to this log, and so were unaware that she had been bullied. As has already been observed, in terms of TTM it can be said that the officer who reported the intelligence should also have completed a concern form, in which case the information would have been available to the residential officers. But given the systemic issues with the use - or rather the non-use - of concern forms by prison officers, a specific recommendation in relation to this matter is appropriate:

> **Recommendation 10: SPS should introduce a system so as to ensure, except where there is an over-riding requirement in relation to prison security in a particular case, that where intelligence information is received suggesting that a young prisoner has been or is being bullied it (or at least the gist of it) is promptly and proactively shared with the FLM of the hall in which the prisoner is located, and with SPS staff having contact with them.**

[897] The Crown submitted that SPS and NHS should review their guidance in relation to the sharing of information between themselves. There was information on Katie's VISION record as regards her alopecia, eczema, self-harm, and deteriorating mental health, all of which were relevant as potential indicators of suicidality. There was evidence, for example from Rosemary Duffy, to the effect there was no good reason why this information could not have been shared with SPS.

[898] FVHB pointed out in response that the ISP governed sharing of information and the principles were well established. The ISP was supplemented by a system of healthcare markers, which once identified by healthcare staff would be uploaded to PR2 by administrative staff. This allowed critical healthcare issues - for example if the

prisoner was asthmatic or diabetic - to be made known to SPS staff. FVHB agreed that it was advantageous for healthcare staff to have a clear understanding of what could be shared and that a recommendation for further training would be helpful. SPS submitted information sharing between SPS and NHS was under review, but was subject to legal, regulatory and operational limitations.

[899] The difficulty as I see it was not that no mechanism exists for transfer of information such as that which was on Katie's vision records. The ISP is apt for that purpose. The difficulty was that the healthcare staff who were aware of it - Nurses Macfarlane, Liddle and Brogan in particular, but also Dr Collier, did not see the need to draw it to attention of SPS staff. Put another way, because they did not think that Katie was at a risk of suicide justifying placing her on TTM, they did not therefore recognise the information as relevant to dynamic assessment of her risk of suicide, and so a matter which the SPS staff involved in her day to day care and risk assessment needed to know. Put yet another way, of course, had these members of healthcare staff used the concern form system in relation to Katie's medical problems - all of them were trained in TTM - then there would have been an accessible record of the information available for SPS staff.

[900] So I agree with the proposed Crown recommendation. Arrangements for sharing of health information relevant to risk of suicide should be reviewed, as should training in relation to when FVHB should do so. Although each case will be different, the key principle is the need to recognise that physical health conditions may either contribute to suicidality or be symptoms of its developing, and if so should be shared

with SPS staff. But I am conscious that it is to an extent bound up with the question of whether there might be a more effective mechanism for recording concerns in a consistent and accessible way. SPS have acknowledged that there is scope for reviewing this at an overarching level. But meantime the following specific recommendation will be made:

> **Recommendation 11: SPS and the FVHB should review their guidance in relation to sharing of information in relation to young prisoners in Polmont, and training in relation thereto, so as to ensure that both prison officers and health care staff are aware of all relevant issues which may affect a prisoner's risk of suicide when assessing or reviewing his or her case.**

[901] The Crown proposed that a recommendation should be made that FVHB implement a system for ensuring that mental health referrals made to the healthcare team in Polmont are timeously acted upon. This proposal related to Andrew Doyle's referral in respect of William on 5 October 2018, which was placed in a tray by an administrator and remained unactioned by healthcare staff at the time of William's death more than 36 hours later.

[902] FVHB acknowledged that Andrew Doyle's referral had not been immediately passed on to a member of healthcare staff, but submitted, on the basis of Rosemary Duffy's evidence, that FVHB's system was updated almost immediately. There was now a "single point of contact", with any concerns sent straight to the healthcare manager, the deputy team leader and the mental health care team. Moreover there had been a discussion and debrief about what was required.

[903] As I have already noted in relation to this issue, there was - to my mind - a lack of clarity in the evidence about what the system in the FVHB health care team at Polmont actually was at the time when Andrew Doyle's referral arrived. It was therefore not really clear to me whether the failure to action a referral which obviously required early attention was due to system failure, or staff failure, or both. No documentation was produced by FVHB either in relation to its old system or its new one. Instead, oral evidence was led on this matter from Rosemary Duffy. I made clear in the course of it that I was having difficulty following what she was saying, but matters were not subsequently clarified for me by any documentation relative to the system now in place.

[904] The failure to take timeous action in relation to Andrew Doyle's referral was, as I have already indicated, unacceptable, and it likely contributed to William's death. Action has to be taken at both an individual and systems level to ensure that there is never a repetition of this. FVHB acknowledge its failure, but I am unclear that what has in fact been done since is sufficient to prevent a recurrence. A specific recommendation on the matter is therefore appropriate:

> **Recommendation 12: FVHB should implement a system for ensuring that referrals received by the mental health team in Polmont are immediately passed to and reviewed by a mental health nurse and, where necessary, acted on without delay. Written instruction and guidance for relevant staff should be produced, and if necessary, training given thereon.**

[905] The Crown proposed that the inquiry recommend that the NHS provide further training to staff working within the prison setting on the importance of accurate record keeping, with particular reference to the VISION system. This proposed recommendation related in particular to the various entries made by Nurse Brogan, in which her informal contacts with Katie were inaccurately described as "mental-health reviews" or "assessments". This issue had been identified within the DIPLAR following Katie's death.

[906] FVHB took no issue with the Crown's proposed recommendation. It recognised that accurate notetaking was an essential part of the provision of healthcare, and formed part of every healthcare professional's basic training. However it submitted that it had already taken steps to address the issue. The steps included specifically addressing notetaking during staff induction, monthly audits of notes, speaking to staff or an individual basis (including Nurse Brogan), preparing improvement plans, and developing a competency framework which required individuals to demonstrate competency as a precondition of grade progression. Dr Helen Smith, consultant psychiatrist and expert witness to the ERoMH, had attended at Polmont and had considered these changes to be useful.

[907] I agree that a specific recommendation is still appropriate in relation to this matter. The underlying problem, it seems to me, was that Nurse Brogan's involvement with Katie should have been formal, both in substance and in form. Nurse Brogan was an experienced mental health nurse, and should not have allowed her desire to provide support to Katie for the distress which she was experienced due to her alopecia, to lead

to misleading entries being made in medical records. As a matter of substance, I do not think that anything different would have been done, whether by Nurse Brogan or by Dr Collier, who was misled by the entries made on VISION. But in another case the position may be different.

[908] I will therefore make the following recommendation:

Recommendation 13: FVHB should provide further training to staff working within Polmont on the importance of accurate record keeping, with particular reference to the VISION system.

Talk To Me

[909] In proposing recommendations in relation to TTM, the Crown recognised that, as detailed in the evidence, a delayed 5-year review of the whole strategy by SPS is ongoing. It therefore made a series of proposed recommendations for matters that should be "considered by the review". Thereafter it made a series of recommendations which it submitted "should be considered now".

[910] I was not attracted to this general approach. It was clear from the evidence of Siobhan Taylor, currently NSPM, that the current review would be wide-ranging, and would take into account the findings and recommendations made by this inquiry. Therefore I do not see the value in recommending that any particular matter be "considered" by the review. Rather, I have sought to make specific recommendations as to changes that I am satisfied, on the evidence, should be made to TTM as it currently exists. SPS will either accept these recommendations when reviewing TTM, or it will

not. But if it does not, it will have to address them directly, and not merely appear to accept a recommendation by agreeing only to "consider" it, as would be open to it under the Crown's approach.

