SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT FALKIRK

[2025] FAI 24

FAL-B30-24

DETERMINATION

BY

SHERIFF S G COLLINS KC

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

into the death of

JACK McKENZIE

FALKIRK, 6 May 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"), makes the following findings in relation to the circumstances mentioned in section 26(2):

[1] A table of the abbreviations used in this determination is appended.

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

   Jack McKenzie, date of birth 15 February 2001 ("Jack"), died in in cell 4/56, Monro Hall, HM Prison and Young Offenders Institution Polmont, Redding Road, Brightons, Falkirk ("Polmont") sometime between 0300 hours and 0736 hours on 3 September 2021, his life being pronounced extinct at 0757 hours.

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

   Jack'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 death):

   The cause of Jack's death was hanging.

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

   Jack'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 death, or any accident resulting in death, being avoided):

   It would have been a reasonable precaution for the Scottish Prison Service ("SPS"), prior to September 2021, to have removed and replaced the toilet cubicle door in Jack's cell, or to have modified it, such that it was not readily capable of being used as a ligature anchor point without significant 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 death or the accident resulting in death): **There was no system in place within SPS to (i) regularly audit the physical environment in Jack's cell for the presence of ligature anchor points, and (ii) to remove such ligature anchor points as had been identified by the audit.**

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

1. At 0637 hours on 3 September 2021 Officer David Nelson failed to carry out a hatch check at Jack's cell which was sufficient to ensure that he was safe and well at that time, and in particular, being unable to see Jack within the cell, he failed to take steps readily open to him to ascertain his whereabouts, steps which if taken would inevitably have led to Jack's cell door being opened, and his condition at that time ascertained.

2. Officer David Nelson should have been disciplined for his failure to carry out a hatch check at 0637 hours on 3 September 2021 sufficient to ensure that Jack was then safe and well, contrary to the Monro Hall Patrol Duty Orders (the "Patrol Orders") then in force. Officer Zaira Afzal, who was on duty with Officer Nelson and was jointly responsible for the hatch check, should also have been disciplined. A sanction should have been imposed on both officers and/or corrective training required of them.

3. Neither SPS Talk To Me suicide prevention policy ("TTM") nor its Management of an Offender at Risk from any Substance policy ("MORS") placed any requirement on Nurse Elizabeth Forrester to carry out, and record, a suicide risk assessment prior to removing Jack from MORS at 1430 hours on 2 September 2021.

(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. 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.

2. All cell toilet cubicle doors of the type identified in the book of photographs which forms Crown Production 16 (photographs 22, 24, 30 - 35), and which are of the same or equivalent design as the door used as a ligature anchor point by Jack, should be removed from standard cells occupied by young prisoners in Polmont and either replaced with doors of an anti-ligature design, or modified so as to materially reduce the ligature anchor point risk which they present.

3. 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 within 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.

4. **When a chronic or habitually drug using prisoner is removed from MORS they should be the subject of a suicide risk assessment under TTM. That assessment should involve a review of any previous TTM and MORS records and follow a standardised, approved process. The outcome of the assessment should be recorded in a prescribed form, and stored in an accessible format. TTM and MORS should be amended accordingly.**

5. **TTM Guidance and training materials should be amended to make express reference to, and provide greater emphasis on, the heightened risk of suicide by a young prisoner who abuses drugs whilst in Polmont. In particular these materials should be amended so as to direct staff of the need to take account of chronic or habitual drug use by a young prisoner in assessment of their suicide risk.**

6. **A visual hatch check, around one hour before the end of the night shift, should be reintroduced at Polmont, in order to seek to ensure that all young prisoners are safe and well within their cells at this time.**

7. **SPS should review the instructions given to staff at Polmont regarding active patrolling of residential halls during patrol and night shifts. In the**

context of this review SPS should seek to identify ways to better reduce, at night, abusive and bullying verbal behaviour, drug dealing, and to respond to physical disturbances by prisoners within their cells. This review should also consider the adequacy of present staffing levels for this purpose. It should be completed within 6 months of the date of this determination, and a written report made to Scottish Ministers.

(C) THE INQUIRY – PROCEDURE AND EVIDENCE

[1] This fatal accident inquiry ("FAI") concerned the death of Jack McKenzie. He died while in lawful custody at Polmont and, therefore, an inquiry into his death was mandatory in terms of section 2(4)(a) of the 2016 Act. The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017, SSI 2017/103 ("the 2017 Rules") and was an inquisitorial process.

[2] The First Notice of the inquiry was lodged on 3 November 2023. Following discussions at a preliminary hearing on 9 April 2024 I directed that the main issues for the inquiry would be: (i) the supply and consumption of controlled drugs in Polmont in and around September 2021, and the ongoing efforts to control and prevent such practices (but only insofar as these matters were relevant to Jack's drug use and the extent to which this may have contributed to his death); (ii) the adequacy and operation of MORS, and its connection to TTM, with particular reference to assessments carried out on Jack in Polmont on 1 and 2 September 2021, and having regard to his drug use and any other factors which may have increased

his risk of suicide; (iii) the adequacy and operation of policies, guidance and local procedures in place in Polmont in September 2021 in relation to the number and nature of cell checks to be carried out by residential officers and night shift staff, with particular reference to the checking of Jack in his cell on the night of 2 to 3 September 2021; and (iv) the adequacy and operation of the SPS approach to ligature reduction within Polmont, and its connection to TTM and MORS, with particular reference to the ligature and ligature anchor point used by Jack on the night of 2 to 3 September 2021.

[3] Importantly, therefore, this was not in any general sense an inquiry into the availability and use of controlled drugs in Scottish prisons, nor of the success or otherwise of the efforts of SPS to prevent it. These issues were relevant only if, and insofar as, it was established that drug use caused or contributed to Jack's death. Nor was this an inquiry into the general adequacy or otherwise of the TTM or MORS policies or their implementation. Again, this was relevant only insofar as it was at least relevant to Jack's death, or where changes to the policies might realistically prevent other deaths in similar circumstances to his.

[4] Although at the time of this inquiry I was also engaged in the ongoing FAI into the deaths of Katie Allan and William Brown in Polmont in similar circumstances, ("*Allan & Brown*")[2], no motion was made to conjoin the inquiries. There was however significant overlap between them, particularly in relation to

[2] *Determination of the Inquiry into the deaths of Katie Allan and William Brown* (FAL-B19/23) [2025] FAI 1.

anti-ligature issues and the actions and/or inactions of SPS in relation to these. There was therefore much repetition of the evidence led on this topic over the two inquiries, both as regards oral testimony and documentary material. Although the particular facts and circumstances of the cases differed, on matters of principle I have found no good reason to depart from or significantly modify the views on anti-ligature issues which I expressed in the *Allan & Brown* determination. Where possible, therefore, and with a view to shortening the present determination, I have sought to refer to and adopt what I said in *Allan & Brown* – in particular so as to try to focus on other issues particular to Jack's case.

[5] The evidential hearing took place over 9 days between 2 July and 12 July 2024. At this hearing I heard oral evidence from the following witnesses:

1) Kenneth Fyall, prison officer, who restrained Jack and called for a nurse to attend on him pursuant to MORS on 1 September 2021, and discovered his body on the morning of 3 September 2021;

2) Robert Hall, prison officer, who interacted with Jack on 2 September 2021, and assisted Officer Fyall following the discovery of Jack's body;

3) Denise Swift, prison officer, who interacted with Jack on 2 September 2021 and was one of the last officers to see him alive at lock up that afternoon;

4) Jade Forsyth, prison officer, who was on patrol shift in Monro Hall between around 1800 and 2100 hours on the evening of 2 September 2021,

and noted buzzer activity from cell 4/56 at around 2030 hours suggesting that Jack was present in the cell and alive at that time;

5) David Nelson, prison officer, who was on nightshift duty in Monro Hall on 2 to 3 September 2021 and who did a hatch check at Jack's cell at around 0637 hours on the morning of 3 September 2021;

6) Zaira Afzal, prison officer, who was on duty in Monro Hall with Officer Nelson on the night of 2 – 3 September 2021;

7) Zara Stevely, mental health nurse, who attended on Jack on 1 September 2021 and who made him subject to observations under MORS;

8) Maurice Long, a former agency nurse who attended on and assessed Jack after Nurse Stevely, and who reduced the frequency of observations;

9) Adam Elliot, a friend of Jack's, who was accommodated with him in Monro Hall and who spoke to Jack's drug use, threats made to him regarding a drug debt, and of hearing disturbance from his cell on the night of 2 to 3 September 2021;

10) Marianne Finnon, substance abuse caseworker with the Prisons Healthcare Addictions Service ("PHAS"), who attended on Jack for harm reduction sessions in February, March and July 2021, and attempted unsuccessfully to meet with him on 2 September 2021;

11) Elizabeth Forrester, staff nurse, who removed Jack from MORS observations on the afternoon of 2 September 2021;

12) Steven Blunt, mental health nurse, who carried out a TTM Reception Risk Assessment ("RRA") on Jack when he was admitted to Polmont on 25 January 2021 and determined at that time that he was at no apparent risk of suicide;

13) Rosemary Duffy, patient relations nurse and former clinical manager, who was the Forth Valley Health Board ("FVHB") representative on the DIPLAR into Jack's death;

14) Dr Craig Sayers, prison GP and Scottish Government clinical lead, engaged in redrafting the MORS policy;

15) Lesley McDowall, head of Survivors' Support for Scottish Government, and former SPS Head of Health Strategy, who spoke to policy issues relating to TTM and MORS;

16) Gordon McKean, architect, Head of SPS Technical Services, who spoke to ligature prevention issues and his Ligature Anchor Point Review ("the LAP Review") carried out at Polmont in November 2018;

17) Gerry Michie, Governor of Polmont since 30 August 2021, who spoke in particular to the decisions not to discipline Officers Nelson and Afzal in relation to the hatch check at Jack's cell on the morning of 3 September 2021, and to subsequently remove the requirement on night shift staff to carry out such checks.

18) Joanne Caffrey, expert witness and trainer in ligature prevention issues, who spoke to her report of 27 May 2024 (now Crown Production 20) and anti-ligature issues more generally;

19) Stephen Morrison, prison officer, who was Jack's personal officer. He on duty on the morning of 3 September 2021 and assisted following the discovery of Jack's body;

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

21) Sue McAllister CB, retired, former prison governor, area prison manager, director general of the Northern Ireland Prison Service, and Prisons and Probation Ombudsman, who spoke to her report of May 2024 (now Crown Production 19);

22) Duncan Alcock, consultant forensic psychiatrist, who spoke to his report of 22 March 2024 (now Crown Production 18); and

23) Laurence Tuddenham, consultant forensic psychiatrist, who spoke to his report dated 19 May 2024 (now FVHB Production 10).

[6] Affidavits taken from the following further witnesses were also available for the inquiry:

1) Caroline Wright, Jack's aunt; and

2) Stephen MacKenzie, Jack's brother.

[7] Statements taken from the following further witnesses were agreed by the participants as also being available for the inquiry without the need to be adopted in oral evidence:

1) Dr Kerryanne Shearer, consultant forensic pathologist, who carried out Jack's post-mortem and later commented on the scientific evidence relating to the timing of his death;
2) Dr Peter David Maskell, Forensic Toxicologist, who reported and commented on the drugs found in Jack's body post-mortem;
3) Fiona Cruickshanks, SPS Head of Operations and Public Protection, who produced SPS policies and procedure documents in relation to the prevention of managements of illicit drugs;
4) Laura Semple, mental health nurse, who attempted unsuccessfully to offer Jack mental health support in August 2020, and was in attendance at his cell on the morning of 3 September 2021;
5) Steven Pritchard, Paramedic, Scottish Ambulance Service, who attended on Jack following the discovery of his body on 3 September 2021;
6) Ewelina Sneddon, former caseworker with the PHAS, who attempted unsuccessfully to engage Jack with addictions services in July 2020 and discussed his mental health with him at that time;

7) Emma Jenkins, healthcare support assistant, who accompanied Elizabeth Forrester when she attended on and removed Jack from MORS on 2 September 2021;

8) Gregg Pearson, Head of Professional and Technical Services, SPS, who was part of the team led by Gordon McKean who carried out the LAP Review at Polmont in November 2018;

9) Richard Coupe, Head of Public Protection at SPS HQ, who described the background to drug use in Scottish prisons, how they are brought in, and the means used to seek to control this, in 2021 and now. He also described the procedures for searching of prisoners, cells, visitors and staff for drugs;

10) Robert McAinsh, Head of Operations and operational lead for MORS at Polmont, who described similar issues to those described by Richard Coupe, but more specifically in relation to their application to Polmont;

11) Sharon Holloway, Development Manager, Highland Alcohol and Drugs Partnership, and formerly seconded to SPS with a remit to develop alcohol and drugs strategy, who spoke to the MORS policy and changes to it since 2021;

12) William Simpson, prison officer and acting First Line Manager ("FLM"), who interacted with Jack in Monro Hall on 1 and 2 September 2021 and saw him just before lock up on the latter date; and

13) Andrew Brolly, former prisoner, who knew Jack and was detained in Monro Hall in the cell next to him on the night of 2 to 3 September 2021.

[8] Two lengthy joint minutes were agreed by all the participants and read into the record:

1) Joint minute number one, dated 2 July 2024, which agreed many matters relating to Jack's personal details and medical history, his time in Polmont, his death, post-mortem, and the DIPLAR 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, also dated 2 July 2024, which agreed facts in relation to controlled drugs in prison settings, including controls by way of prisoner and cell searches, visits, prisoner mail, deliveries, throw overs, and testing.

[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 total the documentary productions ran to more than 4000 pages.

[10] At the conclusion of the evidential hearing on 12 July 2024 a timetable was agreed for lodging written submissions. These were later produced and ran to a

total of around 200 pages. No participant sought an oral hearing on these submissions. I gave leave to lodge supplementary written submissions to address contentious points in the other participants' written submissions. None were received. On 23 September 2024 I reserved my determination.

[11] In the inquiry the Crown was represented by Ms Cross, senior advocate depute, assisted by Mr Halliday, advocate. Caroline Wright, Jack McKenzie's aunt and next of kin, was represented by Mr Lamb, KC, assisted by Mr McGowan, advocate. Ms Davie, KC, assisted by Mr Dundas, advocate, represented FVHB. Mr Ross, KC, assisted by Ms Arnott, advocate, represented SPS and the Scottish Ministers ("SM"). Mr Kennedy, advocate, represented the Scottish Prison Officers Association ("SPOA").

[12] 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 logistical and practical difficulties which arose.

(D) LEGAL FRAMEWORK

[13] 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.

[14] 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."

[15] I have set out my understanding of the approach which the court should take to the various legal issues arising from this provision, with particular reference to deaths of young prisoners by suicide, in the determination following *Allan & Brown*: see [2025] FAI 1, at paragraphs 15 - 33. I adopt what I said in these paragraphs without repeating them. Where further comment is necessary on legal issues relevant to the particular facts and submissions in this case it is set out below in the analysis of the statutory findings and recommendations.

(E) FINDINGS IN FACT

Introduction

[16] 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 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

[17] In 2021 Polmont was the national Scottish detention facility for young male offenders aged between 16 and 21. Since the coming into force of the Children (Care and Justice) (Scotland) Act 2024 males aged 16 and 17 are no longer detained in Polmont. Brenda Stewart was the Governor of Polmont between April 2017 and November 2021. Gerry Michie was acting Governor in charge from August to September 2021, when he became interim Governor. He was formally appointed as Governor in Charge in January 2022. He was still the Governor at the time of this inquiry.

[18] There are two main accommodation blocks for young males in Polmont: Iona and Monro Halls. Monro Hall is split into 4 levels which accommodate different parts of the prisoner population. In 2021, level 4 accommodated offence and non-offence protection young male prisoners, aged between 18 and 21. This included prisoners remanded in relation to charges of serious sexual offending.

[19] There is a Separation and Reintegration Unit ("SRU") in Polmont called Dunedin. This is for young males. Prisoners may sometimes, but not always, be transferred from a residential hall to the SRU when subject to removal from association with other prisoners under rule 95 of the Prisons and Young Offenders Institution (Scotland) Rules 2011, SSI 2011/331 (as amended) ("the Prison Rules").

Staffing and shift patterns

[20] Ordinarily, between Monday and Friday, there would be three prison officer shifts. These are (i) the early shift from 0630 hours to 1230 hours; (ii) the late shift from 1200 hours to 2130 hours, and (iii) the night shift from 2100 hours to 0645 hours.

[21] In 2020 the prison regime was modified to prevent the spread of COVID-19. A more restrictive regime was put in place, with less out of cell time for prisoners. The COVID-19 staffing regime was still in place as at September 2021. There was a day shift from 0730 hours to 1800 hours 7 days a week. A short patrol shift was in place from 1800 hours until night shift commenced at 2100 hours. There was no recreation or visiting permitted in the evening. During the patrol and night shifts, prisoners were locked in their cells. Cells would only be opened for an emergency or welfare issue. Between 0730 hours and 1800 hours there would be four members of staff on each level of Monro Hall. They would all report to a FLM located on level 2. During the patrol and night shifts two officers covered all four floors of Monro Hall. Their duties included responding to prisoners' buzzers and patrolling the halls.