[911] As a general matter, the Crown submitted that TTM should move away from a binary system to a less static or inflexible system with ongoing risk assessment at its core. However I agree with the submission for SPS that the basic structure of TTM is less binary than it at first glance appears, and that while TTM in principle should not be inflexible, in practice its use is more rigid than intended.

[912] I also agree with SPS that it is important to recognise, at the outset, that TTM is a strategy which seeks to identify those prisoners at risk of suicide, such that interventions can be made in order to try to prevent them attempting death by suicide or carrying it out. So TTM is not a policy designed to identify or address all matters affecting prisoners' mental or emotional well-being in a more general sense. It is not designed nor intended to keep a record of a prisoner's journey through their sentence, but rather to try to capture concerns related to the risk of suicide or self-harm, both at the outset, and on a dynamic and ongoing basis.

[913] The scheme of TTM begins, in effect, with a RRA on admission to a prison. This necessarily involves assessment by both a prison officer and a healthcare professional, normally a mental health nurse. But as has already been noted, an RRA is not, and is not intended to be, a full mental health assessment of the prisoner. It is more akin to a screening assessment. The only outcomes for the decision following RRA, by both the prison officer and the nurse, are whether the prisoner is "at risk", or "at no apparent

risk", of suicide. If the prisoner is assessed by both of these assessors as being at no apparent risk of suicide, then they will enter the establishment without any suicide prevention measures being put in place for them.

[914] The empirical evidence available to this inquiry suggests that this approach is problematic, in particular in relation to young prisoners being admitted into Polmont. In the first place, as more than one witness accepted, and as the evidence suggests, all young persons entering custody are vulnerable, in the sense that they are statistically at a significantly higher risk of suicide, both compared with young people in the community, and also with older prisoners. Secondly, the evidence also suggests that there is a significantly elevated risk of suicide in the first hours and days after a person enters prison. Professor Towl was very clear about this, and I accepted his evidence in the light of his expertise and experience in this area. However it is also reflected in the literature review carried out for ERoMH. Thirdly, it is recognised that prisoners often do not disclose suicidality when asked about it, and indeed have understandable reasons for doing so. I have described these above. Fourthly, and as Professor Towl also accepted, there is a good basis to consider that the increased social isolation and lack of activity during the impoverished prison regime at weekends may tend to further increase the risk of suicide.

[915] SPS submitted that blanket suicide prevention measures should not be imposed indiscriminately, in particular as this would jeopardise the critical component of maintaining prisoner wellbeing through preserving normality. The "threshold" approach currently found in TTM should therefore be maintained. To a certain extent

I can agree with this, but it should not be taken too far. Prison is not normal. Young prisoners continue to die by suicide at Polmont, year after year, most of whom have been assessed as not meeting the "threshold" for intervention at the time. The absolute numbers of deaths may seem low, but the proportion appears high relative to other prison populations. That suggests to me that in general terms the balance between intervention and "preserving normality" requires to be adjusted. The need for a more precautionary approach is indicated. And that can and should be focused on those areas where the empirical data has identified heightened risk.

[916] Accordingly, I consider that greater emphasis should be given to the interest of protecting all young prisoners in the very early hours and days of their time in Polmont. Professor Towl said, as I understood him, that there was a good argument for an absolute rule that all young prisoners should be on TTM for at least 24 hours after admission. But in any event he struggled to think of an example where they should not be. Although I see the force in this, I would not want to completely foreclose the possibility, and therefore do not therefore recommend such an absolute rule, for this or any other period of custody.

[917] But there should be greater recognition in TTM of the increased risks of suicide in the early days of admission, and during the weekend. Therefore I consider that there should also be a strong presumption in TTM guidance and training that all young prisoners in Polmont, other than in exceptional circumstances, should be put on TTM for the first 72 hours after admission, and not removed from it until and unless a case conference has so decided. Plainly if this 72 hour period were to expire on a weekend,

this would likely mean that the prisoner would continued to be subject to TTM until the following Monday. But again, I stress that what I envisage is a presumption, not an absolute rule.

[918] I would add two things. First, that a prisoner should be put on TTM on admission says nothing about what protective measures/care plan should be put in place - which may be more or less restrictive, as needs be, as further discussed below. Accordingly the presumption which I have just described does not mean a return to overuse of Safer Cells. Second, that maintaining a prisoner on TTM for 72 hours after admission should better enable the ingathering of background information in relation to any risk of suicide or self-harm before deciding whether to place the prisoner in mainstream conditions. If the requirement for a case conference within 24 hours of being placed on TTM were maintained, it would, as Professor Towl said, principally have the role of ensuring that all relevant information is available or is being sought, not of removing the young prisoner from TTM. The risks of doing otherwise, under unnecessarily tight timescales, are evident from William's case.

[919] Accordingly I recommend:

> **Recommendation 14(i): TTM guidance should be amended to emphasise the increased risk of suicide (a) within a prisoner's first 72 hours in custody and (b) during the more restrictive regime in operation at weekends. TTM should provide as a default, and in the absence of exceptional circumstances to the contrary, that all young prisoners should be made subject to TTM for a**

minimum of 72 hours after admission to Polmont, and not removed from TTM thereafter until and unless a case conference has so decided.

[920] As SPS recognised, the expert evidence in the inquiry suggested that the RRA and case conference forms should be reviewed and revised to ensure that all relevant information is obtained and properly recorded. I agree. When a young prisoner comes into Polmont the aim should be to assess and record, as soon as possible, all relevant risk and protective factors relative to their risk of suicide. These will include historical factors - for example, whether they have self-harmed or attempted suicide in the past. It will include their current non-verbal presentation and self-report. And it will include dynamic factors such as personal or family relationships, which are liable to change over the course of the sentence. The present forms do not sufficiently direct and assist those completing them to focus on each of these three distinct aspects, nor to provide the appropriate level of detail.

[921] Revised forms should include checklists or aide memoires in this regard, as suggested in the evidence. The precise content of these will have to be carefully considered by SPS with the aid of appropriate experts, and should not be prescribed by me in this determination. But the end point should be that, by the time that a young person is removed from TTM - as I have recommended - 72 hours after admission to Polmont, there is TTM documentation providing an informed, and as far as possible comprehensive, reference point against which to consider any concerns that may arise in relation to their risk of suicide while in custody, including factors or triggers which may increase or decrease that risk.

[922] Accordingly I recommend:

Recommendation 14(ii): All TTM risk assessment forms should be amended so as to contain a guided process for the assessor. This should include specific prompts, checklists, and questions to be answered and recorded, so as to better enable (i) the identification, assessment and recording of the prisoner's suicide risk and protective factors at the time of assessment; and (ii) ongoing assessment in the light of any changes in any of those factors thereafter.

[923] As I have said, TTM is not as binary as it first appears. True, the RRA requires a decision between whether a prisoner is at risk or at no apparent risk. But this is, as SPS submits, merely the threshold. If a prisoner is considered to be at risk, the assessor - and then the case conference - must put in place a "care plan" for them. In effect this means that a decision must be made as to the nature and degree of intervention and intrusion which is considered appropriate in order to address the level of risk that the prisoner presents.

[924] A care plan will no doubt typically include a requirement for periodic contact, ranging from constant observation to observations at intervals between 5 and 60 minutes. Restrictions may also be placed on which personal items the prisoner may have in use, that is, items that may potentially be used for self-ligature. Use of a Safer Cell, anti-ligature bedding, and anti-ligature clothing, might also - exceptionally - be stipulated. The point for present purposes, however, is that consideration of what measures to stipulate inevitably requires the assessor to grade the level of suicide risk

that the prisoner presents. Once the threshold for intervention is reached, therefore, TTM is not binary.