[22] Polmont returned to the pre-COVID-19 staffing and shift regimes from October 2021.

Polmont patrol duty orders

[23] Instructions were issued by the Governor to prison officers carrying out duties during patrol and night shifts. In September 2021 these were, in particular, contained in the Patrol Orders, which had last been revised in 2020.

[24] These instructions required, among other matters, that night shift staff carry out a visual hatch check of each cell prior to finishing their shift, to ensure that all young prisoners were safe and well. The requirement to carry out a hatch check at this particular time was unique to Polmont. It may have been instituted as the result of a recommendation following inquiry into the death of a young prisoner. It has been discontinued since September 2021.

[25] All standard cell doors in Monro Hall have a small window in them, with a metal cover. A hatch check involves opening the cover and looking into the cell through the window so as to observe the prisoner within.

[26] If a cell requires to be unlocked during a patrol or night shift, a minimum of three staff must be present. Prison officers are not permitted to open or enter a cell on their own. If there is a need for a cell to be opened, a FLM should be contacted immediately.

Talk To Me suicide prevention strategy

[27] TTM is a multi-agency suicide prevention strategy introduced in December 2016 to replace a previous strategy known as Act2Care ("A2C")[3]. TTM operates in all prisons in Scotland.

[28] When a prisoner comes into a Scottish prison they should receive a RRA under TTM. A RRA should take place whether the prisoner enters the prison as a new admission, a transfer from another prison, returning from a court hearing (including a video hearing where the prisoner does not physically leave the prison), or from an external escorted visit (for example, attendance at a video identification parade). There are often two stages to an RRA: an assessment by a prison officer, and an assessment by a healthcare professional. A healthcare risk assessment should be carried out for an admission, transfer, or where the individual has returned from court as a convicted prisoner following a period on remand. In all other circumstances, a healthcare risk assessment is not required but can be requested if thought appropriate by SPS staff.

[29] The outcome of an RRA will be that the prisoner is either 'At Risk' or at 'No Apparent Risk' of suicide. Where a prisoner is assessed as being at risk of suicide, TTM is initiated and a care plan of protective measures is put in place immediately (typically, regular observations at a specified frequency). Thereafter a case

[3] I made extensive findings on TTM in *Allan & Brown*: see [2025] FAI 1 at paragraphs 94 – 147, 507 – 524. It is unnecessary to repeat these in the present determination, in particular given the different focus of this inquiry, although reference can be made to them for the wider picture they present. What follows is a shorter summary of the main provisions of TTM with particular relevance to Jack's case.

conference will be convened within 24 hours to review the prisoner's risk and determine future care planning (if required).

[30] Following admission, and throughout the period in which they are detained in prison, TTM envisages ongoing and dynamic suicide risk assessment by all those staff with whom the prisoner comes into contact. TTM can be initiated at any time by any member of staff who is trained in the TTM Strategy. If a member of staff considers at any point 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. Again, a protective care plan is put in place pending a case conference.

[31] Where a prisoner is observed to be in distress, but not considered to be at risk of suicide, a pro forma concern form should be completed, to inform ongoing suicide risk assessment, and to ensure that information relevant to it is collated in a single, accessible repository and format.

[32] TTM provides guidance to staff on assessment of suicide risk. In doing so it acknowledges certain high risk categories of prisoners, including persons with a "history of substance misuse including alcohol". TTM training materials identify "key indicators" that a prisoner may be at risk of suicide. These include that they "are suffering from withdrawals (drug or alcohol)". Healthcare factors are highlighted, including "history of drug/alcohol abuse". These training materials also suggest "events and triggers" for suicide, which include "immediate, or near, completion of drug detoxification", and if the prisoner is "still in withdrawals".

Against this background staff are trained to look for verbal and non-verbal cues and clues that a prisoner may be at risk of suicide. The non-verbal cues include "anger and aggression (especially young people)" and "self-harm behaviour" - although these cues are not expressly linked to drug abuse.

[33] 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: (i) TTM Conversion Training for staff who had completed core A2C training; (ii) TTM Core Training delivered to all new staff; (iii) TTM Awareness Training for those who do not have unescorted access to prisoners; (iv) TTM Refresher Training, which must be completed by staff at least once every 3 years. This refresher training is classroom based and lasts for 2 hours.

[34] SPS is responsible for implementation of TTM. The National Suicide Prevention Management Group ("NSPMG") is a multi-disciplinary steering group with overall governance responsibility for TTM. Its membership includes representatives from SPS, NHS Health Boards, Public Health Scotland, Families Outside, Breathing Space, and the Samaritans.

[35] The remit of the NSPMG is (i) to monitor and review TTM strategy; (ii) review all self-inflicted deaths in custody and monitor progress against any actions identified through the DIPLAR process; (iii) review all FAI determinations and monitor any actions identified for SPS; (iv) monitor local activity and issues and agree any actions or changes to policy that are required; (v) monitor national compliance with suicide prevention training; (vi) identify and agree any changes to

prison facilities to improve the safety of at risk people in prison; (vii) communicate any changes to suicide prevention policies within the community and agree actions where there are implications for SPS, and (viii) commission research to provide evidence and inform future review of the TTM strategy.

Management of an Offender at Risk due to any Substance

[36] The MORS policy was introduced in December 2014 and is set out within a SPS management instruction with reference GMA 079A/14. MORS is not derived from statute or the Prison Rules. It is a national, operational SPS policy. It sets out a guided process for prison staff to follow which seeks to ensure that prisoners at risk due to illicit substances are appropriately managed and receive an appropriate level of care, so as to ensure preservation of life. Although it refers to "offenders", the policy is equally applicable to remand prisoners. There is nothing equivalent to MORS in prisons in England and Wales. It provides a formalised, structured system for management of those at risk from drug use and is of benefit for this reason. It is generally fit for its purpose, and generally effective to achieve it.

[37] MORS is directed, in particular, to the potentially acute adverse effects on a prisoner's physical health from ingestion of drugs, for example and most typically, resulting from an overdose. It is not expressly concerned with any acute or long term effects on a prisoner's mental health resulting from drug use, nor with treatment and/or support to reduce ongoing drug use by the prisoner. It does not refer to nor seek to address any increased risk of suicide arising from a prisoner's

drug use, and so does not provide guidance in relation to this. It makes no express reference to TTM, and nor does TTM make reference to it.

[38] During normal working hours the MORS procedure is as follows. Where a member of prison staff suspects that a prisoner is at risk due to ingestion of an illicit substance, including a controlled drug, that member of staff should complete an observation referral (the form at Appendix A of the guidance), notify healthcare staff, and request their attendance. A member of healthcare staff - normally a nurse - should immediately attend and assess the prisoner.

[39] FVHB have issued a Standard Operating Procedure ("SOP") in relation to MORS assessments. In September 2021 this provided that the nurse who attended on the prisoner should carry out a baseline set of assessment of vital signs and observations, assuming that it was safe to do so (ie, blood pressure, pulse, respirations, oxygen saturation, temperature, neurological observations in line with Glasgow Coma Scale). The prisoner could also be asked to provide a sample of urine for drug screening for health care purposes, and/or to identify or confirm any substance taken.

[40] The nurse was also required to complete the form at Appendix C of the MORS guidance. When completed this should provide written details of an appropriate care plan for the prisoner, including in particular the frequency with which they should be observed by prison staff, the type of observation (verbal or visual response, or both), and when they would be further reviewed by healthcare staff.

[41] Prison officers were thereafter required to carry out observations in accordance with the care plan, and record these on the form at Appendix D of the guidance. The purpose was to regularly monitor the prisoner's need for medical intervention. If their condition deteriorated, the observing officer was required to contact health centre staff immediately. A completed written narrative of events was also to be made available by the officer at handover for the oncoming shift.

[42] Within 24 hours of being assessed by a nurse, MORS provides that a multi-disciplinary case conference should take place, arranged by the FLM and attended by a member of health care staff. This should decide and agree on the future management of the prisoner. This should be documented on the form at Appendix E of the guidance. However when and if healthcare staff were satisfied that the offender was no longer at risk due to any substance, they would be removed from MORS and observations would be discontinued. Prison officers could not themselves make this decision.

[43] In 2021 it was standard practice for a prisoner to remain on MORS observations for 24 hours. However this was not compulsory. A prisoner might be reviewed and MORS observations ceased within this period if they were assessed as no longer being under the influence of substances. Alternatively a longer period than 24 hours might be considered appropriate, for example in relation to a chronic drug user, as a precautionary measure.

[44] Where a prisoner was suspected by a prison officer of being under the influence of drugs during a patrol or nightshift period, the officer should notify the

FLM, complete an incident form, and commence (and document) visual observations every 15 minutes and obtain a verbal response every 60 minutes. The FLM should be informed, and out of hours medical assistance sought, if there were observed to be changes to the prisoner's presentation or their ability to give coherent and clear responses to questions. If necessary an emergency ambulance should be contacted. Healthcare services were be informed immediately from the outset of the following day shift, and a case conference convened by the FLM.

[45] No formal training on MORS was provided to prison officers or healthcare staff in post as at 2014. They were sent a copy of GMA 079A/14 and were expected to learn the policy on the job. Training on the MORS policy is however provided to new SPS staff as part of their general initial training at SPS College, which includes training on prisoner substance abuse. Healthcare staff are trained on the MORS policy as part of the induction process when they begin working in a custodial environment.

[46] In the absence of formal training for all SPS and healthcare staff there was and is inconsistency in practice in Polmont in their understanding of some aspects of MORS. This includes, in particular, whether there is a minimum period of time for which a prisoner should be kept under observations, who should complete the form at Appendix A, and exactly how observations should be carried out and/or recorded. The quality of the MORS documentation can be poor, with mandatory boxes left blank, care plans not completed, and poor or illegible handwriting. Where

this occurs it suggests a lack of recognition of the importance of record keeping, and of management action sufficient to audit and correct this.

[47] Where a prisoner has been placed on MORS observations, an FLM may consider whether they should be removed from association with other prisoners for up to seventy two hours in accordance with rule 95(1) of the Prison Rules. This may be necessary to maintain good order or discipline, to protect the interests of any prisoner, or to ensure the safety of other persons. However the mere fact that a prisoner is placed on MORS does not of itself necessarily require or justify the making of a rule 95 order. And even if such an order is made, it can and should be revoked within 72 hours if no longer necessary for any of the purposes set out in rule 95. This may be the position, for example, if and when the prisoner is removed from MORS.

[48] In February 2023 SPS issued GMA 007A/23, containing updates to the MORS guidance. It introduced a revised, and electronic, observation referral form and introduced new data recording and audit and monitoring requirements.

[49] In June 2023 SPS issued a standard operating procedure in relation to MORS with reference number OPS 044A. The purpose of this was to detail how staff within Polmont should support young people and women and proactively manage individuals suspected to be under the influence of an unknown substance. It contains guidance in relation to reducing the risk of second hand exposure to hazardous substances. It requires that, where a person is being managed under the MORS policy, an FLM should consider a review under the Prisoner Supervision

System; a mental health referral; a referral to PHAS; input from the prisoner's personal officer such as an Integrated Case Management meeting or a Positive Futures Plan; and/or contacting a Family Contact Officer.

[50] On 10 October 2023 Forth Valley Health Board updated their SOP in relation to MORS. This update provided further guidance on the practice to be followed at the end of a day shift due to there being no 24 hour nursing service within the prison environment.

[51] At the time of the hearing of the inquiry MORS was under review by both SPS and NHS. Dr Craig Sayers, clinical lead for the National Prison Care Network, had drafted a revised policy. Consideration had been given by him to various matters, including a scoring system as regards hospitalisation, details as to what verbal and visual observations should entail, and emphasising greater clinical control over MORS decision-making.

Prisons Healthcare Addiction Services

[52] In 2021 PHAS provided support to prisoners in Polmont who abused drugs and other substances. PHAS was operated by FVHB. Prisoners could self-refer into it, either by asking an officer or clinical member of staff, or by using a self-referral form. Those who chose to engage with PHAS were assigned a case worker, assessed, and a care plan would be drawn up.

[53] PHAS staff did not have any involvement with a prisoner while they were on MORS. However PHAS was notified of all the prisoners placed on MORS at daily

meetings. When a prisoner had been removed from MORS, PHAS would send them a letter containing harm reduction advice and offering their services. From March 2021, if the prisoner was put on MORS for a second time within a month, a second letter was sent. Where the prisoner was put on MORS for a third time, a PHAS worker would arrange a one to one meeting with the prisoner, and offer a referral.

[54] Where a prisoner did choose to engage with PHAS they would be subject to a wide ranging assessment by their allocated case worker. The prisoner's particular goals would be discussed – for example, complete abstinence, reduction in use of drugs, or a change in the particular drugs being used. A care plan would be drawn up, monitored and reviewed.

[55] PHAS was a voluntary service. A prisoner could refuse to be seen by a PHAS worker. There were also instances where a PHAS worker was unable to see a prisoner for operational reasons, for example a lockdown due to a disturbance, or short staffing on the hall. In this event the worker would diarise to come back and try again as soon as possible taking into account their own operational issues and caseload/workload**.**

Prison Records

[56] The SPS prison records system is referred to as PR2. This is a live, electronic prisoner management system. It should hold records relating to areas such as a prisoner's personal details, appearance, location history, sentence, case management,

risk and conditions, prisoner finance, prisoner visits, suicide prevention history etc. It is generally accessible by prison officers. It does not hold a prisoner's medical records.

[57] The healthcare recording system in Scottish prisons is known as VISION. In Polmont, VISION is administered by FVHB. It only contains health records generated while the prisoner is in prison. Community-based medical records must be specifically requested. SPS staff cannot access VISION.

[58] Prison officers can submit intelligence reports to the Intelligence Management Unit ("IMU") at Polmont, for analysis and recording as entries on a prisoner intelligence log. The information on such logs cannot be accessed by all SPS staff. It is only available to the IMU who may choose to share it with operational staff if and when this is deemed appropriate. Intelligence is graded for the reliability of the source, an evaluation of its veracity, and its handling sensitivity, that is, whether dissemination of it might give rise to a risk to any individual or whether the information is of a common knowledge within the prison.

Death in Prison Learning, Audit, and Review

[59] A DIPLAR is a process for reviewing deaths in prison in Scotland (not just suicides). It provides a system for the SPS and NHS to record any learning and identify actions following a death. The aim of a DIPLAR is to learn from the incident and consider the circumstances and the immediate actions taken. The

process also focuses on how the incident impacted on staff involved, other prisoners, the person's family, and the establishment as a whole.

"Spice", Etizolam and Flubomazepam

[60] Spice and Etizolam are controlled drugs which were particularly prevalent in Polmont in 2021 and abused by young prisoners detained there, including Jack. Spice is a common user name for a synthetic cannabinoid receptor agonist. It acts on the same receptors within the body as cannabis but is significantly more potent and exhibits more severe and diverse side effects. In particular, it exhibits cardiovascular and central nervous system effects more typically associated with drugs such as cocaine and amphetamine. The effect of a specific dose of Spice is unpredictable, and subject dependent. It can produce high blood pressure, high heart rate, irregular heartbeat, chest pain and even heart attack. It can precipitate seizures and strokes. Spice has also been associated with delirium, psychosis, hallucinations, paranoia and acute anxiety. Repeated administrations may induce sudden and unexpected intoxication, increasing the risk of accidental overdose.

[61] Etizolam is a benzodiazepine, that is, of the same class of drugs as valium. It is licenced for medical use in some countries but not in the UK. The reported effects of use include drowsiness, sedation and loss of coordination. With chronic use symptoms may include slurred speech, difficulty in concentration, poor comprehension, memory impairment, emotional lability, irritability and depressed

mood. Flubomazepam is also a benzodiazepine, not licenced for clinical use in the UK, and which can be expected to exhibit similar effects to Etizolam.

Jack McKenzie

Background

[62] Jack was born in Glasgow on 15 February 2001. Both his parents were drug users and Jack was taken into care shortly after his birth. From around 2002 he lived with his maternal grandmother. Jack's maternal uncle hanged himself in 2007. Jack's father and mother died drug related deaths in 2008 and 2010 respectively. His grandmother died of cancer in 2012. Thereafter Jack lived with his aunt, Caroline Wright, along with his older brother, Steven McKenzie.

[63] Jack's behaviour as a child was challenging and he was diagnosed with ADHD in 2012. He was prescribed medication for ADHD, but did not take it consistently. His treatment was regularly reviewed thereafter by the Child and Adolescent Mental Health Service ("CAMHS").

[64] In 2013 Jack was assessed by a clinical psychologist due to concerns regarding his learning ability. He was found to score in the average or low average range on standard assessment tests. These results did not indicate any global of specific diagnosable learning problems, nor the need for further cognitive assessment.

[65] Jack attended mainstream education until around 2016. Thereafter, in the course of 2017, he increasingly became involved in offending behaviour, often in the

company of peers and while under the influence of alcohol and/or drugs. His offending included assaults, vandalism, theft, carrying offensive weapons, possession of controlled drugs and road traffic offences. He was repeatedly granted bail, but repeatedly breached his bail conditions.

[66] In October 2017 Jack was assessed by Dr Leighanne Love, Clinical Psychologist. Dr Love noted that Jack's chaotic childhood, multiple bereavements, difficulties in expressing and regulating emotions, and an avoidant coping style, may have predisposed him to engaging in violent and antisocial behaviour. There were no concerns in relation to his mental health and no further input from CAMHS was thought to be required.

[67] In February 2018 Jack was discharged from CAMHS and his ADHD medication prescription discontinued. This was due to multiple missed appointments by him for the purpose of reviewing his earlier ADHD diagnosis, and information from Caroline Wright that Jack was no longer taking the medication in any event.

[68] Jack was first remanded to Polmont between 10 and 18 January 2018. In March 2018 he was made subject to a community payback order with supervision and unpaid work requirements. He failed to comply with this order.

[69] In May 2018, Jack was struck by a car and suffered left frontal contusions with subdural haematoma, multiple facial fractures, and a fractured wrist. He was admitted to hospital and treated as an inpatient for 7 days.

[70] Jack continued to offend, and his offending became more serious. He was remanded to Polmont for a second time between 10 and 25 January 2019, and for a third time on 23 May 2019. On this latter occasion he was subsequently sentenced to a period of detention, and as a result he remained in Polmont until released on 21 December 2020.

[71] On 25 January 2021 Jack again appeared in court. On this occasion he was charged with rape, sexual assault by penetration, and sexual assault, contrary to sections 1, 2 and 3 of the Sexual Offences (Scotland) Act 2009. He was refused bail and remanded to Polmont. He continued to be remanded there until his death on 3 September 2021.

Jack's cell

[72] On admission to Polmont in January 2021, and due to the nature of the offence with which he had been charged, Jack was allocated to a cell on the fourth floor of Monro Hall. From 20 April 2021 Jack was accommodated in cell 4.56. This was a standard cell[4]. It contained a toilet cubicle with a hinged, rectangular shaped, panel door. When closed, the gap between the top of the door and the cubicle door frame was around one centimetre. The top of the door was not horizontal but slightly sloped. The hinge was a continuous piano style hinge, running the length of the door. There was an observation hatch in the cell door. However almost all of

[4] As opposed to a Safer Cell: see *Allan & Brown* [2025] FAI 1 at paragraphs [67] – [72].

the toilet cubicle door, and the area directly in front of it, were not visible when looking into the cell through the hatch.

Visits

[73] Jack had only one visit while in Polmont in 2021, from two male friends. He did not want visits from his family. In around August 2021 he had telephone contact with his uncle, and also attempted to phone his brother without success.

Reception Risk Assessments

[74] Jack was subject to RRAs under TTM following his admissions to Polmont in January 2018, January 2019, May 2019 and January 2021. On each of these occasions he was assessed by a nurse (a different nurse on each occasion) as being at no apparent risk of suicide. On each occasion it was recorded in the RRA forms that he denied any history or current thoughts of suicide or self-harm. His previous history of ADHD was noted, and also that he was not then receiving nor wishing to receive medication for this condition. His use of illicit drugs was also recorded.

[75] Jack was also subject to RRAs following court appearances which took place whilst he was detained Polmont, including appearances which were conducted by live video link from within the prison. These RRAs took place in July 2019, February 2021, and July 2021. They were conducted by prison officers, who on each occasion assessed Jack as being at no apparent risk of suicide, and as denying any

history or current thoughts of suicide or self-harm. On none of these occasions was it considered necessary to obtain a further assessment from a nurse.

[76] Jack was also subject to RRA following his attendance at a video identification parade in Glasgow in January 2021. Again, this RRA was conducted by a prison officer, and again the assessment was that Jack was at no apparent risk of suicide and did not require further assessment by a nurse.

[77] On each occasion when Jack was taken to Polmont, whether from court or the video identification parade in January 2021, Prisoner Escort Records were produced in respect of him by security escort staff. None of these records contains any concerns that Jack was at risk of self-harm or suicide.

[78] Accordingly Jack was subject to RRA on four occasions during his final period of detention at Polmont between January and September 2021: on admission on 25 January, following attendance at the video identification parade on 28 January, and following his court appearances on 2 February and 1 July. In none of these assessments was Jack considered to be at risk of suicide. Nor was he so assessed at any other time during any of his periods of detention in Polmont.

Jack's use of controlled drugs

[79] By 2020 Jack was using cannabis on a daily basis when in the community. But controlled drugs were readily available to prisoners in Polmont throughout the periods when Jack was detained there between 2018 and 2021. Notwithstanding the efforts by SPS to prevent it, drugs were brought into the prison by various means

and exchanged or traded between prisoners[5]. Spice and Etizolam were, as noted, prevalent. While detained in Polmont Jack used both these drugs on a regular basis, particularly Spice.

[80] The prison officers working dayshift in Monro Hall in 2021 knew that Jack was a regular drug user, and he admitted as much to them. They warned him of the dangers of drug use, but he told them that he enjoyed it. They came to recognise when Jack had been abusing drugs. In general, they regarded him as jovial, quite pleasant, funny, likeable and talkative. However when under the influence of drugs he was known to become louder, angry, aggressive, erratic, agitated and anti-authority. He would also stop taking care of his cell, and it would become dirty and untidy.

[81] Jack was one of a number of prisoners in Monro Hall who regularly abused drugs, including Andrew Brolly and Adam Elliot. Mr Brolly occupied cell 4.57 located next door to Jack's cell, and Mr Elliot occupied cell 4.45, opposite Jack's cell across the hall. Along with other prisoners they would arrange for drugs to be brought into the prison and/or would trade or exchange them between themselves.

Placement on MORS

[82] Whilst in Polmont Jack was placed on observations under MORS on a total of 33 occasions. Nineteen of these occasions were during his period of detention

[5] Much detail regarding these matters is provided in the agreed statements of Richard Coupe and Robert McAinsh. For reasons later discussed, it is not necessary to set these out in this determination.

between May 2019 and December 2020. The remaining 14 occasions were during the period of his detention between January 2021 and September 2021, 6 of which were in July 2021[6]. Prior to September 2021, the last time that Jack was placed on MORS was between 24 and 26 July 2021. This was an unusually frequent use of MORS, indicating chronic or habitual drug use. Fewer than 10% of prisoners in Polmont in 2021 had been placed on MORS so many times.

Non engagement with PHAS

[83] PHAS sought to engage with Jack in relation to his drug use on multiple occasions between May 2019 and September 2021[7]. Although Jack met with addictions support workers occasionally, overall he was not willing to engage with the support being offered. Where sessions did take place, they were information giving sessions, rather than true counselling sessions, as Jack refused to accept this aspect of the service. Only on 23 July 2020 did he attend and engage with a PHAS support worker, Ewalina Sneddon. On that occasion they discussed Jack's mental health including his ADHD, and he also described hearing voices. He agreed to a mental health referral, but - as detailed below - failed to attend for further meetings, or to respond to a request to make contact. The voices Jack described hearing were transient symptoms caused by use of Spice, and are a known symptom of this drug.

[6] A schedule of all the occasions when Jack was placed on MORS between July 2019 and September 2021 is appended to the first Joint Minute.
[7] A schedule of all PHAS contact and attempted contact with Jack between May 2019 and September 2021 is appended to the first Joint Minute.

[84] Throughout his detention in Polmont, Jack was not motivated to stop using controlled drugs, and so was not willing or able to engage with PHAS to assist him to do so. Prior to September 2021, the last occasion on which PHAS attempted to engage with Jack was on 14 July 2021. On that date he attended a harm reduction session with Marianne Finnon, a substance abuse caseworker. Jack again declined a formal referral to PHAS. Ms Finnon had earlier met with Jack on 23 February and 9 March 2021, with the same result. He had declined to see her on 21 and 30 March 2021.

Mental health services

[85] Mental health services within Polmont also sought to engage with Jack on more than one occasion. For example on 10 August 2020 Mental Health Nurse Ailsa Russell attempted to see Jack in connection with the referral made by Ewalina Sneddon on 23 July 2020. Jack refused to engage, declining to attend the appointment. On 11 August 2020 Mental Health Nurse Laura Semple attempted to carry out a mental health assessment for Jack. Jack again refused to be seen. As a result, Nurse Semple spoke to him at his cell door. Jack denied any mental health issues or concerns, attributing the mental health referral made on 23 July 2020 to Ms Sneddon. Jack said to Nurse Semple that he had ADHD however did not wish to discuss this or receive support from the mental health team. Nurse Semple advised Jack that he could complete a referral to the mental health team should he

require it. He did not do so. Nurse Semple noted that staff reported no concerns regarding Jack, other than that he was a regular drug user.

Other health service contact

[86] Between May 2019 and September 2021 Jack was seen by medical staff on various occasions due to disruptive behaviour. On 17 July 2019, 4 October 2019, 12 February 2020, 26 March 2020, 13 September 2020, 14 September 2020, and 14 August 2021 Jack was seen by health centre staff after being involved in altercations with other prisoners. On 29 November 2019 Jack was seen by Nurse Aileen Alexander after an unspecified incident which caused a red graze to the outside area of his right eye. On 18 March 2020 Jack was seen by Nurse McBeth due to him sustaining injuries to his hands whilst attempting to climb a fence in the exercise yard. Jack's wounds were treated and dressed. On 7 October 2020 Jack was seen by Nurse Curtis following another incident where he attempted to climb a fence. On 9 June 2021 Jack was seen by Nurse Livingston after punching a wall in his cell.

Jack and TTM

[87] Notwithstanding the various formal RRAs to which he was subject under TTM, and the numerous occasions when he came into contact with other healthcare, support and prison staff, all of whom were trained in TTM and authorised to initiate it, at no point during any of his periods of detention in

Polmont was Jack placed on TTM. No member of staff with whom he had contact over a total of more than 2 years in Polmont assessed him as being at risk of suicide.

Discipline

[88] Jack was subject to multiple reports for breaches of discipline throughout his periods of detention in Polmont. He was placed on report three times for assault and four times for fighting. Officers received intelligence in May 2021 to the effect that Jack was involved with other prisoners in bullying and targeting weaker prisoners within the hall, including in relation to use of drugs.

Events of 1 September 2021

[89] On 1 September 2021 Andrew Brolly returned to Monro Hall after a period in which he had been detained in the SRU. He knocked on Jack's cell door, and spoke to him through the hatch. Jack appeared to Mr Brolly to be under the influence of drugs. He asked about this, and Jack told him that he had taken Etizolam.

[90] At approximately 1415 hours on 1 September 2021 prison officers in the hall observed Jack in an angry and agitated state. He was adamant that he should have been at court that morning. In fact his case was calling in court in Glasgow for a procedural hearing that day, but with his lawyer alone in attendance. Officer Kenneth Fyall suggested that Jack phone his lawyer. Jack went to one of the telephones in the hall, but shortly afterwards was heard shouting and seen smashing the receiver against the wall. He then moved to another telephone and did the same.

He was asked to return to his cell, but he refused to do so. Officers Fyall and Robert Hall then restrained him and physically returned him to his cell.

[91] Officer Fyall suspected that Jack was under the influence of drugs. He used his radio to request the attendance of a nurse. Nurse Zara Stevely was already in the hall in relation to another prisoner, and so attended on Jack to carry out a MORS assessment. She was not able to carry out a full assessment in accordance with the FVHB SOP because she did not have all the necessary equipment with her at that time, and because Jack was too agitated and aggressive to be fully assessed. Nurse Stevely was told by officers that Jack's behaviour was characteristic of him having taken drugs. She thought that his presentation (slurred speech, not steady on his feet, not orientated to time and place, unable to obey simple commands) could at least in part have been due to drug use. Accordingly she placed Jack on MORS at 15 minute observations until he could be fully assessed, indicated that he should be re-assessed twice daily. She completed the paperwork to this effect at 1430 hours. Thereafter Nurse Stevely left the hall.

[92] Around 15 minutes later Nurse Maurice Long attended on Jack to fully assess him. He waited until Jack had calmed down and physically examined him. Nurse Long found that Jack was lucid in speech, and that his heart rate was within normal limits, which was inconsistent with him having taken Spice. Accordingly Nurse Long did not consider that Jack was under the influence of drugs, but was more likely just angry about not being taken to court and/or not seeing his solicitor. But Nurse Long was concerned about Jack's emotional state. He varied the

15 minute observations directed by Nurse Stevely to 60 minutes observations instead, and wrote this on the MORS form.

[93] In the circumstances, Nurse Stevely's decision to place Jack on MORS was appropriate, as was Nurse Long's decision to maintain him on it.

[94] At 1509 hours Officer Andrew Elder completed paperwork authorising that Jack be removed from association with other prisoners in accordance with rule 95(1) of the Prison Rules. The reason for the order was stated to be because:

> "[Jack]…has become non-compliant and appears under the influence of an unknown substance and has also been involved in a relocation today by staff using C + R techniques due to his behaviour and aggression. I hereby request that he is placed under R95 conditions pending an orderly room appearance."

This order would have expired at 1509 hours on 4 September 2021, unless earlier revoked by the Governor. Given Jack's aggressive and violent behaviour towards the hall phones and prison officers, making this order and removing him from association was appropriate.

[95] At 1530 hours Officer Fyall completed paperwork preferring a charge of a breach of discipline against Jack in terms of rule 110 and schedule 1, paragraph 12 to the Prison Rules. The specific charge was that Jack had disobeyed Officer Fyall's lawful order for him to return to his cell following the incident at the telephones around 1415 hours, leading to his being restrained.

[96] At 1600 hours Officer Bill Simpson completed paperwork preferring a charge of a breach of discipline against Jack under paragraph 7 of schedule 1 to the Prison Rules. The specific charge was that Jack had recklessly endangered the health or

personal safety of others by being found to be under the influence of an unknown substance at 1430 hours by a nurse who had placed him on 60 minute observations.

[97] At around the same time, 1600 hours, Officer Simpson gave Jack a copy of the rule 95 order. While subject to this order Jack was confined in his own cell rather than removed to the CSU, or to a different, "sterile" cell within the hall. Notwithstanding the concerns that he may have been under the influence of drugs, neither Jack nor his cell were searched for the presence of further drugs before confining him within it.

[98] By between around 1630 and 1700 hours Jack had calmed down sufficiently to apologise to the prison officers for his earlier behaviour. He was allowed out of his cell to use the shower. By 1730 hours, when Officer Fyall went off shift, Jack was acting normally again.

[99] Jack was not further reviewed under MORS in the afternoon or evening of 1 September 2021 notwithstanding Nurse Stevely's care plan. However MORS observations at 60 minute intervals were carried out in accordance with Nurse Long's instructions.

Events of 2 September 2021

[100] At around 0730 hours on 2 September 2021 Officer Denise Swift unlocked Jack's cell along with Officer Simpson. Jack was in bed. The contents of the shelves of his cell had been pulled down. Jack was woken up and asked what had happened. He said that he could not remember. He did not appear to be under the

influence of drugs. Officer Swift spoke to Jack after breakfast and he asked for a mop and bucket to clean his cell. This was provided and Jack cleaned and tidied his cell over the course of the morning. He appeared to Officer Swift to be his usual self.

[101] Meantime Officer Simpson had noticed that the glass observation hatch of Jack's cell had been smashed. At 0800 hours he completed paperwork preferring a further charge of a breach of discipline against Jack, this time in terms of paragraph 17 of schedule 1 to the Prison Rules. Specifically he was charged with destroying or damaging any part of the prison or prison property.

[102] Officer Swift carried out the 60 minute MORS observations of Jack throughout the morning. Officer Simpson completed the relevant paperwork indicating that this had been done. Although there was no indication that Jack was by then under the influence of drugs in the course of the morning, there was no attempt to have him reviewed and removed from MORS. In common with other officers, Officers Simpson and Swift erroneously believed that a prisoner placed on MORS would require to remain subject to observations for a minimum of 24 hours.

[103] At some point in the morning of 2 September 2021 Marianne Finnon attended at Monro Hall in an attempt to meet with Jack. She did so because PHAS had been made aware that he had again been placed on MORS the previous day, and might by then have been removed from it. She was told by Officer Simpson that she was unable to see Jack because he was still on MORS and because of his behaviour. Accordingly no meeting between Ms Finnon and Jack took place.