[925] What the evidence suggested to me is that just as the TTM forms should be revised to assist and focus the decision-making in relation to the threshold question, so they can and should be similarly revised to assist and focus the decision-making in relation to care planning once the threshold has been passed. There was confusion in at least one prison officer's mind about this, for example, whether 15 minute observations could only be applied if a Safer Cell was stipulated as well. One of the reasons for the change from A2C to TTM, it will be remembered, was that assessors had difficulty in grading between low and high risk. But TTM does not, in reality, remove that difficulty. I consider that there is therefore scope here too for checklists and aide memoires to guide and assist assessors, and to provide a clearer structure for care planning for those subject to TTM.

[926] Accordingly I recommend:

> **Recommendation 14(iii): Where a prisoner is assessed to be at risk of suicide, TTM initiation forms should be amended as to contain a guided process for the assessor in relation to care planning for a prisoner being made subject to TTM. This should include specific prompts, checklists, and questions to be answered and recorded, so as to better enable the initiating member of staff to grade the level of risk presented and so put in place protective measures for the prisoner which are sufficient and proportionate to it.**

[927] The issue of information gathering on admission, in relation to a prisoner's background that may be relevant to their suicide risk, figured large in this inquiry. TTM guidance in relation to assessment does contain a single short reference to the importance of including appropriate provision from "other relevant parties who may have been involved in previous care". But this is given nowhere near enough prominence within the guidance. And the guidance specifically in relation to RRA - other than emphasising the need to consider the PER - says nothing about the importance of proactively seeking to obtain background information. It is clear, in particular from the circumstance of William's case, that this should be amended.

[928] There may well be practical difficulties in obtaining background information. But TTM guidance should make clear the importance of trying to do so, and give practical advice to assessors as to what they should look to obtain and how to do it. In many cases - William's being almost a paradigm - there will be a need to look to obtain information from social work, from third sector organisations, and from CAMHS. I also consider that where the prisoner is young - and particularly where it is their first time in prison, and/or there is evidence which may suggest a history of self-harm or suicide attempts - TTM guidance should make clear that the default position, pending receipt of such information, should be that the prisoner is made - or should continue to be - subject to TTM. This reflects the precautionary approach to which, as will be already apparent, I consider that greater emphasis should be given.

[929] Accordingly I recommend:

Recommendation 14(iv): TTM should contain specific guidance to prison staff in relation to obtaining background information relative to a prisoner's suicide risk on admission, with express reference to the particular types of information which should be sought, when it is appropriate to obtain them, the process to be followed, and the person or persons who are responsible for doing so. In particular TTM should require staff to try to obtain background information relevant to suicide risk from the prisoner's family, and from relevant health and social care agencies, (i) where the prisoner is young, (ii) it is their first time in prison, and/or (iii) there is evidence which may suggest a history of self-harm or suicide attempts. In such circumstances, and pending receipt of such information, the default position should be that the prisoner is made - or should continue to be - subject to TTM.

[930] I have recommended that SPS create a ligature audit tool and uses that tool to assess and grade the ligature point risk in standard cells, as a precursor to taking steps to reduce it. Assuming that this recommendation is accepted, the result of the audit should be integrated into the TTM assessment process - and in particular the RRA process on admission. This would reflect the proposition that it is not possible to fully assess a person's risk of suicide simply on the basis of their own history, current presentation and dynamic circumstances. Because the overwhelming majority of suicides are by self-ligature, it is also necessary to take into account the safety of the cell environment in which they are, or are to be, accommodated.

[931] For example, whether a prisoner put on TTM is subject to observations every 30 minutes, or every 60 minutes might, in part, by determined by the ligature point grade of their cell. The safer the cell, the less frequent might need to be the observations. But in any event the assessor must at least consider the ligature point risk of the actual cell in which the prisoner is - or is to be - accommodated and the ligature point risk within that cell (when audited). Further, the TTM assessment forms should require them to demonstrate that they have done so.

[932] In William's case, although he was initially assessed as being at risk of suicide, no thought was given to the ligature anchor point environment of the cell in which he was to be accommodated. TTM guidance did not require this to be done, whether at RRA or case conference. Cell allocation was and is a matter for the FLM. Accordingly William was initially placed in a cell with an obvious ligature point in the form of a double bunk bed, and no change was made to this after he was taken off TTM. Proper integration of anti-ligature strategy within TTM carries the consequence that such lack of consideration of suicide risks arising from a prisoner's cell environment must stop.

[933] Therefore I recommend:

> **Recommendation 14(v): TTM guidance as regards risk assessment should be amended so as to better emphasise the importance of reduction of the risk of self-ligature in the context of suicide prevention. All risk assessment forms should be amended to require the assessor to consider the cell environment in which the prisoner is (or is to be) accommodated, and to assess the ligature**

anchor point risk within that particular cell as part of the overall risk assessment.

[934] When a young prisoner is assessed at no apparent risk of suicide on admission, Katie's case shows the extent to which, in practice, ongoing risk assessment by residential staff can be overly reliant on self-report and visual presentation - the so-called cues and clues set out in TTM guidance. These are of course important, but they are not sufficient for a proper system of dynamic risk assessment. Gradual changes in a prisoner's presentation may not be obvious day to day. Staff may be on leave, off sick or - as happened in Blair House in 2018 - be called away to cover staff shortages in other halls. Accordingly they may not get a complete picture of a prisoner's presentation over time. In any event some prisoners may not give any verbal or non-verbal cues or clues. What is needed for proper ongoing risk assessment is essentially the same as described above in relation to the RRA: consideration of both historical and dynamic risk and protective factors, so as to provide the essential context in which any cues and clues can be considered.

[935] Two things are required. First, the TTM guidance should be amended to make much clearer the need for any ongoing assessment to consider information in relation to a prisoner's historical and dynamic risk factors. Accordingly, and for example, if a prisoner is seen to be in distress in circumstances which should trigger the completion of a concern form, there should be a requirement on the prison officer to review all available TTM documentation prior to deciding what if any action to take in relation to the concern. If, as I have recommended, the RRA process better identifies risk

and protective factors, all (or almost all) young prisoners are subject to a TTM case conference procedure on admission, and relevant background information is routinely obtained, then there should be a repository of material readily available for this purpose.

[936] Accordingly I recommend:

> **Recommendation 14(vi): TTM guidance as regards ongoing risk assessment should be amended so as to better emphasise (i) the importance of obtaining background information in relation to a prisoner, (ii) identifying dynamic risk and protective factors in relation to the particular prisoner, and (iii) that a prisoner's self-report and non-verbal presentation in relation to a risk of suicide should not be taken as determinative, but must be considered in the light of such information. Where a prisoner is observed to be in distress such as should trigger the completion of a concern form, guidance should place a requirement on the officer concerned to review all TTM documentation in relation to the prisoner.**

[937] Second, I consider that there should be a proactive, periodic review of a young prisoner's suicide risk. What I have in mind is that following admission - perhaps as part of a transitional plan after the prisoner is taken off TTM - a date is set for a review of their suicide risk by - for example - one or both of their personal officers. Precisely when that review should be could be decided on a case by case basis. For some vulnerable young prisoners, it might be a week; for others it might be a month or more. It might coincide with a potential stress point, for example, the date of an appeal or other court appearance, or the anniversary of the death of a loved one.

[938] But whenever it happens, the purpose would be to review all available TTM documentation relevant to the prisoner's suicide risk, to consult with the FVHB mental health team and so obtain relevant information from their VISION records, assess the prisoner's verbal and non-verbal presentation, and decide whether the prisoner is at risk of suicide justifying use of TTM measures. If not, then a record of the review should be made in the TTM records, and a suitable date fixed for a further review. In most cases, and assuming that proper records have been kept, this should not be a lengthy or onerous process. But it would ensure - as so obviously did not happen in Katie's case - that a regular overview would be made of each young prisoner's ongoing risk of suicide, and one which did not wholly rely - in effect - on reacting to verbal and non-verbal cues and clues.