[104] At 1430 hours on 2 September 2021 Nurse Elizabeth Forrester attended on Jack in Monro hall, along with Emma Jenkins, a healthcare assistant. The purpose of the visit was for Ms Forrester to review Jack under MORS. She had previously assessed him when he was on MORS, twice in 2020 and three times in 2021 - including only a few weeks earlier. Jack came out of his cell and they had a discussion at a table in the hall lasting several minutes. Jack made good eye contact. He was still angry as he believed that he had missed a court date the previous day which would have resulted in him being released from Polmont. He spoke about "getting his act together" when he got back in the community, and about steering clear of drugs. Having assessed and examined him, Nurse Forrester did not consider that Jack was then under the influence of drugs. He seemed physically well. He denied that he had more drugs available to him. Accordingly Nurse Forester removed Jack from MORS and observations were discontinued.

[105] Ms Forrester was trained in TTM, and was a very experienced primary care nurse. In her career she had placed prisoners on TTM around a hundred times, had attended TTM case conferences, and was familiar with the TTM policy and procedures. She considered it appropriate to ask Jack directly whether he would harm himself, and he denied that he would. Nurse Forester did not detect any non-verbal cues or clues that Jack might be at risk of suicide. Although angry about missing his court appearance, he presented as upbeat, and showed no signs of mental ill health. From her interactions with Jack, Nurse Forrester did not consider

that he was at risk of suicide. Had she thought that he was, she would have placed him on TTM.

[106] Jack had an appointment to meet his solicitor at 1500 hours. However although he had now been removed from MORS, he was still removed from association with other prisoners under rule 95. Accordingly he was not permitted to attend the meeting with his solicitor, which caused him anger and upset. It is unclear which officer made this decision, or why. Prisoners subject to rule 95 are not thereby ineligible to speak to their lawyers. In any event Jack was no longer considered to be under the influence of drugs and his behaviour was "back to normal". Moreover his behaviour the previous day was linked to confusion or frustration at the legal process, which a meeting with his solicitor might have alleviated. The rule 95 order was not however revoked, as could have been done.

[107] Jack was allowed out of his cell to have a shower later in the afternoon. However, still angered by not being allowed to meet with his solicitor, he then refused to return to his cell. The hall manager was called and spoke to Jack. He then returned to his cell without further incident.

[108] Jack interacted with prison officers via his cell intercom after at around 1607 hours and 1632 hours. He was polite, and Officer Hall described the contact as a normal positive interaction. Jack began tidying his room. He asked for toastie as he did not like the dinner option. Officer Swift saw Jack at 1730 hours when carrying out her final checks before going off shift. Jack was calm. His cell was tidy. His demeanour was normal. He was sitting on his bed, watching television. None

of the officers who interacted with Jack in the afternoon of 2 September 2021 had any concerns for his wellbeing at that time, mental or physical. His presentation at that time gave officers no reason to consider that he was then at risk of suicide.

Patrol and nightshift, 2 to 3 September 2021

[109] Two patrol officers, one of them being Officer Jade Forsyth, commenced duty in Monro Hall at 1800 hours on 2 September 2021. Officer Forsyth attended at Jack's cell between around 2026 hours and 2030 hours and conducted a routine hatch check. Jack was observed by her to be present in his cell at this time. No signs of disturbance within the cell were noted by her.

[110] Officers David Nelson and Zaira Afzal commenced nightshift in Monro Hall at 2100 hours, taking over from Officer Forsyth and her patrol shift colleague. No written or oral note was passed to Officers Nelson or Afzal indicating any concerns in relation to Jack. Officer Nelson was an experienced prison officer of around 30 years' service. Officer Afzal was much more junior, having only around 2 years' service.

[111] Sounds of disturbance came from the area around Jack's cell between around 2330 hours on 2 September 2021 and 0300 hours on 3 September 2021. This disturbance consisted of shouting, verbal abuse and threats by a number of prisoners, including Jack and Andrew Brolly. There were also sounds of banging and smashing, consistent with damage being done to the fittings in a cell or cells.

[112] At some point during the night Jack consumed Etizolam. He also put his cell into a state of disarray, strewing items of clothing and other personal possessions around the desk and floor area.

[113] Officers Nelson and Afzal patrolled Monro Hall intermittently during the course of the night. Overnight noise from prisoners was common in the hall, and in Polmont generally. When the officers approached on patrol, the prisoners could hear them coming, and therefore any noise generally abated until they had gone elsewhere.

[114] At one point during the night Officer Nelson attended at the hatch of cell 4.55 in response to intermittent banging from within. Cell 4.55 was occupied by a prisoner who was another associate of Jack, and also a drug user. The door of cell 4.55 was about 20 feet away from the door of Jack's cell on the same side of the hall. Officer Nelson did not attend at the hatch of Jack's cell at this time.

[115] At around 0630 hours on 3 September 2021 Officers Nelson and Afzal began carrying out the hatch checks as required by the Patrol Orders prior to going off shift. Officer Nelson checked the west side of level 4 of Monro Hall, which included cell 4.56, and Officer Afzal checked the east side.

[116] Officer Nelson opened the hatch of Jack's cell at around 0637 hours. He saw that the cell was in a state of disarray. He could not see Jack. He called to Officer Afzal, and asked her to check the hall boards.

[117] In 2021 there were two whiteboards on level 4 of Munro Hall displaying information for prison officers: (i) a "numbers board" at the staff desk, which recorded the number of prisoners in the hall, and (ii) a "location board" or "work party board" which would display the location of each prisoner. This board would also record whether a prisoner was on rule 95, and whether they had been moved to a different location. Prisoner movements were also recorded in a diary on the staff desk.

[118] Officer Afzal checked the boards, and told Officer Nelson that Jack was listed on the locations board as being in cell 4.56, but that he was subject to rule 95 procedure. Officer Nelson assumed that Jack had been removed to the SRU, and so took no further action. He was wrong to do so. There was no good basis to assume that Jack had been moved to the SRU. If cell 4.56 was empty, then there was a discrepancy with the information on the boards, and thus in the prisoner numbers in the hall. If cell 4.56 was not empty, then Jack was not responding and potentially in need of assistance.

[119] Accordingly Officer Nelson should have taken steps to clarify Jack's location, such as telephoning the SRU to check if Jack was there. He could easily have done so. Had such steps been taken, Officer Nelson would have established that Jack ought to have been in his cell. He should then have sought the assistance of other officers and opened Jack's cell. Taking no further action was not a course which was reasonably open to him in the circumstances.

[120] Officer Afzal was also at fault. She had joint responsibility with Officer Nelson to ensure, in general, that the recorded prisoner number in the hall was correct before the end of the shift and, in particular, that Jack was safe and well at this time. She knew - or in any event ought to have realised - that Officer Nelson's question to her indicated that he had not seen a prisoner in cell 4.56 when checking the hatch. However she did not clarify this with him, nor question or query his decision to do nothing to check Jack's whereabouts, and in particular not to take steps to open his cell.

[121] Officers Nelson and Afzal went off shift shortly afterwards. They did not provide any handover note to the incoming dayshift officers, written or verbal, regarding what Officer Nelson had - in effect - assumed was a prisoner number discrepancy in cell 4.56. This was a further error, for which again both Officers Nelson and Afzal were jointly responsible.

Discovery of Jack's body

[122] Officer Kenneth Fyall came on shift at 0730 hours on 3 September 2021. At around 0736 hours he opened the door to cell 4/56 to conduct his start of shift numbers check. The cell was in a state of disarray. Officer Fyall saw Jack suspended from a ligature tied around his neck. The ligature was a torn strip of bedsheet one end of which was knotted and wedged into the gap at the top of the toilet cubicle door close to the hinge. Jack was sitting on a large square shaped bed box, resting on its side, located just outside the toilet cubicle door, which was closed.

[123] A bed box is a wooden box used to store personal belongings under the cell bed. Jack's bed box is shown in photographs 7, 10, 11, 12, and 21 of Crown Production 16. The ligature used by him is shown, in situ, in photographs 11, 12, 22, 23, and 30 of Crown Production 16.

[124] Officer Fyall alerted his colleagues. He removed the ligature from Jack's neck and moved him onto the bed. He felt for a pulse, but was unable to detect one. He commenced CPR. Healthcare staff, including Nurse Forrester, arrived shortly afterwards. They placed Jack on the floor and continued CPR.

[125] An ambulance crew comprising a paramedic, Stephen Pritchard, and a technician, arrived at 0751 hours. Having assessed Jack's condition Mr Pritchard indicated that resuscitation attempts should discontinue. He pronounced Jack's life extinct at 0757 hours.

[126] Jack's cell was secured pending the arrival of the police. At approximately 0808 hours Prison Officer Stephen Ballantyne covered the observation hatch to ensure the interior of the cell could not be seen from the hall. The covered observation hatch can be seen in photographs 10, 1 1, and 25 within Crown Production 16. It had not previously been covered.

[127] The police arrived at approximately 0914 hours and began taking witness statements. A scenes of crime officer arrived at approximately 1015 hours and took the photographs contained within Crown Productions 16 and 17. However prison officers had earlier disturbed the scene - including the location of the bed box - in

removing the ligature from Jack's neck and moving his body in an attempt to resuscitate him.

[128] After the scene had been photographed, at around 1031 hours, police officers entered Jack's cell. They left at 1110 hours. At around 1122 hours undertakers arrived to collect Jack's body.

Post-mortem examination

[129] A post-mortem examination was carried out on 10 September 2021 by Consultant Forensic Pathologists Dr Kerryanne Shearer and Dr Ralph BouHaidar. Their report, dated 12 January 2022, is produced as Crown Production 2. It contains a true and accurate record of the post mortem examination which they carried out.

[130] In particular, a ligature mark was observed around Jack's neck with the suspension point below his left ear. This ligature mark is shown in photographs 2, 3, 4, 5, 6, 7, and 10 of Crown Production 17. The cause of death was confirmed to be hanging. The internal examination revealed no significant abnormalities. The precise time of Jack's death could not be scientifically determined.

[131] Samples of blood and urine were taken during the post-mortem examination. On 1 October 2021 these samples were analysed for alcohol and drugs by Forensic Toxicologists Dr Peter Maskell and a colleague. Their report is contained within Crown Production 2. It contains a true and accurate record of the toxicological analysis carried out.

[132] In particular Jack's blood was found to contain 0.34mg per litre of Etizolam, 0.096mg per litre of Alpha-hydroxyetizolam (the metabolite of Etizolam), and 0.31mg per litre of Flubromazepam. The time when these drugs were consumed by Jack, could not be scientifically determined.

Officers Nelson and Afzal – post death investigation

[133] Following an incident such as a death by suicide in Polmont, prison officers with information about it would be asked to submit a written account to the Governor setting out their recollection of events. But there was no formal investigation or interview carried out by the Governor.

[134] In accordance with this approach, Officer Nelson was spoken to on an informal basis by Governor Michie following Jack's death. A principal purpose of doing so was to offer him support. Governor Michie recognised that Officer Nelson had been at fault for failing to conduct a proper hatch check at 0637 hours on 3 September 2021. However he believed that he was contrite and had learned from his mistake. No disciplinary action, reprimand, warning or sanction was taken against Officer Nelson. Governor Michie's decision not to do so was ratified at a senior level, by SPS Director of Prisons.

[135] Officer Afzal was also not disciplined, reprimanded, warned or sanctioned in relation to her failure to correct Officer Nelson's error, notwithstanding that she had joint responsibility with him for carrying out the hatch checks on 3 September 2021. Unlike Officer Nelson, Officer Afzal was not spoken to by Governor Michie at all.

[136] Officers Nelson or Afzal were not offered, nor required, to undertake additional training in relation to hatch check procedures.

DIPLAR

[137] On 15 November 2021 a DIPLAR was carried out in relation to Jack's death. This has been produced as Crown Production 10. The DIPLAR contains a list of "action points" which were considered to have arisen from the process. The action taken by SPS following the DIPLAR is recorded within SPS Production 59. The DIPLAR contained no reference to the means by which Jack had been able to hang himself, that is, to the particular ligature item and ligature anchor point used by him.

Prisoner suicide in Scotland[8]

[138] More than 120 prisoners died by suicide in all Scottish prisons in the years 2011 to July 2024. Hanging is by far the most common means employed, being used in around 90% of all cases.

[139] Ten young prisoners died by suicide at Polmont between 2010 and 2023. There has been at least one such death since then. All these young prisoners died by hanging themselves in their cells. Although the total numbers of deaths are relatively small, young prisoners are statistically at a substantially higher risk of

[8] I made extensive findings on this subject in *Allan and Brown*: see [2025] FAI 1 at paragraphs [427] to [446]. There is no need to repeat them here. What follows is a short summary, with particular relevance to Jack's death. The findings are based on the data available to the inquiries, but there are limitations to this data and caution must be exercised. Further research is required.

suicide, both as compared with older prisoners, and with young people not in prison.

[140] In the years 2015 to 2019 at least six prisoners in Scotland, including at least one young prisoner at Polmont, hanged themselves from their cell toilet cubicle doors. Since 2019 as many as a further twelve prisoners, including Jack, have also done so.

[141] None of the ten young prisoners who died by suicide at Polmont between 2010 and 2023 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.

[142] It is 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 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.

Polmont Ligature Anchor Point Review, November 2018[9]

[143] In November 2018 Gordon McKean, architect, then Head of Technical and Professional Services within the SPS estates department, was instructed by the Chief Executive to carry out a survey and review of ligature anchor points at Polmont. This had not been done before in SPS and there was no recognised methodology. However Mr McKean became aware that there were already policies, processes and procedures commonly in place across the NHS estate in relation to evaluating ligature anchor points as an aspect of suicide risk assessment - particularly in secure mental health settings. These were generally based on an anti-ligature assessment toolkit developed by Greater Manchester West Mental Healthcare Trust: the Manchester Took Kit ("MTK").

[144] Mr McKean recognised that the MTK approach could be adapted for use by SPS. At the end of November 2018, together with other SPS colleagues, he carried out a ligature anchor point survey at Polmont and produced a report, Sample Review of Ligature Anchor Points, HMYOI Polmont ("the LAP Review"). This attempted to apply the MTK ligature anchor point rating system to a random but representative sample of rooms within the prison, including cells in Monro Hall. It identified the presence of numerous fixtures or other items which could be used as ligature anchor points, including cell toilet cubicle partition doors.

[9] I made detailed findings in relation to this matter in the *Allan & Brown* determination, [2025] FAI 1 at paragraphs [458] to [487]. Reference should be made to these paragraphs and there is no need to repeat them here. What follows is a short summary of the findings which are particularly relevant to the present inquiry.

[145] Mr McKean and his colleagues did not survey cell 4.56 in Monro Hall. They did however survey very similar cells, including cell 4.37. In this cell nine ligature points were identified with a "high" category in terms of the MTK scoring system, including the toilet cubicle door, given the capacity for a ligature trap at the top of the hinge and its height from the floor (above 1.7 metres). Five further ligature points were identified with a "medium" category, and four with a "low" height category. Broadly speaking this cell could be regarded as high risk, applying the MTK ligature anchor point scoring system. Cell 4.56 would have had the same or similar score. These were both single occupancy cells. If a young, vulnerable prisoner was accommodated in them, without regular observation by staff, the resulting overall MTK scoring for the cell would have indicated the highest level of risk, calling for remediation as a matter of course.

[146] Replacement or modification of cubicle doors such as those in cell 4.56 could have taken a number of forms. The existing doors could have been replaced with doors with magnetic hinges, designed to detach were the weight of the prisoner's body applied to it. This product had been in existence since around 2012. The existing doors could have been replaced by saloon style doors, with a large gap between the top and the frame, so as to prevent a ligature being jammed into it. Such doors had been used in new prisons built prior to 2021 (such as HMP Stirling). Their cost was in the region of £1,200 each in 2018, although that cost will by now have risen substantially. Alternatively, the existing doors could have been modified, at lesser cost, by cutting a more pronounced slope on the top of the door so as to

prevent a ligature from being secured over it. The piano hinges could also have been covered or sealed so as to reduce the risk of a ligature being jammed into them.

[147] The LAP Review was submitted to the office of the Chief Executive of SPS shortly thereafter. In short summary, and for the reasons set out in his letter of 15 February 2019 to the then Cabinet Secretary for Justice[10], a policy decision was taken not to replace or modify cell fittings such as the toilet cubicle doors in standard cells such as cell 4.56 in Monro Hall. Rather, it was decided that SPS should invest in the provision of further Safer Cells (that is, for prisoners assessed as being at high risk of suicide under TTM), in making procedural improvements in relation to TTM assessment, and in providing revised staff guidance and training. Accordingly the toilet cubicle door in cell 4.56 in Monro Hall (and the many other cubicle doors of similar design in Polmont), were not replaced or modified so as to reduce the high ligature anchor point risk which had been identified by Mr McKean in the 2018 LAP review. That risk remained in September 2021, when Jack died by suicide in cell 4.56, and also at the time of the hearing of this inquiry in July 2024.

(F) STATUTORY FINDINGS – DISCUSSION AND DETERMINATION

Introduction

[148] Jack was a young man whose circumstances will sound depressingly familiar to anyone with significant experience of the Scottish criminal justice system.

[10] SPS Production 66 (duplicated at SPS Production 111).

He came from a background blighted from the outset by familial drug abuse, lack of parental care, and multiple bereavements. From an early age he exhibited challenging behaviour, began himself to abuse drugs and alcohol, and to commit criminal offences. The seriousness of his offending escalated, leading first to periods of remand in Polmont, then breach of a community sentence, and then to a substantial custodial sentence. At the time of his death he was remanded in relation to an allegation of rape and other serious sexual offences, allegations which he denied. Even if Jack had not died when he did, he might have succumbed to an early, drug related death, or spent his life in and out of prison. Sadly, young men with similar life stories pass through the Scottish criminal courts on a regular basis.

[149] Yet as the affidavits from his aunt Caroline Wright and his brother Stephen MacKenzie[11] show, Jack was much loved by his remaining family, and is much missed by them. Without seeking to ignore his faults, they cited examples of his behaviour to show that he could be kind and helpful to others. Jack's next of kin also said that he had completed a joinery course when 16 or 17 (and later a bricklaying course[12]) with a view to finding a trade, giving a glimmer of hope that had he not died there might have been a more positive future for him at some point. The prison officers who knew Jack also spoke of positive sides to him – that he could be funny, likeable and talkative – at least when he was not abusing drugs. In any event his death, like the death of any young person dying by suicide, whether in or

[11]Stephen Mackenzie spells his surname differently to Jack.
[12] While Jack was in Polmont in 2020 – see the DIPLAR of 15 November 2021, Crown Production 10, at page 1.

out of prison, was a tragedy, and will have been devastating for his family and friends.

Time, place and cause of Jack's death

[150] The findings to be made under sections 26(2)(a) - (d) of the 2016 Act in relation to the time, place and cause of Jack's death were largely, but not entirely, uncontroversial. As to place, there was no dispute that his death occurred in cell 4.56 of Monro Hall in Polmont. As to cause, there was no dispute, as confirmed at post-mortem examination, that he died by hanging. A toxicology report confirmed that controlled drugs were present in Jack's body, but they did not play any part in the mechanism of his death. As to timing, there was unchallenged evidence that Officer Forsyth did a hatch check at Jack's cell at around 2030 hours on 2 September 2021, and that he was alive at this time. It was also clear and undisputed that Jack was already dead when his cell was opened by Officer Fyall at 0736 hours on 3 September 2021, albeit that his life was not pronounced extinct until 0757 hours, after paramedic Stephen Pritchard had arrived on the scene.

[151] It is however not possible to determine precisely when within this 11 hour period Jack's death occurred. In the first place, it was agreed by all participants that it was not scientifically possible to do so. Although not called to give oral evidence, the inquiry had a statement to this effect from Dr Kerryanne Shearer, Consultant Forensic Pathologist, dated 15 March 2024, produced at my request. In this statement Dr Shearer commented on the statements of prison and healthcare staff

who had come into contact with Jack's body shortly after it was discovered. She noted that Jack's body at this time was said to be "warm to the touch", and "floppy" (that is, flaccid, and therefore not in rigor mortis). But she said that these non-scientific findings did not provide any clear indication as to the time of Jack's death. She cited an academic publication for the general proposition if a body is warm and flaccid it has been dead for less than 3 hours, if warm and stiff it has been dead from 3 to 8 hours, and if cold and is stiff it has been dead from 8 to 36 hours. But she explained that individual and physical and environmental factors are likely to affect such timings. In particular, in Dr Shearer's opinion, it was impossible from a scientific standpoint to say whether Jack had died prior to 0637 hours that morning, or between 0637and 0736 hours. These time periods are of significance in relation to the involvement of Officer Nelson, discussed below.

[152] There is some other evidence that Jack was still alive at around 0300 to 0400 hours. The inquiry had an agreed police statement dated 9 September 2021 from Andrew Brolly, a prisoner who on the night in question was accommodated in cell 4.57, the cell located immediately next door to Jack's cell. He told the police that he heard Jack shouting at around 0300 hours. Mr Brolly admitted to having taken drugs himself that night (which he said that he had received from Jack), and blacked out as a result, so there is reason to doubt the reliability of what is in his statement. There is also a sharp dispute between the contents of this statement and the evidence of Andrew Elliot, who was accommodated in cell 4.45, located opposite Jack's cell across the hall. Mr Elliot claimed that Jack had a drug debt to Mr Brolly and that he

was being threatened by him and another prisoner in relation to this in the course of the night. If this is true, then Mr Brolly might have had reason to be less than truthful when speaking to the police, so as to seek to deflect any blame from himself for Jack's death. However it is not clear that this would necessarily bear on the credibility of his statement as to when he last heard Jack's voice.

[153] A further piece of evidence relating to the timing of Jack's death is in an IMU log entry made the following day, and reproduced in Crown Production 4. It states that "between midnight and 4am a line was passed" into Jack's cell, that is, that by some means drugs were conveyed to him. This intelligence came from a unidentified source, although one who was graded by the prison officer who received it as being sometimes reliable. The 4 hour time period referred to in the entry, although too broad to be reliable or useful in itself, is at least not inconsistent with evidence of Mr Brolly that Jack was still alive at 0300 hours.

[154] The evidence of Officer Nelson does not assist in timing Jack's death. It is clear from what he said, as confirmed by the hall CCTV, that he did a hatch check at Jack's cell around 0637 hours. He said that he did not see Jack in his bed or elsewhere in the cell, and could not obtain a verbal response. Although the cell is small, the evidence from Officer Nelson, and also from Officers Hall and Morrison, was to the effect that the area in front of the toilet cubicle, where Jack was found hanging an hour later, is a "blind spot" which cannot be seen through the hatch. That in itself is concerning, as a matter of cell/hatch design. But in any event, given that Jack's body - and the bed box on which he was found - were moved after

discovery in an attempt to resuscitate him, it is now impossible to reconstruct his exact position, for example, from the photographs of the cell in Crown Production 16. The upshot is that Officer Nelson's evidence does not exclude the possibility that Jack was already dead at 0637, but was just not visible from the hatch. And nor does it exclude the possibility that Jack was still alive, albeit either unwilling or unable to respond, but again positioned at a point in the cell not visible from the hatch.

[155] The evidence is therefore sparse, but in the light of the foregoing discussion, and on balance, I find that Jack died at some point between 0300 hours and 0736 hours on the morning of 3 September 2021, and that it is not possible to say when exactly between these times he died. It follows that it is not possible to find that Jack was still alive at 0637 hours when Officer Nelson conducted his hatch check.

[156] Accordingly I will make the following findings in terms of subsections 26(a) - d) of the 2016 Act:

In terms of section 26(2)(a) (when and where the death occurred):

Jack McKenzie, date of birth 15 February 2001, died in in cell 4/56, Monro Hall, Polmont, sometime between 0300 hours and 0736 hours on 3 September 2021, his life being pronounced extinct at 0757 hours.

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

Jack'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):

The cause of Jack's death was hanging.

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

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

Reasonable precautions by which Jack's death might realistically have been avoided - section 26(2)(e)

[157] By September 2021 Jack had been detained in Polmont on four separate occasions, for a total of more than 2 years. During that time he had been subject to multiple RRAs under TTM, had come into contact with healthcare staff on numerous occasions in connection with MORS, had come into further repeated contact with support workers attempting to engage him with PHAS, and will also have had numerous daily interactions with prison officers. All of these members of staff were trained in TTM, and some of them (particularly the prison officers) came to know Jack reasonably well. Yet at no time was any concern raised, from any source, that he was at risk of self-harm or suicide. He strongly denied this when asked about it

at RRAs, and there was nothing in the background materials – for example his health and social work records – to indicate otherwise.

[158] Jack agreed to a formal referral to mental health services while in Polmont in July 2020, but he was not assessed as being at risk of suicide at that time. He described hearing voices, but these were likely the transitory result of drug abuse, as Dr Tuddenham suggested. In any event Jack did not follow through with the referral. Even Jack's fellow prisoner Adam Elliot, who had known him for more than 3 years, said that Jack had never said anything to him about mental health problems or suicidal thoughts. It is apparent that he was not given to expressing his emotions or feelings, or asking for help. But in any event, prior to his death Jack had not been considered to be at risk of suicide by anyone with whom he came into contact in Polmont, and he was never made subject to TTM.

[159] Jack's suicide was therefore likely impulsive, but was in any event unpredicted and unpredictable. That was the opinion of both Dr Duncan Alcock and Dr Laurence Tuddenham, and I agree with it. There was simply nothing to indicate, prior to 3 September 2021, that Jack had any thoughts or intention of dying by suicide - notwithstanding the ample opportunities for any such thoughts or intentions to have been detected if they had been voiced or otherwise evidenced.

[160] Jack did however present with a number of factors which can indicate an increased risk of suicide, some of which are identified in the TTM guidance and training materials. In particular, as at September 2021 Jack was a remand prisoner, he had a childhood diagnosis of ADHD, he was a young person who was known to

regularly display anger and aggression, and he was a drug user. But the evidence before this inquiry, and in particular the evidence of Drs Alcock and Tuddenham, was that - at least from a psychiatric perspective - such suicide risk factors should not be treated in an actuarial way, or as a tick box exercise from which the degree of individual risk can be extrapolated. Assessment of risk, in these experts' opinion, must be personal, and based on the individual as they present at any particular point in time. That approach - they said and I accept - reflects guidance from both the National Institute for Health and Clinical Excellence, and the Royal College of Psychiatrists.

[161] In Jack's case, therefore, although he presented with a number of risk factors, these alone did not mean that he could or should have been identified as being at an increased risk of suicide at the relevant time. He was on remand at the time of his death, but it was not the first time he had been remanded, and he had spent more than 2 years in Polmont by September 2021. He displayed anger and aggression when things were not going his way, but this was not new, and nor was his behaviour unusual within the prison population. Although Jack was diagnosed with ADHD as a child, there was little evidence that he still had it as an adult. Certainly he did not want to have attention or treatment for ADHD at any time after 2018, even though this would have been available. And although Jack was a chronic drug abuser, and there is population based evidence that this indicates an increased risk of suicide, this was but one factor to weigh in the balance when assessing his risk of suicide overall. Fundamentally, and as Drs Alcock

and Tuddenham explained, population based studies should not be the basis for assessing individual suicide risk - even though I understood them to accept that they can inform such assessment.

[162] All this indicates that there was no evidential foundation for a finding that Jack could or should have been identified as being at risk of suicide prior to his death, or that his suicide could or should have been predicted. As noted, he was never placed on TTM throughout his detention in Polmont, and there was no good basis to suggest that he should have been. No participant to the inquiry submitted otherwise.

[163] Notwithstanding all this, however, both the Crown and Jack's next of kin, Caroline Wright, submitted that there were reasonable precautions by which Jack's death might have been avoided, and therefore invited the inquiry to make findings under section 26(2)(e) of the 2016 Act. Caroline Wright submitted that Jack's death might realistically have been avoided had Officer Nelson not failed to carry out a proper hatch check at 0637 hours on the morning of 3 September 2021, and had caused Jack's cell to be opened given the absence of a verbal or visual response. It was accepted that it was not possible to determine the time of Jack's death. But it was submitted that there was no evidence to suggest that it was more probable than not that Jack was already deceased at 0637 hours. Therefore it was entirely possible in terms of the statutory test that he was still alive at this time. Accordingly had Officer Nelson caused the cell to be opened to check on Jack's welfare there was a realistic possibility that his death could have been avoided.

[164] At first blush this submission has some attraction to it. It is correct that Officer Nelson failed to do a proper hatch check. When he looked through the hatch at 0637 hours he could not see Jack nor raise a verbal response, but he noticed that the cell was in disarray. He asked Officer Afzal to check the hall boards and she advised that Jack was recorded as being in cell 4.56 but was subject to rule 95 proceedings. Officer Nelson assumed that Jack had been moved to the SRU. He had no good basis for this assumption. He could easily have made further checks on Jack's whereabouts, for example by calling the SRU, but he did not do so. Carrying out such checks would inevitably have resulted in Jack's cell door being opened.

[165] Officer Nelson was a very experienced prison officer. He will have carried out thousands of hatch checks in the course of his career. He will have been aware that if Jack was not in cell 4.56 then there was a discrepancy in the prisoner numbers recorded as being in the hall. He ought to have been aware that such a discrepancy was a serious matter which should not have gone unexplored. Therefore it is of concern that he failed to take action necessary to verify the position, and which would have led to Jack's cell being opened. There is no question that it would have been a reasonable precaution to have taken such action. Officer Nelson was at fault for failing to do so.

[166] But thereafter Mrs Wright's submission is based on a misunderstanding of the statute. The question is not whether there was a realistic possibility that Jack was alive at 0637 hours. It is whether there was a realistic possibility that the taking of a reasonable precaution might have resulted in Jack's death being avoided. The

reasonable precaution was, as just noted, that Officer Nelson should have caused Jack's cell to be opened at 0637 hours. But such a precaution could only have avoided the death if Jack was still, in fact, alive at that time. Being a matter of fact, this is to be determined, on the evidence, on a balance of probabilities. But as there is no evidence to establish when between 0300 hours and 0737 hours Jack died, there is no evidence on which it could be concluded that it was more probable than not that he was still alive at 0637 hours. That being so, it is not possible to make a finding in fact that Jack was still alive at this time. And in the absence of such a finding it is not possible to say that there was a realistic possibility that the death would have been avoided had his cell been opened. Put another way, the test of realistic possibility is to be applied in assessing the effect of taking the precaution, not in determining the factual circumstances in which it could have been taken. For these reasons I reject Mrs Wright's submission.

[167] The Crown submitted that it would have been a reasonable precaution for Officers Nelson and/or Afzal to have carried out a hatch check at Jack's cell "in the early hours" of 3 September 2021. Had they done so, it would have been apparent to them - from his presentation and the disarray in his room - that he was under the influence of drugs. Accordingly it would have been a reasonable precaution for them to have placed Jack on MORS and made him subject to observations until he could be medically assessed later that morning. Had these precautions been taken, the Crown submitted, there was a realistic possibility that Jack would have been unable to hang himself without this being detected and prevented.

[168] Again, there are elements of this submission with which I can agree. MORS is not a suicide prevention strategy. Its primary purpose is to seek to ensure the safety and wellbeing of a prisoner who is suspected to have taken drugs while those drugs work themselves through their body. Most obviously, it is to monitor risks to the prisoner's physical health rather than their mental health, for example, from a possible overdose. But in common with TTM, MORS has as a key practical component keeping the prisoner concerned under frequent observations in order to seek to ensure that they are alive and well. And although the purpose of those observations is not to try to prevent suicide, they are likely to the have the same effect, by reducing the time during which the prisoner is left undisturbed - this time period being one side of what Joanne Caffrey, an expert in safer custody issues, graphically described as the "ligature triangle"[13]. So to have placed Jack on regular MORS observations prior to his death would not necessarily, or even probably, have prevented him from hanging himself. But there is no difficulty in concluding that there would have at least been a realistic possibility that it might have done so.

[169] Furthermore, if Officer Nelson and/or Afzal had carried out a hatch check when Jack was under the influence of drugs, then it can at least be inferred, on balance, that this would have been apparent to them, and thus that it would have been a reasonable precaution for them to have initiated MORS observations. In the first place, as was said by the dayshift officers who knew Jack well, consumption of

[13] The other 'sides' of the triangle being the availability of a ligature item, and an anchor point to attach it to.

drugs had significant and recognisable effects on him. In particular he would become more aggressive and hostile. He would also put his cell into a state of disarray. It is therefore reasonable to infer, if Jack had taken drugs in the early hours of 3 September 2021, that they would have such effects on him, and - at least with hindsight - that they would likely have been apparent to Officers Nelson and Afzal had they carried out a hatch check.

[170] Next, it is clear from the post mortem toxicology that Jack had consumed Etizolam at some point before his death. It was not scientifically possible to determine what dose of this drug was taken by him, or the effect of it on him. However the drug concentration found in Jack's blood was noted by Dr Maskell to be higher than average relative to concentrations generally seen by the post-mortem toxicology service at the University of Glasgow. This suggests, on balance, that it would have been sufficient to have put Jack significantly under the influence, and so to affect his behaviour and presentation to a noticeable degree, for example in the manner described by the day shift officers. Accordingly this evidence too is supportive of the Crown submission that observation of Jack at a time when he was under the influence of the drugs later found in his system post mortem would likely have revealed that he was in a condition which would have made it a reasonable precaution to place him on MORS.

[171] Where the Crown submission breaks down is on the factual questions of whether there were grounds for Officers Nelson and/or Afzal to have carried out a hatch check on Jack in "the early hours of the morning" of 3 September 2021, and if

so, whether he would have been under the influence of drugs at that time. Neither has been established on the available evidence.