[939] Accordingly I recommend:

> **Recommendation 14(vii): In addition to the present system of suicide risk assessment based on RRAs and reactive day to day assessment by prison officers, TTM should include periodic proactive reviews and evaluations of a prisoner's suicide risk and protective factors in the light of all available information. This should include review of prisoners who are not currently subject to TTM, and be at such frequency as may be determined on a case by case basis.**

[940] All this is, however, dependant on the assumption that proper TTM records have been kept. Leaving aside the RRA and case conference documentation, the key issue for ongoing assessment is the use of concern forms. To repeat, these are fundamental to

the TTM process: they are the mechanism by which this strategy sought to reduce the perceived overuse of interventions under A2C. Yet the evidence in this inquiry showed that prison officers generally failed to recognise this, and in any event failed (or refused) to use these forms (at least for internal concerns). They saw them, in effect, as unnecessary paperwork. Efforts since 2018 to make the process more robust have not been effective. But without concern forms - or at least some form of recording information relevant to a prisoner's ongoing risk of suicide - TTM is reduced to reactive assessment of cues and clues by a particular officer at a particular point in time, and which may be devoid of any wider context.

[941] Concern forms are also a reason why, at least in principle, TTM does not simply involve a binary (at risk/no apparent risk) assessment. Unlike the RRA outcomes, the guidance in relation to concern forms expressly gives the assessor the outcome of "no apparent risk with referral". The policy intention is that even if a prisoner is thought to not be at risk in the light of a concern it may still be appropriate to seek further support for them, for example, a referral to the mental health team, or to the chaplaincy service. The guidance, and the concern form, require the prison officer to consider this, to make a decision about it, and to make a record of it. This is what should have happened when Officer Morrison was sufficiently concerned about Katie to refer her to Nurse Brogan, even though she did not think that Katie was at risk such as to justify TTM.

[942] It should be acknowledged, as both SPS and SPOA sought to stress, that just because prison officers do not complete concern forms, this does not mean that they do not act appropriately in response to prisoners' concerns. They will go and speak to

the prisoner, and if they consider that they are at risk of suicide they will initiate TTM. But it is where the concern does not meet the threshold that potentially important information for future assessment is lost. For example, even if a prisoner were eventually put on TTM, their subsequent care planning - and then any transitional planning thereafter - would have to take place without a record of any previous concerns.

[943] SPS acknowledged the disconnect between the envisaged use of concern forms under TTM and their use in practice. It acknowledged that training and GMAs had not been effective to address this disconnect. It acknowledged the potential for relevant information to be lost. SPS also rightly recognised the confusion that arises from the multiple places where a non-TTM threshold concern might be recorded - for example, on a PR2 narrative entry, on a TT SBR, or on an intelligence log - and the need for a single repository. In the light of this SPS acknowledged the need for a more effective mechanism for recording concerns in a consistent and accessible way. The ongoing TTM review would consider whether some form of regular reporting, particularly for young people, should be mandated.

[944] I agree with all this. In the light of the evidence led in the inquiry it is a realistic and sensible approach which is to be welcomed. I recommend as follows:

> **Recommendation 14(viii): SPS should develop a new system of recording issues of concern which relate to a prisoner's suicide risk under TTM, so as to ensure that all relevant information in relation to such a risk is recorded in writing, collated in a single place, and is available to be periodically reviewed**

and assessed. Pending development of a new system of recording issues of concern, SPS should issue further guidance and provide specific training so as to clarify when a concern form should be completed by prison staff and its importance and purpose for TTM. This should emphasise: (i) that concern forms should be used where prison staff have witnessed a prisoner in distress, and are not only for use by external agencies or staff without regular access to prisoners; (ii) that a concern form should be completed even where it is not thought that the prisoner is at risk of suicide; and (iii) the importance of accurate and timeous record keeping in relation to concerns relevant to ongoing assessment of suicide risk.

[945] It is important not only to record information relative to ongoing assessment of a risk of suicide and to collate it in a single place, but also to ensure that it is securely held, and readily accessible. I consider that this requires that all TTM documentation be recorded and held in electronic format, and is accessible as part of the prisoner's record through terminals in the residential hall in which they are accommodated at any given time. There is a need to move away from the largely paper-based system which still exists.

[946] The difficulties associated with maintaining TTM as a paper-based system are apparent from the evidence in Katie's case. She was subject to an RRA at Cornton Vale on 5 March 2018. The form went missing, for reasons unknown. In any event, it would physically have remained in the office at Cornton Vale, and so would not have been accessible to prison staff at Polmont after Katie's transfer. Katie was subject to a

second RRA at Polmont on 7 March 2018, which was filed in an office in the reception area. Had any officer thought to look at it they would have had to physically go to the office and retrieve the file, a trip of 5 to 10 minutes each way. This was an obvious disincentive for them to do so in the course of a busy day. Katie was then subject to a third RRA following her court appearance on 29 May 2018. This too went missing, again for reasons unknown.

[947] Since 2020 concern forms have been in electronic format, which is welcome. But if, as I have recommended, prison officers are to be required by new guidance to review a young prisoner's TTM documentation if a concern arises, and in any event to do so when carrying out periodic proactive TTM reviews, then ready access to all documentation is obviously essential. The only sensible and realistic way to do this is to move TTM from a largely paper based to a wholly electronic system. The intention as stated in the revised 2021 TTM guidance was that uploading documentation to PR2 was being developed, but that has not happened. But Siobhan Taylor gave evidence that a business case was being developed in connection with this, and it should be taken forward.

[948] Accordingly I recommend:

> **Recommendation 14(ix): SPS should develop a system of electronic recording for all TTM documentation, that is, relating to a prisoner's suicide risk assessment, recorded concerns and reviews, so as to ensure that all such documentation is not lost or mislaid, and is in any event readily accessible to frontline SPS staff.**

[949] In 2018 TTM included guidance on transitional plans where a prisoner was removed from TTM. Such a transitional plan was not mandatory and there was no specific guidance as to what it might contain. There was, for example, no transitional plan for William, though as noted, as he should have remained on TTM no realistic transitional plan short of this would have been appropriate. But as in William's case, the available data suggests that while few prisoners die by suicide while currently subject to TTM, many of those who do have previously been on TTM. These are therefore not prisoners who - like Katie - have never given prison staff reason to think that they are at risk justifying TTM before dying by suicide, but prisoners about whom there previously was an identified risk. This suggests that either - like William - they were removed from TTM too soon, or that the necessary supports to keep them safe while no longer on TTM were not identified and/or put in place.

[950] With such issues in mind, the revised TTM guidance from 2021 provided that transitional plans should be mandatory in relation to prisoners who had been subject to 15 minute observations, and for young prisoners. It was further provided that there should be a review of the transitional plan within 7 days, with agreed actions and allocation of responsibility. This was welcome. But other than stating that the aim was a "gradual phased removal" from TTM, there was no guidance on what a transitional care plan might involve in practice. There was evidence from at least one prison officer in the inquiry who was unsure about this.

[951] Accordingly this is, as SPS acknowledge, an area which requires greater attention and specific guidance. The starting point for a transitional plan will be a decision that

the prisoner is no longer at risk of suicide justifying TTM measures. But they are, in effect, "previously at risk", rather than simply "no apparent risk". So consideration will have to be given, in the light of their whole TTM documentation, to the circumstances which led to them being assessed as being at risk in the first place, why that assessment has changed, and what specific and concrete actions can and should be taken to support this change. There may be circumstances where the prisoner is assessed as being no longer being at risk, but if, and only if, certain supports are put in place for them. Therefore if in practical terms these supports are not immediately available, then the precautionary approach should dictate that the prisoner should remain subject to TTM. Specific practical guidance should be given about all this.