[172] Post-mortem examination was unable to determine when Jack consumed the Etizolam found in his system, or how long prior to his death he did so. It can be inferred that he did so at some point after 1730 hours on 2 September 2021, as the evidence of Officer Denise Swift was that he appeared normal at that time and that his cell was tidy, these being indicators that he was not then under the influence of drugs. But thereafter the only evidence to more precisely time Jack's ingestion of Etizolam comes from other prisoners in the hall that night and the entry in the IMU log already referred to.

[173] This evidence is contradictory. As already noted, the intelligence in the log indicates that "a line" attaching an Etizolam soaked card was passed into Jack's cell from another (unidentified) cell sometime between 1200 hours and 0400 hours. But the only cell within 20 feet of Jack's cell was cell 4.57, occupied by Andrew Brolly. I cannot discount that ingenuity might have found a way to send a line to another cell, but it seems unlikely. In any event Mr Brolly said in his statement that it was Jack who had passed Etizolam to him by making "some kind of device with paper where he slid it out of his cell and swung it towards my cell and I hooked it under my cell door". And indeed there is an item which might fit this description which can be seen on the floor of Jack's toilet cubicle in the photographs in Crown Production 16. But if Andrew Elliot's evidence is to be believed, a disturbance arose around 2330 hours because Mr Brolly was threatening Jack with violence over a

drug debt, and it is hard to see that if this were correct, why any drugs would be being passed between them, either way.

[174] There is another piece of evidence from Mr Elliot which is significant. He said that when the noise died down and things "went quiet", this indicated to him – from past experience – that those involved had now consumed drugs. But if that is correct it follows that if the prison officers had attended on Jack's cell because of an ongoing disturbance by him, this would likely have been *before* he had consumed drugs. The evidence of the dayshift officers was that Jack tended to damage or mess up the contents of his cell *after* consuming drugs, not before, although Officers Nelson and Afzal did not know Jack and were not aware of this. But this piece of evidence from Mr Elliot suggests that even if Officers Nelson and Afzal had opened Jack's hatch in response to the disturbance which he described, Jack would not at that time have either taken drugs or put his cell into disarray. Therefore the officers would have had no good reason to place him on MORS. On the other hand, by the time Jack had taken drugs, there would have been no disturbance, and so no reason to check on him in the first place.

[175] Accordingly the Crown's argument rests on inviting the inquiry to accept and stitch together a number of unreliable, inconsistent and self-serving pieces of evidence in order to find that at some unspecified point of time during the night, being a time after which Jack had consumed Etizolam and would have been obviously under the influence of this drug, it would have been reasonable for Officers Nelson and Afzal to have checked on him by looking through his cell hatch.

I am unable to accept that. It invites a high degree of speculation, rather than the drawing of reasonable inferences from the available evidence. I cannot and do not make any clear finding as to when Jack consumed Etizolam that night, nor when he put his cell into disarray. I therefore cannot and do not find that after that unknown point in time it would have been a reasonable precaution for Officers Nelson and Afzal to have checked on him. I therefore reject the Crown's submission for a finding under section 26(2)(e) in relation to this.

[176] Separately, the Crown submitted that it would have been a reasonable precaution, prior to September 2021, to have replaced or modified the toilet cubicle door in Jack's cell such that it could not have been used as a ligature anchor point by him – or at least so readily used without ingenuity or adaptation. By no later than 2018 such cubicle doors had been identified by SPS as a high risk ligature anchor point. Prisoners had repeatedly used such doors to hang themselves prior to 2021. Solutions were available to SPS by which it could have replaced or modified the cubicle door so as to remove or reduce the risk it presented. Had this precaution been taken, the death which occurred to Jack could not have happened. Alternatively, removal of this obvious ligature anchor point would have made it more difficult for Jack to hang himself, and so his death might realistically have been avoided. Accordingly the Crown submitted that a finding to this effect should be made under section 26(2)(e).

[177] SPS resisted such a finding. It submitted that standard cells such as that in which Jack was accommodated are not ligature free environments, and that a toilet

cubicle door resulted in an inevitable and inherent ligature anchor point risk. Such doors were and are necessary to preserve a prisoner's privacy and dignity, so as to effectively segregate their toilet from the living area of the cell. A new design of magnetic, non weight bearing saloon doors had been installed at HMP Stirling, but changes to cubicle doors across the whole of Polmont, and indeed the whole prison estate, presented a variety of challenges and substantial cost. The door in Jack's cell had a piano hinge, and the top of it was sloped, these being anti-ligature measures. It was not defective. There was uncertainty as to the precise mechanism by which Jack hanged himself, and so as to what further steps could have been taken to reduce the risk of it. Overall, there was nothing that could reasonably have been done to further reduce the ligature risk it presented.

[178] I accept the Crown's submission on this matter. Jack's death was spontaneous, unpredicted and unpredictable. But it is well known that prisoner suicides can be so. Accordingly prisoners should, insofar as reasonably possible, be detained in environments which are safe, in the sense of minimising the risk of such suicides. As almost all suicides are by hanging, this means in particular removing or modifying obvious ligature anchor points. The toilet cubicle door in Jack's cell was of a standard SPS design, and no doubt identical or very similar doors are used in standard cells across the prison estate. And it was well known within SPS, for at least 3 years prior to Jack's death, that such cubicle doors presented an obvious ligature anchor point.

[179] In the first place, many prisoners have hanged themselves from such toilet cubicle doors. These include Robert Cook (discussed at a NSPMG meeting on 8 December 2015), James Grahames (on 27 July 2018, see [2021] FAI 51 at 28), Simon Stewart (on 18 September 2018, see [2021] FAI 27 at 16, 117), Scott McMillan (on 28 January 2019, see [2020] FAI 6 at 6), Brian Connor (on 5 November 2019, see [2023] FAI 14 at 19), and Phillip Hutton (on 6 December 2019, see [2023] FAI 3 at 35). I understood Siobhan Taylor, the current head of SPS suicide prevention policy, to agree in evidence that it was likely that there had been 12 such deaths *since* 2019, including Jack's.

[180] In the second place, Gordon McKean's 2018 survey of Polmont, instructed by the then SPS Chief Executive in the wake of the deaths of Katie Allan and William Brown, specifically identified the toilet cubicle doors in Monro Hall as presenting a high risk ligature anchor point by reference to MTK methodology. Mr McKean's team recognised that it was possible to create a trap at the top of the hinge, at a height of more than 1.7 metres from the floor (see SPS Production 63 at pages 6, 14, 66 to 71, and 93 to 96). Caution should be exercised in seeking to apply MTK to Polmont – as Mr McKean recognised it requires adaptation for use in the prison environment. But in broad terms it can still be said that under the MTK approach it is likely that the ligature anchor point risk presented by the toilet cubicle doors such as that in cell 4.56 in Monro Hall would be assessed in the health care sector as one which called for replacement or remediation as a matter of course. Or as Joanne Caffrey put it, access to the hinges and gap of the door facilitating the

passage of a torn bedsheet to create a ligature would not have been acceptable in a secure mental hospital or in a police cell. It should not have been so readily available in Polmont either.

[181] Faced with the mounting death toll prior to 2021, and the results of its own assessment of the specific risk arising from toilet cubicle doors in Polmont, SPS' submission that there was "nothing that could reasonably have been done" by the time of Jack's death to make his cell toilet cubicle door safer from an anti-ligature perspective is jarring and unacceptable. On the contrary, it was doing nothing that was not a reasonable option.

[182] So what could have been done? Gordon McKean gave evidence that anti ligature toilet cubicle doors were available from around 2012. Their hinges were magnetic and so non weight bearing. They also had saloon style doors, with a large gap between the top and the door frame. As at 2018 they cost around £1,200 per door[14] - although costs will likely by now have risen considerably. Such cubicle doors had been installed in new build prisons, in particular HMP Stirling. There were concerns as to their adequacy where the cubicle contained a shower as well as a toilet, but that was the not the situation in cells such as Jack's in Monro Hall. It was not suggested that, from a technical perspective, such doors could not also have been installed in Polmont.

[14] See Gordon McKean's *Ligature Free Accommodation Costing Report* (February 2019) SPS Production 65/9.

[183] But even if replacement of the doors was not financially possible, they could still have been modified, more cheaply, so as to materially reduce the risk they presented. Joanne Caffrey's evidence was that the piano hinges in the door of Jack's cell were not fully anti-ligature - as a ligature could still be jammed into them - but that sealed or embedded hinges were available which should prevent this. She also suggested significantly increasing the presently narrow gap between the top of the door and the door frame thereby making it impossible to jam a knotted ligature into the gap. And although - as Mr McKean said - the top of the door is sloped, the incline is so shallow as to be barely perceptible in the photographs in Crown Production 16. As Ms Caffrey said, it would be possible to cut a much more severe slope to the top of the door, such that any ligature placed over it would slide off. She also gave evidence that anti-ligature electronic door alarms were available, which can alert staff if the load on a door exceeds 5 kilograms

[184] It is true, as SPS observed in their submissions, that there is some doubt as to the precise mechanism of self-ligature used by Jack. The photographs in Crown Production 16 were taken after his body was removed from the ligature in an attempt to resuscitate him. The bed box on which he was said to have been sitting had also been moved, and then repositioned, prior to being photographed. It was not entirely clear what use Jack made of this box, why the ligature was so long, and precisely how it was secured over the toilet door.

[185] My assessment, from looking at the photographs and reflecting on the matter, is that Jack likely tied a knot in a piece of ripped bedsheet, jammed that knot

in the narrow gap between the top of the door and the door frame at the point of the hinge, and positioned the bed box in order to stop the door opening (and so releasing the ligature) under the weight of his body once suspended. Replacement of the door with an anti-ligature substitute such as was suggested by Mr McKean, or modification of it such as was suggested by Ms Caffrey, would have prevented Jack from hanging himself as he did.

[186] As to the SPS submission that standard cells are not anti-ligature environments and that - in effect - there will always be some measure of ligature anchor point risk from a toilet cubicle door, two points can be made. The first is that SPS control the whole physical environment of the cell. They alone are responsible for the design of the fixtures, and they alone are responsible for redesigning or reconfiguring them. They alone are responsible for what fittings or other items are permitted to be used within the cell. They alone are responsible for repairs to the cell, should a ligature point be created by prisoner damage or misuse. Accordingly if there are identified ligature point risks in the cell then these are all ultimately SPS' responsibility. It cannot rely on its failure to remove or remediate a particular known anchor point risk by pointing to other anchor point risks which it has also failed to remove or remediate.

[187] The second point is that it is likely true - human ingenuity being what it is - that there is no such thing as a wholly ligature free cell. But that does not mean, and cannot reasonably be used as a justification, for failing to take steps which would make the cell materially safer. Removal or remediation of a known high risk

ligature anchor point would be such a step, precisely because it should make it significantly more difficult for a prisoner to hang themselves without having to use significant amounts of ingenuity, or to make significant adaptations to the fixtures or fittings within the cell, in order to fashion a ligature point.

[188] Clearly there would be a cost as regards replacement or remediation of the toilet cubicle doors. Even at £1,200 per door (by 2018 prices) the cost of replacement of all the cubicle doors in Polmont with magnetic hinged doors - let alone the wider prison estate - would have been significant. But again, this does not make it reasonable to do nothing, rather than to make a long term plan, allocate a budget, identify priorities, and make a start. And a reasonable starting point would have been in Polmont, given the young and particularly vulnerable prisoner group which it accommodates.

[189] For all these reasons, I find that the replacement or at least remediation of Jack's toilet cubicle door, such as would have prevented him using it as a ligature anchor point as he did, would have been a reasonable precaution for SPS to have taken prior to September 2021. I also find that had it been taken there would have been a realistic possibility that Jack's death could have been avoided. As more fully discussed in the *Allan & Brown* determination[15], section 26 of the 2016 Act directs attention to reasonable precautions by which "the" death which actually occurred could have been avoided. In this case, had his cubicle door been replaced with an

[15] [2025] FAI 1, paragraph 29.

alternative such as that suggested by Mr McKean, or modified in the ways suggested by Ms Caffrey, Jack would have been unable to hang himself as he did. The death which he in fact suffered would have been avoided, and it is no bar to a finding under section 26(2)(e) that he might have found and used another ligature point within the cell.

[190] I will therefore make the following finding under this subsection:

> **It would have been a reasonable precaution for SPS, prior to September 2021, to have removed and replaced the toilet cubicle door in Jack's cell, or to have modified it, such that it was not readily capable of being used as a ligature anchor point without significant ingenuity or adaptation.**

Systemic defects contributing to Jack's death - section 26(2)(f)

[191] The Crown submitted that there was no system in place in SPS prior to Jack'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.

[192] SPS resisted the making of a finding under this subsection. It accepted that it should develop ligature assessment criteria but submitted it would be going too far to say that the lack of it contributed to Jack's death. That would be to prejudge the outcome of the assessment. In effect - if I understood it correctly - the submission seemed to be that it could not be said that it was reasonable to suppose that the toilet

cubicle door used by Jack would have been audited as meriting replacement or remediation, nor that this would have been done even if it had, nor when.

[193] The Crown submission mirrors very similar submissions made and accepted by me in relation to the deaths of Katie Allan (in relation to a rectangular toilet door stop) and William Brown (in relation to a double bunk bed). I accepted the Crown submission in that inquiry and see no good reason to take a different view in the present case.

[194] The absence of a system of ligature point audit was spoken to by Gordon McKean. As noted, it was at the end of 2018 that he was tasked with carrying out the LAP survey at Polmont and he was not aware of anything similar having been done by SPS before. Indeed, he had to fashion his own methodology to carry out his survey, based on his coincidental awareness of the use of MTK in the secure health sector. Had there been an audit of Monro Hall prior Jack's death in 2021, it would have identified - as Mr McKean's survey had done 3 years previously - that the toilet cubicle doors in this hall constituted a high risk ligature point. Had there been a system to act on such an audit, it would - and should - have secured the removal and replacement of these doors with anti-ligature alternatives, or to have modified them to the same purpose and so materially reduced the risk which they presented.

[195] The position advanced by SPS seems to have implicit in it the proposition that the toilet cubicle doors might, under some audit of its devising, not be assessed as presenting a high risk ligature anchor point. Given the number of deaths which

have occurred in Scottish prisons in recent years where toilet cubicle doors have been used as ligature anchor points, that would be a dismaying submission. On the basis of the evidence before this inquiry, any form of audit which did not identify this particular item as a high risk ligature anchor point would hardly be worth the paper it was written on. It would also run counter to the learning absorbed and applied by Gordon McKean in his 2018 survey, drawn as it was from the longstanding use of MTK in the secure health sector throughout the UK. As Mr McKean recognised, MTK would require to be adapted for use in Scottish prisons in order to fashion a proper audit tool, but any reasonable adaptation is likely to lead to toilet cubicle doors such as that used by Jack being graded as an obvious ligature anchor point.

[196] It is also seems to be implicit in SPS' submission that even if the toilet cubicle doors had been formally audited by it and found to present a high ligature point risk, that this would not necessarily have led to a decision to replace or remediate them. This would also be dismaying. Given the number of suicides from toilet cubicle doors which had occurred even prior to September 2021, any reasonable response to any reasonable audit should have prioritised their replacement or remediation - and in particular those in Polmont given its vulnerable young prisoner population.

[197] The presence of the cubicle door in Jack's cell provided him with an obvious ligature anchor point which he was able to use at his time of crisis without significant ingenuity or adaptation. There was a failure to have in place systems

prior to 2021 to carry out a ligature point audit, and to act on that audit by removing or remediating the toilet cubicle door. This failure was not the sole or even the main cause of Jack's death, but it did contribute to it. A finding under section 26(2)(f) of the 2016 Act is therefore appropriate in relation to this matter.

[198] Accordingly I will make the following finding under this section:

> **There was no system in place within SPS to (i) regularly audit the physical environment of Jack'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 Jack's death - section 26(2)(g)

[199] The Crown submitted that it was appropriate to make a formal finding in relation to Officer Nelson's failure to carry out a proper hatch check at Jack's cell at 0637 hours on 3 September 2021. He was obliged to do so in terms of the Patrol Orders. Had he done so, Jack's cell would have been opened, and there was at least a chance that he would have still been alive and his death avoided. The time of Jack's death was unknown and accordingly a finding under section 26(2)(e) could not be made, but a finding was still appropriate under section 26(2)(g).