[952] A transitional plan should also be specifically required to address the cell environment in which the prisoner is - or is to be - accommodated. Assuming that my recommendation for an audit is accepted and acted on, then the cell ligature risk grading should be considered. While allocation of the safest standard cells should in principle be for those currently on TTM (but who do not require a Safer Cell), the next safest should be for those who have recently or previously been on TTM. Reallocation of cells may be appropriate. Again, guidance to case conferences on this will be necessary.

[953] The 2021 revised TTM guidance appears to envisage a decision to put certain measures in place by way of a transitional care plan, and then a single 7 day review to ensure that they have been. If my recommendation for proactive periodic reviews for all young prisoners is accepted, then more than one TTM review of a previously at risk prisoner will likely take place. It might reasonably be expected that such periodic

reviews will be more frequent than in the case of a prisoner who has never been subject to TTM. But this should be decided on a case-by-case basis, and guidance given in relation to it.

[954] Accordingly I recommend:

> **Recommendation 14(x): A transitional care plan should continue to be mandatory for all young people removed from TTM, so as to ensure appropriate supports and follow-up checks are in place, and that their cell environment is appropriate in relation to potential ligature anchor points. Specific guidance and training should be provided on the options available to staff when compiling a transitional care plan for a young prisoner, including referrals to the FVHB mental health team, other agency referrals, counselling/other supports, or chaplaincy visits. This guidance and training should emphasise the prevalence of suicide by persons who have previously been subject to TTM.**

[955] The Crown submitted that TTM training should be provided to staff annually rather than once every 3 years. It should focus on the importance of accurate record keeping, obtaining information from external agencies, how to properly conduct a case conference, the use of concern forms, and any changes implemented as a result of this FAI. In response, SPS responded that training on TTM following the present review would be mandatory, and the frequency of training thereafter would be a matter which the review itself would consider.

[956] Different staff will have had different initial training in TTM, in particular dependant on whether they were earlier trained on A2C. But TTM refresher training is currently only required to be completed by staff at least once every 3 years. This refresher training is classroom based and lasts for 2 hours only. But the TTM documentation is relatively lengthy and not easily digestible. It is at least questionable whether splitting the guidance into two main parts has had the desired aim of making it more practical than was the case in relation to the A2C guidance. There were areas of uncertainty and misunderstanding for a number of prison staff who gave evidence to the inquiry. There have been a number of changes in the policy and guidance since 2016. And there will be more changes as a result of the ongoing review and, I hope, this inquiry.

[957] While taking the point that the frequency of training is itself a matter for expert consideration in the course of the current review, all the above points towards a need for a significantly greater amount of formal, periodic training on TTM than has hitherto been the case. Whether more frequent, short periods of training would be better than less frequent, but longer periods, I do not have the evidence to say. All I feel able to find is that 2 hours every 3 years is not nearly enough, that the quantity of training should increase significantly, and that it should focus on certain areas highlighted as problematic by the evidence in this inquiry.

[958] Accordingly I recommend that:

Recommendation 14(xi): TTM refresher training should be provided to all staff at a significantly greater frequency and/or duration than 2 hours every

3 years, the precise amount to be determined by the current TTM review. Training should place particular focus on ligature anchor point and ligature item risks, the importance of accurate record keeping, the importance of obtaining information from external agencies, how to properly conduct a case conference, the use of concern forms, and any changes implemented as a result of the ongoing TTM review and this inquiry.

DIPLARs

[959] The Crown proposed that the inquiry recommend that issues of physical environment, including potential ligatures and ligature points, should be considered as part of any future DIPLAR process. SPS agreed with this proposed recommendation without qualification. It pointed out that a review of the DIPLAR process and guidance is currently commencing and will be informed by any relevant recommendations from this inquiry.

[960] As noted above, DIPLAR provides a system for SPS and NHS to record any learning points and identify actions following a death in custody - not just death by suicide. It is designed in particular to examine management processes and practice, and in particular how the deceased was being managed in prison. DIPLARs are not, and are not intended to be, an independent inquiry into the death. Calls for them to be chaired by someone other than an SPS or NHS official seem to me to rather miss this point. For all the criticisms sometimes made, it is the FAI process which constitutes the mandatory, independent inquiry into deaths in custody. It is the FAI process which

serves to satisfy the procedural aspect of Article 2 of the European Convention on Human Rights.

[961] But as I have sought to stress many times in this determination, suicide prevention in Scottish prisons cannot be properly addressed without also addressing issues in relation to self-ligature. It is not enough to consider *why* a prisoner died by suicide, without also considering *how* they were able to do so. That the DIPLAR process wholly failed to address this issue in either William or Katie's case is therefore a significant omission and should be rectified in relation to any similar cases in future. It is indicative of an approach by SPS which has hitherto seemed to assume without question that the safety of the prison environment, from a ligature perspective, is solely a matter "for the estates department". It is not: it is an operational matter too. But in any event, learning how to reduce the risk of suicide by self-ligature - both in relation to the ligature item and the ligature point employed - should be a necessary part of a DIPLAR into such a death.

[962] I therefore recommend:

> **Recommendation 15: Where a prisoner has died by suicide, the DIPLAR process must consider, and if so advised make recommendations, in relation to the safety of their physical environment with Polmont and the means by which they were able to complete suicide. Where suicide has been by self-ligature, the DIPLAR process must consider the ligature anchor point risk of the cell or other place in which the death by suicide took place, and the nature and availability of the item used as a ligature.**

Further proposed recommendations

[963] Katie was subject to two random body (strip) searches following visits, on 21 March and 13 April 2018. There was evidence that these searches caused her distress. Random body searching of 16 and 17 year olds ceased in 2021, following the installation in Polmont of body scanners. Intelligence led body searches of prisoners continues at Polmont, although as 16 and 17 year olds will no longer be detained there as a result of the 2024 Act, they will not be subject to such body searches either.

[964] Katie's next of kin proposed that the inquiry recommend that all body searches of prisoners under 18 should cease forthwith, that scanners be installed in all Scottish prisons, and that body searches only be permitted in exceptional circumstances. SPS suggested that any criticism of the use of body searches in respect of Katie was ill-founded. They were performed in accordance with SPS policy. SPS submitted that body searching is a necessary part of prison regime, as recognised by the expert evidence in the inquiry, and was used appropriately in Katie's case.

[965] For the reasons just mentioned, any recommendation in relation to body searching of prisoners under the age of 18 at Polmont would now be otiose. In any event William, who was under 18, was not body searched, and although Katie was searched, this occurred when she was 20 years old. Accordingly the proposed recommendation has no basis in the evidence relating to their cases. Furthermore, while the searches Katie was subjected to were - unsurprisingly - distressing, the evidence does not justify moving from that to the proposition that recommending the cessation of routine body searches for 18 to 21 years olds might realistically avoid

the deaths of such prisoners by suicide in Polmont. The use of body searches in relation to adult prisoners and/or other prisons is beyond the scope of this inquiry.

[966] Accordingly no formal recommendation will be made in relation to this matter. I would only comment that if scanning technology was available at Polmont in order to avoid random searching of 16 and 17 year olds until the coming into force of the 2024 Act, then presumably it is now available in order to avoid the random searching of 18 to 20 year olds. If so, I would hope that it is put to this use. SPS should be encouraging visits - in particular because family contact is a protective factor viewed from a suicide prevention perspective. But the more visits that a young prisoner has, the more they likely they are to have to face - what should now be - the unnecessary indignity of a random body search; it may therefore tend to act as a discouragement. If technology can be used to end the use of such searches for such prisoners, it should be. Intelligence led body searches remain a quite different issue and I make no comment in relation to them.

[967] Katie's next of kin also sought a recommendation that because of a lack of accountability by both SPS and NHS staff there should be an effective system of governance with national oversight put in place to ensure compliance with all systems and guidance.

[968] I consider that this is a rather sweeping and general proposal which goes beyond the statutory scope of this inquiry, and which is not justified on the evidence led. There may be a case for making SPS staff and management liable to health and safety prosecution, and by this means seeking to improve compliance and accountability in

relation to systems and guidance relative to deaths in prison but, as already noted, no submission to this effect was made, and I offer no present view on it.

[969] William Brown Senior invited the inquiry to make a recommendation that SPS and NHS should consider ways to improve the culture among staff at Polmont to ensure that all staff with responsibilities under TTM feel free and able to raise concerns regardless of whether a member of staff, or skilled member of staff, have made a decision regarding risk levels.

[970] The evidence does not justify such a general recommendation. TTM is clear that any member of staff trained in it has both an entitlement and a responsibility to initiate it in respect of a prisoner if they have concerns in relation to them being at risk of suicide. That should and no doubt will be re-emphasised in any refresher training. The dangers of overly deferring to more experienced, respected or medically qualified members of staff should be evident from the criticisms of Officers Baird, Dowell and Cameron set out above. But I was not satisfied that overall the evidence sufficiently established the existence of the supposed general institutional culture of undue deference which was alleged, or in any event which justified the recommendation proposed.

[971] William Brown Senior submitted that the inquiry should recommend that SPS should provide more support to remand prisoners, who form around half the prison population. It was submitted that should be allowed access to classes and work on the same terms as convicted prisoners.

[972] I consider that it would go beyond the statutory remit of this inquiry to make this proposed recommendation. In a general way I can see the argument that providing

more support and regime to young remand prisoners might reduce the risk that they complete suicide, for example, by reducing isolation and time alone in their cells - although I express no concluded view on this. But this was not focused as an issue for the inquiry, and I do not consider that evidence was led sufficient to establish it.

[973] William Brown Senior asked the inquiry to consider making a recommendation that SPS consider their processes locally and nationally for collation of findings, learning points and recommendations arising from FAIs. It was submitted that this could assist both SPS and sheriffs.

[974] As to SPS, the evidence suggested that all FAI determinations in which statutory findings or recommendations are considered by NSPMG at its quarterly meetings. The NSPMG decides which recommendations to accept and any actions which it proposes in the light of them. These are then fed down to the local prison suicide management groups. GMAs may also be issued. I do not suggest that this system is perfect, and it is true that there was evidence before this inquiry - for example from Siobhan Taylor - which suggested a lack of clarity in some respects. But short of a more concrete proposal as to what any revised system should look like, I am not prepared to make a recommendation in relation to this matter in the general terms sought.

[975] As for assisting sheriffs, all FAI determinations are now published on the Scottish Courts website. The search facility could certainly be improved, but beyond that information as to what findings and recommendations have been made in previous prison suicide cases is available to sheriffs. Even in a similar case the value to be gained from the sheriff's determination is limited. Formally, it is limited by section 26(6) of the

2016 Act, which provides that an FAI determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature - and I take that to include another FAI. But in any event, the evidence led and submissions made will be different from inquiry to inquiry, and different sheriffs may reasonably take different views on the complex issues involved. Overall, therefore, I do not consider that a recommendation should be made in the terms suggested.

(I) POSTSCRIPT

[976] In common with all the participants in the inquiry, I offer my condolences to the families of Katie and William. I would wish to particularly acknowledge the contributions of Linda and Stuart Allan, at least one of whom attended every day of the inquiry, and whose dignity and courage were evident throughout.

APPENDIX 1: TABLE OF CONTENTS

APPENDIX 2: TABLE OF ABBREVIATIONS

A2C	Act 2 Care suicide prevention policy
AER	Adverse Event Review
CAMHS	Child and Adolescent Mental Health Services
CARE PARTNER	FVHB mental health recording system
CJSWR	Criminal Justice Social Work Report
COPFS	Crown Office and Procurator Fiscal Service
DIPLAR	Death In Prison Learning Audit Review
DOCMAN	NHS healthcare documents storage system
ECS	Emergency Care Summary
ERoMH	HMIPS Report on an Expert Review of the Provision of Mental Health Services, for Young People Entering and in Custody at HMP YOI Polmont
FAI	Fatal Accident Inquiry
FLM	First Line Manager
FVHB	Forth Valley Health Board
GMA	SPS Governors and Management: Action
HDC	Home Detention Curfew
HMIPS	His Majesty's Inspectorate of Prisons for Scotland
HSCP	Health and Social Care Partnership

IMU	Intelligence Management Unit
IRRDPC	Independent Review of the Response to Deaths in Prison Custody
ISMS	Intensive Support and Monitoring Service
ISP	NHS/SPS 2013 Information Sharing Protocol
LSPC	Local Suicide Prevention Coordinators
MTK	Manchester Took Kit
NSPM	National Suicide Prevention Manager
NSPMG	National Suicide Prevention Management Group
PER	Prisoner Escort Record
PR2	SPS electronic prisoner record system
RRA	Reception Risk Assessment
SAN	Secure Accommodation Network
SBR	Suspected Bullying Report
SCRA	Scottish Children's Reporter Administration
SGCFD	Scottish Government Children's and Families Directorate
SHAREPOINT	SPS electronic document repository
SOP	SPS Standard Operating Procedure
SPOA	Scottish Prison Officers Association
SM	Scottish Ministers
SPS	Scottish Prison Service

TT	SPS Think Twice anti bullying policy
TTM	SPS Talk To Me suicide prevention policy
VISION	NHS electronic prison healthcare recording system
VPR	HSCP Vulnerable Prisoner Report
WSA	Whole Systems Approach to young offending in Scotland

APPENDIX 3: SUMMARY

Note: this summary is provided to assist in understanding the determination. It does not form part of the reasons for it. The full determination is the only authoritative document.

Introduction

Sheriff Simon Collins KC has issued his determination following a Fatal Accident Inquiry into the deaths by suicide of Katie Allan and William Brown, which occurred at HM Prison and Young Offenders Institution Polmont.

Katie, 21, was found dead in her cell on 4 June 2018. William, 16, was found dead in his cell on 7 October 2018.

The sheriff has found that there were reasonable precautions by which both deaths might realistically have been avoided, that there were systemic failures contributing to the deaths, and that there are other facts relevant to the deaths which it is appropriate to formally record.

The sheriff has made a total of 25 recommendations which might realistically prevent other deaths in similar circumstances.

Background

Katie

Katie was a student at Glasgow University. She had a positive background and supportive family [**paras. 165 – 172**]. But on 10 August 2017 she drove her car while under the influence of alcohol, lost control, mounted a pavement and struck a pedestrian. She later pled guilty to causing serious injury by dangerous driving and drink driving and, on 5 March 2018, was sentenced to 16 months' detention [**paras 173 – 175**].

On admission (first to HMP Cornton Vale and shortly afterwards to Polmont), Katie was assessed under the Scottish Prison Service Talk to Me suicide prevention strategy (TTM). She was not assessed as being at risk of suicide at that time, nor at any time prior to her death almost three months later [**paras. 176 – 187**]

Katie disclosed on admission that she had previously self-harmed, but the form recording that information was lost [**paras. 177, 744**], and this information was not recorded on a

subsequent risk assessment as it should have been [**paras. 182 – 184**]. Healthcare staff were therefore aware of this information, but prison officers were not.