[200] The finding proposed by the Crown under this subsection was not opposed by either SPS or SPOA. I have rejected, for the reasons set out above, Caroline Wright's submission to the contrary. In the absence of any finding in fact that Jack was still alive at 0637 hours on 3 September 2021, the necessary causal connection between Officer Nelson's actions or inactions and Jack's death, necessary

for a finding under section 26(2)(e), is absent. But they are still relevant to the death, and the following finding under section 26(2)(g) is therefore appropriate:

> **At 0637 hours on 3 September 2021 Officer David Nelson failed to carry out a hatch check at Jack's cell which was sufficient to ensure that he was safe and well at that time, and in particular, being unable to see Jack within the cell, he failed to take steps readily open to him to ascertain his whereabouts, steps which if taken would inevitably have led to Jack's cell door being opened, and his condition at that time ascertained.**

[201] The Crown submitted that a finding should be made under section 26(2)(g) to the effect that Officer Nelson ought to have been held accountable for his assumption that Jack was not in his cell at 0637 hours on 21 September 2021, and his subsequent failure to check his whereabouts. The Crown further submitted that Officer Afzal too should have been held accountable for abdicating her own responsibility to verify Jack's whereabouts. Caroline Wright strongly supported and adopted these submissions. SPS and SPOA resisted them.

[202] Rule 139(b) of the Prison Rules requires prison officers to "obey any lawful instructions of the Governor". The Patrol Orders, revised in August 2020 and in operation as at September 2021, constituted such instructions to Officers Nelson and Afzal, and which they were therefore obliged to obey. They included instructions in the following terms: "prior to finishing shift, staff will carry out a visual hatch check to ensure all [young prisoners] are safe and well". They also

carry the warning that "Failure to comply with this instruction could lead to staff being disciplined."

[203] It is clear that Officers Nelson and Afzal did not obey this instruction. Officer Nelson failed to obtain a response from Jack when he checked his hatch at 0637 hours. He assumed without good reason that Jack had been transferred to the CSU, but without confirming this he could not know whether he was safe and well. Even if Jack had been transferred to the CSU this would have meant that the prisoner number recorded on the hall boards was inaccurate, itself a serious matter requiring immediate inquiry. And even if Officer Nelson had not been then able to inquire into this, it was plainly a matter of which the incoming day shift should have been notified at handover. This too was not done.

[204] Officer Afzal, although also bound to obey the Patrol Orders, and jointly responsible for ensuring that Jack was safe and well, was also at fault. The very fact that Officer Nelson asked her whether cell 4.56 was marked on the board as occupied or not carried the obvious implication that he had not seen anyone in the cell when checking the hatch, and therefore that there was a possible discrepancy with the hall numbers. She knew or ought to have realised this, and the seriousness of it. However she did not inquire of Officer Nelson why he needed to know what was on the board in relation to Jack, she deferred to him as a senior colleague, and she assumed that a prisoner subject to rule 95 order would normally be moved to the SRU. These were all mistakes, and areas for further training or retraining.

[205] The seriousness of the officers' failure to follow the Patrol Order instruction is underlined by the fact that but for it there was at least a theoretical, if not a realistic, possibility that Jack's death might have been avoided. Yet no disciplinary action was taken against either Officer Nelson or Officer Afzal by the Governor in relation to their failure to comply with the Patrol Orders. They were asked to provide written accounts of their involvement, but they were not challenged in relation to them. Governor Michie spoke to Officer Nelson, but this was done informally, and principally - as I understood it - to offer him support. Officer Afzal was not even spoken to. Neither officer was disciplined, reprimanded, warned or sanctioned. Neither officer was required to attend for, nor offered, further training. Governor Michie's approach was influenced by the fact that the end of nightshift hatch check required by the Patrol Orders was unique to Polmont, and was not required by the Prison Rules or a GMA. Indeed he did not agree with the requirement to do this check, and it was subsequently discontinued by him. His decision to take no action against Officer Nelson was, he said, ratified at a senior level, by SPS' Director of Prisons.

[206] Sue McAllister, an expert in prison management, gave evidence that in relation to cell checks it was crucial to create and nurture a culture where the basics were done well, where good supervision and strong, visible leadership made sure that staff did what they should, when they should, and that they did it properly. In Ms McAllister's view, management checks, acknowledging good practice and challenging poor practice were key to that. It was therefore disappointing to her to

see that decision-making short of acceptable standards continued to be repeated and that management response appeared ineffective. Ms McAllister described Officer Nelson's actions as unacceptable and poor practice. She was aware of examples from England and Wales where prison officers had been dismissed for failing to carry out proper checks.

[207] I accept Ms McAllister's evidence, in the light of her long and distinguished career in prison management across different jurisdictions. I find her observations to be apposite in the present context, and accept the Crown submission for a finding in relation to this matter. I do not suggest - nor did Ms McAllister - that Officer Nelson should have been dismissed for his actions. Nor do I suggest what particular form any disciplinary action should have taken (although a formal warning and remedial training might seem obvious). But the absence of *any* disciplinary action whatsoever, given the seriousness of the breach of the Patrol Orders, and the possible seriousness of the consequences of it, is incongruous and unacceptable. I do not accept, as SPS submitted, that this was within the range of reasonable responses open to Governor Michie. Rather, it was a response which sends a message to prison officers that they will not be held to account for a failure to "do the basics well", and a message to the wider public that the first response of SPS to poor staff practice in the context of the death of a prisoner is to close ranks and protect its own. It is also of concern that Governor Michie's approach appears to have been sanctioned at the highest level within SPS.

[208] It is of no significance for present purposes that the hatch check requirement in the Patrol Orders was unique to Polmont, and not itself a specific requirement of the Prison Rules. What the Rules require, as noted, is that prison officers obey the lawful orders of the Governor, and the hatch check requirement in the Patrol Orders constituted such an order as at 3 September 2021. A failure to carry out this order therefore constituted at least an indirect breach of the Prison Rules. Whether Governor Michie disagreed with it is beside the point. The Patrol Orders expressly informed prison officers that they could be disciplined for failing to obey them. There was a clear case for doing so in relation to Officers Nelson and Afzal.

[209] I recognise and do not underestimate that being a prison officer can be a difficult and demanding job, and that it does not always get the public recognition which it deserves. I also do not suggest that officers will not need to be supported by SPS in the wake of incidents such as that with which this inquiry is concerned. But none of this is incompatible with a proper recognition that poor practice must be investigated and sanctioned, not ignored and therefore - apparently - condoned. The purpose of imposing a sanction is not to criticise prison officers for the sake of it, but to seek to drive up standards in the hope - in the present context - of preventing the deaths of further young prisoners by suicide. For the reasons articulated by Ms McAllister, a finding such as is sought by the Crown is important in the context of encouraging cultural change within SPS in this regard. Accordingly the failure to discipline Officers Nelson and Afzal, while not a cause of Jack's death, is relevant to it, and justifies a finding under section 26(2)(g) of the 2016 Act.

[210] Accordingly I will make the following finding:

Officer David Nelson should have been disciplined for his failure to carry out a hatch check at 0637 hours on 3 September 2021 sufficient to ensure that Jack was then safe and well, contrary to the Monro Hall Patrol Duty Orders then in force. Officer Zaira Afzal, who was on duty with Officer Nelson and was jointly responsible for the hatch check, should also have been disciplined. A sanction should have been imposed on both officers and/or corrective training required of them.

[211] The Crown submitted that the inquiry should make a finding under section 26(2)(g) that the absence of formal staff training in relation to MORS - rather than a practice of "learning on the job" - has led to inconsistences in its operation and some fundamental misunderstandings of its content. SPS resisted the making of such a finding on the basis that this issue was not relevant to Jack's death.

[212] I agree with the SPS submission. Jack was placed on MORS many times, and in particular on 1 September 2021. The evidence about this highlighted inconsistencies and misunderstandings by staff in relation to the policy as identified in the Crown's submissions. It was also apparent that there was no formal training given to those staff members who were in post when MORS was introduced in 2014 and that this may have contributed to such inconsistencies and misunderstandings. But Jack's placement on MORS on 1 September 2021 was appropriate, as was his removal from it on 2 September 2021. By then he was assessed as not being under the influence of drugs. No participant suggested that this assessment was incorrect

or that he should not have been removed from MORS at this time. There is no evidence to suggest that his death around 12 hours later was related in any way to any of the inconsistences and misunderstandings identified, nor to any consequent failure to implement the MORS policy correctly. Accordingly I will make no finding on this matter under section 26(2)(g) of the 2016 Act.

[213] The Crown also sought a finding under this subsection that Jack ought to have been reviewed by healthcare staff in accordance with MORS on the evening of 1 September 2021 and the morning of 2 September 2021, but was not. Had he been reviewed and removed from MORS earlier than he was, Marianne Finnon might have seen him on 2 September 2021 as she had hoped, to offer further drug addiction support. He might also have been able to meet with his solicitor that day as planned, albeit the outcome of such a meeting and his reaction to it were unknown.

[214] SPS again resisted this proposed finding. It submitted that there was no evidence that Jack would or should have been removed from MORS even if he had been reviewed as suggested. It was possible in terms of the policy for Jack to have been removed from MORS within 24 hours, but even if this had been done it is likely that staff would have erred on the side of caution and kept him on it. As to what might have happened had he been removed from MORS earlier, this was speculation.

[215] Again, I agree with the SPS submission on this issue. MORS requires that the nurse drawing up the care plan must include "when the offender will be reviewed

by healthcare staff". In Jack's case Nurse Stevely wrote "2 x daily" on the relevant form at 1430 hours on 1 September. This was ambiguous in that it did not make it entirely clear whether she envisaged further reviews later in the afternoon of 1 September[16] and the following morning, or simply two reviews within a 24 hour period. Jack was in fact assessed on two further occasions during this period, first by Nurse Long, at around 1445 hours on 1 September, and then by Elizabeth Forrester, at around 1430 hours on 2 September. But it is not possible to say whether he would have been removed from MORS had he been further reviewed in the morning of 2 September 2021. I think it more likely that he would not have been, for the reasons suggested by SPS. But if he had, and had been seen by Marianne Finnon, the likelihood is that he would have refused to engage with PHAS, as he had done many times before. It is also speculative to suggest that he might then have spoken to his solicitor, as the reason given for denying him a meeting was that he was still subject to rule 95 proceedings.

[216] Accordingly, the question of whether Jack should or should not have been reviewed by a nurse on the afternoon of 1 September or the morning of 2 September 2021 is not relevant to his death. There is no basis to suppose that a further review would have made any difference to what in fact happened. Jack was made subject to MORS observations on 1 September 2021 in order to ensure his physical safety in the wake of him having ingested drugs on that date and while he was under the

[16] In evidence, she said that did intend that matters should be reviewed later that afternoon, as she had been unable to carry out a full examination of Jack in accordance with the FVHB SOP.

influence of them. It was successful in doing so. His death in the early hours of 3 September 2021, having by then ingested more drugs, was in no way related to any failure to review him the previous morning, in circumstances where there was no dispute that he was appropriately removed from MORS following a review by Nurse Forrester in the early afternoon. Accordingly I will make no finding on this matter under section 26(2)(g) of the 2016 Act.

[217] The Crown next submitted that the evidence showed that there was a link between substance abuse and increased risk of suicide, and so sought a finding to the effect that the MORS policy should include a reference to TTM, in particular to prompt staff to assess and record a person's risk of suicide at the point when they were removed from MORS observations. SPS resisted the making of such a finding. While accepting that it would be sensible to include a prompt on the MORS forms to keep TTM in mind, and that this would be considered in the ongoing review, it again submitted that there was no evidential basis for a finding that the interaction between MORS and TTM was relevant to Jack's death.

[218] MORS itself does not make reference to TTM, nor does it highlight the increased risk of suicide in relation to persons who abuse drugs. It does not require that a formal suicide risk assessment be carried out, and recorded, prior to a member of healthcare staff removing a prisoner from MORS and discontinuing observations under this policy.

[219] Jack was removed from MORS at around 1430 hours on 2 September 2021 following a review by Nurse Forrester. She was a very experienced primary care

nurse, and also had experience of mental health nursing. She had worked in Polmont for many years and was trained in TTM. Her evidence was that in addition to assessing and reviewing Jack to decide whether he was still under the influence of drugs for the purposes of MORS, she also actively considered whether he was at risk of harming himself for the purposes of TTM. In other words, although not required to carry out or document a formal TTM assessment, in practical terms she said that she did assess Jack's suicide risk. She said that she asked him directly whether he had thoughts of self-harm and he denied this. She was well aware that he was a chronic drug user and had previously assessed him for MORS purposes. But his presentation at that time, verbal and non-verbal, gave her no cause to think that he was at risk of suicide.

[220] However none of this is recorded in writing. Nurse Forrester did complete a VISION entry in relation to her meeting with Jack. This merely records - somewhat at variance with Nurse Forrester's evidence as summarised above - that Jack was "very angry", said that he "needed illicit drugs due to [an] outstanding court appearance", and that he "calmed down following chat with officer." This entry appears to have been completed the following day, after Jack's death - Ms Forrester having been involved in efforts to resuscitate him after he was found at 0736 hours. The statement of Emma Jenkins, the healthcare assistant who attended on Jack along with Nurse Forrester on 2 September 2021, only partially corroborates the details of her account of what was said to and by Jack in relation to suicide risk assessment.

[221] Given the differences between her oral evidence, her VISION entry and the statement of Emma Jenkins, I was concerned that there might be an element of retrospective embellishment in relation to what Nurse Forrester said about her suicide risk assessment of Jack on 2 September 2021. I do however accept Nurse Forrester's evidence that she did carry out an informal assessment, and that she would have placed Jack on TTM had she had any concerns that he was at risk of suicide. Of course, around 12 hours later Jack hanged himself. The proximity is of course concerning, but this does not necessarily meant that Nurse Forrester's assessment was inadequate or defective. Either Jack was successfully masking suicidal thoughts when speaking to her, or they came on him spontaneously and unpredictably at some point shortly before he died a few hours later.

[222] But as Dr Alcock said, scientific studies have shown an increased risk of suicide in those who misuse illicit substances, a matter which is to some extent reflected in the terms of TTM. Nurse Forrester knew that Jack was a chronic or habitual abuser of drugs, one of a relatively small group of prisoners who were repeatedly subject to MORS. And although not obliged to do so, on her evidence she did in fact think it appropriate to carry out a suicide risk assessment of him before she discontinued MORS observations. None of this means that the absence of a requirement to carry out and record a formal TTM assessment prior to removing Jack from MORS contributed to his death. But it means that it is at least relevant to it. Had there been a requirement for such an assessment, there would have been a formal, contemporary, written record of it, which would have at least have helped

inform consideration of why Jack died by suicide, so soon after being assessed as not being at risk of doing so. A finding as sought by the Crown under section 26(2)(g) is therefore appropriate.

[223] The Crown submission on this chapter also appeared to suggest that MORS should provide guidance for prison officers in relation to the heightened risk of suicide arising from abuse of controlled drugs. If I have understood this correctly, it is misconceived. MORS is not a suicide prevention policy. TTM is. All prison officers are trained in relation to TTM, and have to assess prisoners by reference to it on a daily basis. While it may be that TTM should be revised to further highlight the increased suicide risk from drug use (discussed further below), there is no evidence to suggest that even if it had done Jack would have been assessed as being at risk of suicide and put on TTM before 3 September 2021. Neither the factual nor expert evidence supports such a view, and there was no submission by any participant to this effect. That TTM did not make more fulsome reference to the suicide risks associated with drug abuse has not been shown to be relevant to Jack's death.

[224] I will however make the following finding under section 26(2)(g) of the 2016 Act:

> **Neither TTM nor MORS placed any requirement on Nurse Elizabeth Forrester to carry out, and record, a suicide risk assessment prior to removing Jack from MORS at 1430 hours on 2 September 2021.**

[225] The Crown next invited the inquiry to make a finding that there was a failure to incentivise Jack's engagement with PHAS. MORS does not provide any guidance

in this regard, and FVHB policy is in essence a system of letters and attempts at face to face meetings, providing no guidance on incentivisation. Management of Jack by repeatedly placing him on MORS and confining him in his cell without incentive to address his drug misuse was not sufficient. SPS resisted the making of such a finding. It submitted that there was no evidence that more could have been done to incentivise Jack to engage with PHAS in the circumstances, or that any lack of incentivisation in relation to PHAS engagement was relevant to Jack's death by suicide.

[226] On this matter I accept SPS' submission. The evidence suggests that statistically there is a higher risk of suicide among persons who are drug abusers. That alone points to a need to take measures in relation to prisoners who do abuse drugs in prison to assist them to stop or reduce their consumption. Improving such measures as already exist - principally through PHAS - is therefore a goal which should be pursued. And the evidence also suggested that provision of greater incentives for prisoners to engage with PHAS is a means by such which an improvement might be achieved. It is therefore possible that greater incentivisation to engage with PHAS may lead to reduced drug consumption by some prisoners, or cessation of drug use, thereby lowering at least their statistical risk of suicide.