Katie had previously suffered from eczema and alopecia and these conditions began to present again in Polmont, the latter in particular causing her great distress. The extent of this distress, although disclosed to healthcare staff, was not effectively shared with prison officers [**paras. 197, 212, 217 – 226**].

Although Katie was identified as having been bullied by another prisoner in April 2018, this was recorded in an intelligence log which was not accessible by frontline prison officers [**paras. 209 – 210**].

Katie appealed against her sentence, but accepted legal advice to abandon the appeal at a hearing at the end of May 2018. This was stressful and upsetting for her as she had hoped the appeal might be successful [**para. 234**]. However, she would likely have been released on home detention curfew in early July 2018 in any event [**paras. 205, 237**].

On the days prior to her death in June 2018 Katie was subjected to further bullying and abuse. She was distressed by this and reported it to her family during a visit on 3 June 2018. This was passed on to SPS staff but not properly recorded [**paras. 242, 244 – 254**].

In the early morning of 4 June 2018 Katie was found hanging in her cell. She had used the belt from her dressing gown to suspend herself from a rectangular metal toilet cubicle door-stop. She had self-harmed by cutting herself shortly prior to her death. She left a suicide note in which she expressed distress at the abuse which she had received, her sense of personal failure, and her fear of going home [**paras. 256 – 269, 272, 289 - 290**].

William

William was exposed to domestic violence, and drug and alcohol misuse from a very young age. He spent most of his short life in care, with numerous different foster parents, in a kinship arrangement with his paternal grandfather, and in several specialist residential and/or secure units. His mother, sister and half-sister are all deceased [**paras. 291 – 296**].

Prior to being taken into custody, William had self-harmed and made threats of self-harm and suicide on multiple occasions [**paras. 297 – 320**].

On 3 October 2018, William walked into a Glasgow police station with a knife. He was arrested and charged. His position was that his actions were, in effect, a cry for help. He was already on deferred sentence for other offences. A social care officer who met with him was concerned that he was a suicide risk [**paras. 321 – 325, 411**].

William appeared at Glasgow Sheriff Court on 4 October, bail was opposed, and he was remanded in custody. No beds were available at secure units so he was taken to Polmont [**paras. 328 – 339**].

While in the custody of G4S prior to arriving at Polmont, he was documented as being a suicide risk, and was subject to high supervision and constant observation [**para 343**]. A social work vulnerable prisoner report was provided to Polmont staff, which set out that William was a looked-after/accommodated child. It advised that, after being remanded, William had indicated that he was not suicidal, but 'doesn't know how he will be later when locked up' [**para. 344**]. The Crown Office and Procurator Fiscal Service also faxed Polmont to notify staff that William should be considered a suicide risk [**para. 345**].

On admission, William was put on TTM with a requirement that he be subject to 30-minute observations, but was accommodated in a standard cell which contained a double bunk bed [**paras. 347 – 362**].

Following a case conference the next morning, 5 October 2018, the decision was taken to remove William from TTM. William's denial that he was suicidal was accepted. This was notwithstanding the documents stating that he was a suicide risk, and the absence of any other background information about him [**paras. 376 – 383**].

In the course of the morning further information underlining William's risk of suicide was provided to SPS and healthcare staff at Polmont by his social worker, his support worker, and by William himself. This was not shared nor acted upon. William was not reassessed nor put back on TTM [**paras. 371 – 372, 387 – 399**].

William was found hanged in his cell on the morning of 7 October 2018. He had used a torn bedsheet to hang himself from the double bunk bed [**paras. 404 – 411, 424 – 426**].

Suicide in Scottish prisons

More than 100 prisoners in Scottish prisons have died by suicide since 2011. Ten of these have been young prisoners in Polmont. Most were not subject to suicide prevention measures at the time, although many previously had been.

This indicates a suicide rate much greater than that for the general population, particularly as regards young prisoners. The first days in custody are recognised as being particularly critical as regards suicide risk.

The available evidence suggested that the rate of suicide by prisoners in Scotland may be one of the highest in Europe - and that it may be increasing - although the data is incomplete.

More than 90% of Scottish prisoner suicides are by self-ligature (hanging). Around 50% involve the use of ripped bedding materials as a ligature, and almost 10% involve the use of a belt.

Existing prison suicide prevention policies and practices based on person-centred risk assessment have not been sufficient to reduce the suicide rate, particularly among younger prisoners [**paras. 427 - 447**].

Reasonable precautions

Katie

The sheriff found that there were multiple failures by prison and healthcare staff to properly identify, record and share information relevant to Katie's risk in accordance with TTM. However, it was not established that, but for these failures, her death might realistically have been avoided. Even with the benefit of hindsight, Katie's death was spontaneous and unpredictable. She had suffered distress as a result of and during her imprisonment, which had adversely affected her mental and emotional wellbeing, but had appeared resilient in the face of it. She was supported by her family and by prison and healthcare staff. She did not say or do anything to suggest that she was contemplating suicide. The evidence did not establish that Katie should have been assessed as being at risk of suicide prior to her death and placed on TTM [**paras. 668 – 728**].

However, the sheriff found that it would have been a reasonable precaution to accommodate Katie in a cell without a rectangular toilet cubicle door-stop. This item had long been known to be an obvious potential ligature anchor point, and could have been removed and replaced without significant cost. Had it been, the death which Katie suffered would not have occurred [**paras. 729 – 736**].

William

The sheriff found that William's death resulted from a catalogue of individual and collective failures by SPS and healthcare staff in Polmont. Almost all of those who interacted with him were at fault to some extent [**para. 765**].

Reasonable precautions would have been for the case conference to have kept William on TTM [**paras. 764 – 781**], or in any event for him to have been reassessed and put back on TTM in the light of the further information later received by prison staff [**paras. 782 – 799**].

Another reasonable precaution would have been not to accommodate William in a cell on his own with a double bunk bed. This was well known to be a ligature anchor point risk. Another young prisoner had hanged themselves from such a bunk bed in Polmont four

years earlier. Double bunk beds could have been removed and replaced without significant cost. Alternatively, William could have been accommodated in a cell without a bunk bed in it. Had either been done, the death which he suffered would not have occurred [**paras. 801 – 807**].

Defects in systems of working

Katie

The defect in the system of working which contributed to Katie's death was that SPS had no system in place to regularly audit her cell for the presence of ligature anchor points, nor to remove or reduce such points as had been identified [**paras. 738 – 742**].

William

The same systemic defect was also present in William's case [**paras. 808 – 810**]. Further defects contributing to his death existed in relation to:

(a) the system for providing Polmont with all the information relevant to suicide risk which had been available to the remanding court [**paras. 811 – 817**];

(b) the system within Polmont for sharing information from external agencies on the risk of suicide [**paras. 818 - 823**];

(c) Forth Valley Health Board's system for actioning mental health referrals at Polmont [**paras. 824 - 827**]; and

(d) the system for assessing the risk of suicide under TTM, insofar as it permitted William to be removed from TTM in the absence of any background information about him or as to his risk of suicide [**paras. 828 – 834**].

Other facts relevant to the circumstances of the deaths

Katie

Other facts relevant to Katie's death, but which were not shown to have contributed to it, included:

(a) that the documentation relative to the TTM reception risk assessment carried out at HMP Cornton Vale was lost [**paras. 743 - 746**];

(b) that her history of self-harm was not recorded in the reception risk assessment at Polmont [**paras. 747 - 749**];

(c) that there were inaccuracies in the entries about Katie in the healthcare system used by medical staff [**paras. 750 - 752**];

(d) that there was a systemic failure by SPS staff in Polmont to use concern forms in accordance with TTM [**paras. 753 - 755**];

(e) that there was no single repository of information on Katie's suicide risk accessible to staff [**paras. 756 - 758**]; and

(f) that the SPS/FVHB Death in Prison Learning Audit Review (DIPLAR) into Katie's case did not consider the ligature and ligature anchor point which she used to die by suicide [**paras. 759 - 761**].

William

Other facts relevant to William's death included:

(a) that William's social worker was not contacted by the nurse carrying out his pre-case conference assessment [**paras. 835 - 836**];

(b) that William's record of previous self-harm was not detailed in writing for all those who attended his case conference assessment [**para. 837**];

(c) that the case conference was not carried out in line with TTM in multiple respects [**paras. 838 - 839**]; and

(d) that, as in Katie's case, the DIPLAR did not consider the ligature and ligature anchor point which William used to die by suicide [**para. 840**].

Recommendations

Recommendations have been made by the inquiry under the following headings.

Ligature prevention

The sheriff stressed the need for greater recognition by SPS of the importance of ligature prevention as an essential aspect of suicide prevention policy, and the need to commit to taking concrete and practical steps to address it. Its failure to do so in the period since

Katie and William's deaths was criticised [**paras. 842 – 855**]. Accordingly the sheriff recommended:

(a) that SPS remove double bunk beds from all cells in any wing or hall in Polmont in which young prisoners are accommodated [**paras. 856 - 857**];

(b) that all rectangular toilet cubicle door-stops within Polmont be replaced with sloping door-stops or an equivalent anti-ligature design [**paras. 858 - 862**]; and

(c) that SPS should take steps to make standard cells at Polmont safer by identifying and removing, so far as reasonably practicable, ligature anchor points. This should include the creation of a toolkit to identify such anchor points, the carrying out of an audit using this toolkit, and a programme for their removal or replacement [**paras. 863 – 868**].

Suicide prevention technology

Suicide prevention technology ('signs of life') is already in use in secure mental health settings and is being developed for possible use in prison estates in Scotland and elsewhere [**paras. 536 – 543**]. If viable, such technology has obvious potential for complementing existing suicide prevention policies. The sheriff recommended that SPS should actively pilot and review use of such technology in Polmont and report its findings to the Scottish Ministers within 12 months [**paras. 869 – 872**].

Ligature items

The sheriff recommended that SPS should review and revise its policy on permitting young prisoners to routinely have items readily capable of being used as ligatures, such as belts and dressing gown cords. The new policy should contain a presumption against possession of such items. The Prison Rules should be amended accordingly [**paras. 873 – 882]**.

SPS should also undertake or commission research into the availability of alternative bedding materials for use by young prisoners in Polmont, looking at the potential for use of rip-resistant materials [**paras 883 – 886**].

Information sharing and recording

Under this heading the sheriff recommended:

(a) that Scottish Ministers should put a system in place which ensures that all written information and documentation available to a court when a young person is sent to custody is passed to SPS at the time of their admission. This should include any Criminal

Justice Social Work Report or other reports by healthcare services or third-sector agencies [**paras. 887 – 889**];

(b) that SPS should introduce a secure electronic portal which will allow external agencies to provide information relevant to a prisoner's suicide risk directly to Polmont, and put in place a system to ensure that such information is immediately acted upon and recorded [**paras. 890 – 892**];

(c) that SPS should provide a dedicated 24-hour telephone number for families to report any concerns they have relevant to the suicide risk of a prisoner, and put in place a system to ensure that such concerns are immediately acted upon and recorded [**paras. 893 – 894**];

(d) that SPS should introduce a system whereby any bullying concerns relating to a young prisoner are promptly and proactively shared with the FLM of the hall where the prisoner is located and the staff having contact with them [**paras. 895 – 896**];

(e) that SPS and Forth Valley Health Board should review their training and guidance on the sharing of information relating to young prisoners to ensure that prison officers and healthcare staff are aware of all relevant issues [**paras. 897 – 900**];

(f) that Forth Valley Health Board should implement a system to ensure that referrals made by the mental health team at Polmont are immediately reviewed by a mental health nurse and, where necessary, acted on without delay [**paras. 901 - 904**]; and

(g) that Forth Valley Health Board should provide further training to staff within Polmont on the importance of accurate record keeping [**paras. 905 - 908**].

Talk To Me Suicide Prevention Strategy

TTM is currently under review by SPS. The inquiry recommends that it should be extensively revised. The sheriff stressed that greater emphasis should be placed on protecting young prisoners from suicide, particularly in the early stages of custody. A more precautionary approach was required. Accordingly:

(a) There should be a presumption that all young prisoners admitted to Polmont will be subject to TTM for a minimum of 72 hours following admission, and not removed from it until a case conference has so decided [**paras. 911 - 919**];

(b) All TTM risk assessment forms should be amended so as to contain a guided process for the assessor including prompts, checklists, and questions to better identify, assess and record the prisoner's suicide risk and protective factors at the time of assessment; and to facilitate ongoing assessment thereafter [**paras. 920 – 922**];

(c) TTM forms should contain a guided process for the assessor in relation to care planning for a prisoner being made subject to TTM. This should include specific prompts, checklists, and questions to assist in grading the level of risk presented and deciding on appropriate protective measures [**paras 923 – 926**];

(d) There should be specific guidance to prison staff in relation to obtaining background information relative to a young prisoner's suicide risk on admission. Pending receipt of such information, the default position should be that the prisoner will be subject to TTM [**paras. 927 – 929**];

(e) TTM guidance as regards risk assessment should be amended so as to better emphasise the importance of reduction of the risk of self-ligature in the context of suicide prevention, and should include assessment of the ligature anchor point risk within the prisoner's cell [**paras. 930 - 933**];

(f) TTM guidance as regards ongoing risk assessment should better emphasise (i) the importance of obtaining background information in relation to a prisoner, (ii) identifying dynamic risk and protective factors, and (iii) not taking a prisoner's self-report and non-verbal presentation as determinative. Where a prisoner is observed to be in distress such as should trigger the completion of a concern form, all TTM documentation in relation to the prisoner should be reviewed [**paras. 934 - 936**];

(g) TTM should include periodic proactive reviews and evaluations of a prisoner's suicide risk and protective factors in the light of all available information, at such frequency as may be determined on a case-by-case basis [**paras. 937 - 939**];

(h) SPS should develop a new system of recording issues of concern which relate to a prisoner's suicide risk under TTM, so as to ensure that all relevant information in relation to such a risk is recorded in writing, collated in a single place, and is available to be periodically reviewed and assessed. Pending this, SPS should issue further guidance and provide specific training on the importance and use of concern forms [**paras. 940 - 944**];

(i) SPS should develop a system of electronic recording for all TTM documentation, so as to ensure that all such documentation is not lost or mislaid, and is in any event readily accessible to frontline SPS staff [**paras. 945 - 948**];

(j) A transitional care plan should continue to be mandatory for all young people removed from TTM. Specific guidance and training should be provided on the options available, which should emphasise the prevalence of suicide by persons who have previously been subject to TTM [**paras. 949 - 954**]; and

(k) TTM refresher training should be provided to all staff at a significantly greater frequency and/or duration than 2 hours every 3 years, the precise amount to be determined by the current TTM review [**paras. 955 - 958**].

Death in Prison Learning Audit Reviews

Where a prisoner has died from suicide, the sheriff recommends that the DIPLAR must consider the safety of the prisoner's physical environment within Polmont and the means by which they were able to die by suicide [**paras. 959 - 962**].

Condolences

In common with the other participants, the sheriff offered his condolences to the families of Katie and William, and paid particular tribute to the contributions of Linda and Stuart Allan [**para. 976**].