[227] As to what those incentives might be, Sue McAllister suggested that that linking desisting drug use to activities a young prisoner was interested in could be effective. As she put it, boredom is the biggest threat - as Jack himself had said. Therefore Ms McAllister said that the approach should be to give prisoners - and I

would add especially remand prisoners - something to do, whether by way of work, training or education. In his evidence Dr Craig Sayers referred to the possibility of putting punishment for a prisoner's drug use on hold if they engage with addiction services. These are positive suggestions and SPS should give consideration to them.

[228] The difficulty with the Crown's submission for a formal finding in this case is that the evidence shows that Jack had no desire to change his drug taking behaviour while in Polmont. He was open about this with prison officers. They tried to point out the risks and to encourage him to stop. He told them that he enjoyed taking drugs. On the many occasions that he was on MORS there were attempts by PHAS to engage him with their services. These came via meetings and attempted meetings as well as by letter. But it is clear that Jack was not interested in engaging with PHAS. He appeared so far from a willingness to engage throughout 2021 that it is hard to see what if any incentives could have been provided which might have made a difference to this. That was the tenor of the evidence of Dr Sayers, Dr Tuddenham, Dr Alcock and Marianne Finnon, an experienced addictions worker who had repeatedly tried to engage Jack. As Dr Alcock put it, Jack was simply not at the point of his life where he was willing to engage. On the evidence available to the inquiry it is speculative to suggest otherwise.

[229] Even if Jack had been incentivised to engage with PHAS, it is also speculative to suggest that this would have made any difference in relation to his death. It remains unclear why he chose to die by suicide - and indeed whether, or if so how, his drug use played any part in it. He may have died while under the influence of

drugs, but there is no evidence that this somehow caused him to kill himself. As Dr Tuddenham put it, it was possible that the effects of Etizolam disinhibited Jack, but it is just speculation, as it is not possible to know what was going through his mind. Therefore even if Jack had been incentivised to engage with drug services, had reduced or stopped taking drugs, and had thereby removed himself from that part of the population which in general has a higher risk of suicide, there is still insufficient evidence to say that his death would have been any less likely. It is therefore not appropriate to make the finding sought by the Crown under this heading.

[230] Caroline Wright submitted that the inquiry should make a finding under section 26(2)(g) that the system of counting prisoners in Monro Hall was inadequate. No other participant supported such a finding and it is not justified on the evidence. The prisoner numbers recorded on the hall boards on the night of 2 to 3 September 2021 was accurate. The problem was not that the system for counting the prisoners was inadequate, but that Officer Nelson assumed, without justification, that the number recorded was incorrect, and then failed to take steps readily available to him to check this. Whatever deficiencies there might be in the system of number counting operated by SPS they were not relevant to Jack's death.

(G) RECOMMENDATIONS - DISCUSSION AND DETERMINATION

Introduction

[231] The Crown proposed some 10 recommendations under section 26(1)(b) of the 2016 Act. These were all adopted by Jack's next of kin, who proposed two more. SPOA submitted that none of the five recommendations affecting its members should be made. Four of the Crown's proposed recommendations related to FVHB. Its position, in particular, was that none of them constituted precautions or steps which might realistically prevent deaths in similar circumstances to Jack, and therefore that they fell outwith the terms of the statute and should not be the subject of recommendations. SPS offered full, qualified or partial acceptance of all but one of those of the Crown's proposed recommendations which affected it. SPS also 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 lessons from Jack's death.

[232] In making recommendations it is important, as I said at the outset, to recognise the limitations on this inquiry, both legal and practical. Jack's drug use featured large in the evidence, but this is not a general inquiry into the incidence of the use of controlled drugs by prisoners in Polmont (or in Scottish prisons more widely), nor in relation to the success of otherwise of the efforts of SPS to control it. Nor is it a general inquiry into the effectiveness or otherwise of the MORS policy. Because it is a fatal accident inquiry, the focus has to be on the particular circumstances of Jack's death, and what lessons for the future might be learned from

it. Recommendations under section 26(1)(b) are limited to those "which might realistically prevent other deaths in similar circumstances" to Jack's. As SPS submitted, therefore, the evidence led was not in the nature of a comprehensive exploration of prison policy and procedure, and any recommendations made will require consideration before decisions can be made as to whether and if so to what extent they are operationally achievable.

[233] As the evidence unfolded, it became apparent that it was not possible to establish a clear link, at an individual level, between Jack's death and his drug use. There was, for example, no evidence on which a finding could be made that his death was caused or contributed to, physiologically or mentally, by either his history of drug use, or the particular drugs which were found in his body post-mortem. It is not even possible to make a finding that he was still significantly under the influence of drugs when he died, or if so, to what extent; whether - for example - these drugs distorted his thinking and/or depressed his mood such that he decided to end his life when he would otherwise not have. Ultimately Jack's suicide was unpredicted and unpredictable. The reasons for it are unknown, and the role of his drug use in it, if any, is unclear.

[234] The "circumstances of Jack's death" are therefore simply the unpredicted death by suicide, by hanging, of a young prisoner in Polmont. That he happened to be a drug user and had consumed drugs before he died are - strictly, and on the available evidence - incidental to these circumstances. So too is his management under MORS, and/or the adequacy of that policy. Given the evidence drawn from

population studies, it can be said in general terms that a higher number of prisoners who abuse drugs die by suicide than those who do not. But the evidence available to the inquiry about this was limited, and not (as I understood it) based on the Scottish prison population. I cannot ultimately say, on the whole evidence, that denying or restricting Jack's access to controlled drugs would realistically have prevented his death. And therefore, logically, I cannot say that denying or restricting other prisoners' access to controlled drugs would realistically prevent deaths in similar circumstances to Jack's.

[235] It is not therefore appropriate to make statutory recommendations regarding drug use in Polmont in general, nor the means employed by SPS to restrict it. These are obviously concerning issues. It might be argued that they are so concerning - for a number of reasons of which prisoner suicide is only one - that they could and should be the subject of an inquiry. Alternatively they might be an issue for closer scrutiny in a FAI where a prisoner has died from a drug overdose - and thus where there is a clear causal relationship between drug use and their death. But the role of the present inquiry is more limited for the reasons just noted. Put another way, it is simply the wrong case to try to embark on a wider exploration of drug abuse and attempts to control it in Polmont. And as discussed below, this impacts on at least some of the recommendations which were proposed by the Crown, particularly in relation to MORS, even taking a relatively expansive approach to section 26(1)(b) of the 2016 Act.

Ligature anchor point reduction

[236] In *Allan & Brown* I made recommendations in relation to reducing ligature anchor point risk at Polmont, both generally and in relation to the particular ligature anchor points used. As to the generality, I recommended the development by SPS of a ligature anchor point toolkit, the carrying out of an audit of Polmont using that toolkit, and the taking of action to remove or reduce the risks presented by those ligature anchor points identified by the audit. The evidence on which that recommendation was based - and in particular the written and oral evidence of Gordon McKean and Joanne Caffrey - was also available to the present inquiry, and I see no good reason to take a different approach. Indeed the circumstances of Jack's death simply underlines the need for it. I understood SPS to accept in principle the Crown's proposal for a recommendation along these lines in the present case. I will therefore simply adopt my findings, reasoning and conclusions on this matter in *Allan & Brown*[17] without repeating them, and will make a recommendation in the same terms:

Recommendation 1: 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

[17] See [2025] FAI 1 at paragraphs [427] – [446], [458] – [485], [842] – [854], and [863] – [868].

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:

iii. 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;

iv. 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;

e. 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.

[237] I also made recommendations in *Allan & Brown* in relation to the particular ligature anchor points which were used in the deaths to which that inquiry related, namely a rectangular metal toilet cubicle door stop and a double bunk bed. I again

adopt the reasoning for these findings and recommendations without repeating it[18]. For much the same reasons a similar recommendation is appropriate in the present case in relation to the toilet cubicle door used as a ligature anchor point by Jack.

[238] As already noted, there have been multiple deaths by suicide, prior to and since Jack's death, in which prisoners have hanged themselves from cell toilet cubicle doors. Doors such as those in Jack's cell were identified as high risk ligature anchor points by Gordon McKean's ligature anchor point review in 2018. Such doors continue present such a risk. Steps should be taken to replace them, or at least to materially reduce the risk arising from them. I accept that there are not insignificant costs involved in replacing such doors with properly anti-ligature alternatives, but modifications to them might be made to them which would provide a cheaper alternative. In any event, doing nothing to reduce the risk is not a reasonable option.

[239] The Crown proposed that the inquiry recommend the replacement or alteration of the toilet cubicle doors in Monro Hall. SPS acceptance of this proposal in principle was qualified by querying the confining of the recommendation to this hall. It also pointed out that the nature of cell toilet cubicle doors varies across establishments, and careful consideration of appropriate and proportionate solutions for each area would be required. This point is a reasonable one. Given the evidence, and the statutory limits on the scope of the inquiry, I can only make

[18] See [2025] FAI 1 at paragraphs [486], [487], [855] – [862].

recommendations in relation to cubicle doors of the same or equivalent design as that in Jack's cell and which are installed in young prisoners' cells in Polmont. Prioritising the replacement or modification of such doors would be reasonable, albeit that the essential features of them giving rise to ligature risk are likely to be replicated in other designs of door, whether in Polmont or other prisons.

[240] I will therefore recommend the following:

Recommendation 2: All cell toilet cubicle doors of the type identified in the book of photographs which forms Crown Production 16 (photographs 22, 24, 30 - 35), and which are of the same or equivalent design as the door used as a ligature anchor point by Jack, should be removed from standard cells occupied by young prisoners in Polmont and either replaced with doors of an anti-ligature design, or modified so as to materially reduce the ligature anchor point risk which they present.

[241] The Crown proposed that the inquiry should recommend that issues of physical environment, including potential ligatures and ligature points, should be considered as part of the DIPLAR process, and also passed to SPS Estates department for consideration. SPS accepted this proposal without qualification. The DIPLAR process is under review. The sharing of information in relation to ligature points should help SPS develop better designs for the future and to identify improvements which could be implemented in the existing estate. Siobhan Taylor agreed in her evidence that in ligature deaths the DIPLAR should consider both the

ligature anchor point and the ligature used, and that revisions to the process in 2023 already sought to capture this information.

[242] The wisdom of this should be apparent from the discussion regarding the mechanics of Jack's death. It is clear that he ripped bedding to create a ligature[19], and managed to anchor it to the cubicle door. Given the door as it presented in September 2021, little ingenuity or adaptation was required to use it as a ligature anchor point. But if such doors were replaced or modified as recommended above, and a further suicide were to occur nonetheless, then it would be important to inquire into and understand how the prisoner had still been able to use it as a ligature point. That in turn could inform, through the DIPLAR process, proposals for further modifications so as to try to prevent yet further deaths.

[243] A recommendation such as is now proposed by the Crown was also made in *Allan & Brown*. For essentially the same reasons, which again it is unnecessary to repeat[20], it is also appropriate here:

Recommendation 3: 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 within 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.

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[19] This being the most common ligature item – see the findings and recommendations regarding ligature items in *Allan & Brown* at [2025] FAI 1, paragraphs [447] to [457] and [873] to [882].

[20] [2025] FAI 1 at paragraphs [959] to [962].

[244] The Crown proposed that the inquiry recommend that MORS policy should be amended to include explicit reference to TTM, and require that an assessment of suicide risk should be carried out whenever a prisoner is removed from MORS. It was submitted that there was a broad consensus of the expert opinion in the inquiry which was in support of such a recommendation. SPS did not accept wholly accept this, but agreed that it would be valuable to include a prompt to staff in MORS to keep TTM in mind. MORS was under review, and the precise form of any prompt should be a matter for that review. FVHB submitted that there was no basis on which such a recommendation might realistically prevent other deaths in similar circumstances, albeit that formalising consideration of a prisoner's suicide risk at the point of removal from MORS might be helpful.

[245] I agree that there should be an express and formal requirement in TTM to carry out a suicide risk assessment prior to removing at least some prisoners from MORS. Such assessments are required by TTM (by way of RRA) following admission to prison, and after each court appearance (even if the hearing is by video link and the prisoner does not physically leave the prison). Sometimes assessment by a healthcare professional is mandatory, on other occasions it is discretionary. But the underlying rationale is that certain events are or may be associated in general terms with a higher risk of suicide, and that therefore they should trigger a proactive, formal and documented assessment of risk in relation to the individual prisoner. Otherwise, ongoing suicide risk assessment of a prisoner under TTM is essentially reactive. The policy requires staff on a day to day basis to be alert to

verbal and non-verbal cues and clues which might indicate a risk of suicide in a prisoner, and if so to either initiate TTM or record concerns on a prescribed form.

[246] Population studies suggest that there is a higher rate of suicide associated with drug users in comparison to non-drug users. I understood this to be the general view of the medical experts and clinical witnesses in this inquiry, albeit that the available data is not derived from the Scottish prison population – and was not itself put before the inquiry. But it can at least be said that where a prisoner is placed on MORS - and more particularly when like Jack they are repeatedly placed on MORS because of chronic or habitual drug use - it is therefore apparent that they are likely to be members of a group of prisoners who in general terms are at an increased risk of suicide. Understandably, where a prisoner is thought to have consumed drugs, the first concern is for their physical well-being, given the risk of accidental overdose or the possibility that they have taken an adulterated and/or potentially poisonous substance. MORS is directed to that concern, and there was no suggestion that it was not in general terms appropriate or effective for this purpose. But when the acute concern for the prisoner's physical health has passed, and consideration is being given to removing them from MORS, the prisoner has not thereby ceased to be in that group of drug using prisoners who are statistically at higher risk of suicide.

[247] Removal from MORS, at least for chronic or habitual drug users, is therefore another appropriate point which should trigger a proactive suicide risk assessment. Nurse Forrester was alive to this in Jack's case. As with a RRA, this would not be a

full mental health assessment, but simply a screening assessment, which need not be overly onerous or time consuming. But it would require a review of the prisoner's MORS and TTM records, and to carry out a formalised assessment according to set criteria and specific prompts as may be devised. Without seeking to prescribe what these might be, there should obviously be emphasis on drug use as an indicator of increased suicide risk even in the absence of other cues and clues. The facts of Jack's case provide a paradigm illustration, and point towards a precautionary approach. But in any event any assessment would require to be recorded in such a way as to be accessible thereafter to both health care and SPS staff for ongoing suicide risk assessment.

[248] It follows from the above that both TTM and MORS would require to be amended to facilitate this change. TTM would have to be amended so as to expressly provide that removal of at least chronic or habitual drug using prisoners from MORS will require the carrying out of a suicide risk assessment by reference to specified criteria and specified forms. MORS would have to be amended so as to expressly prompt the requirement to carry out a TTM assessment in such cases.

[249] Dr Sayers and Dr Tuddenham were of the view - mindful of the sheer numbers of prisoners on MORS[21] - that to require a full mental health assessment or suicide risk assessment on each occasion that a prisoner is taken off MORS would be unrealistic and a misuse of resources. But I am not suggesting that. A requirement

[21] Dr Sayers said that MORS had been initiated more than 3000 times in the first six months of 2023 across the whole SPS estate.

to carry out a TTM assessment should apply when removing chronic or habitual drug users from MORS. But MORS is under review by both the NHS and SPS, and therefore a different or more precise definition of the class of prisoners to which this change should apply might be considered appropriate. However wherever the line is drawn, the requirement to carry out a formalised TTM assessment on removal from MORS should include prisoners such as Jack, that is, those who have frequently and repeatedly been made subject to MORS.

[250] I will make the following recommendation:

Recommendation 4: When a chronic or habitually drug using prisoner is removed from MORS they should be the subject of a suicide risk assessment under TTM. That assessment should involve a review of any previous TTM and MORS records and follow a standardised, approved process. The outcome of the assessment should be recorded in a prescribed form, and stored in an accessible format. TTM and MORS should be amended accordingly.

[251] The Crown proposed that the inquiry should recommend that FVHB should require healthcare staff to review a prisoner's VISION records prior to carrying out a MORS review or removing a prisoner from MORS. Where possible - that is, where the nurse's attendance is not required as a matter of urgency - the Crown submitted that the prisoner's VISION records should also be reviewed prior to the initial assessment. FVHB was opposed to this. It submitted that there was no evidence that healthcare staff did not already routinely review VISION when reviewing a prisoner on MORS. The clinical evidence did not support the suggestion that this

should be formalised. There was also no basis to suggest that it might prevent deaths in similar circumstances to Jack. Requiring staff to review VISION prior to initial assessment could lead to delay and uncertainty into a system that was currently working well, and with no clear or obvious advantage.

[252] I agree with the FVHB submission. I do not see how a requirement to consult VISION, either at the time of an initial MORS assessment, or in later reviewing the prisoner for the purposes of this policy, might realistically prevent other deaths in similar circumstances to Jack. Implicit in the Crown's submission seems to be the proposition that healthcare staff should be required by MORS to assess suicide risk. But MORS is not a suicide prevention policy. And in any event Jack died by suicide at a time when he was not subject to MORS. The policy was appropriately invoked on 1 September 2021 and appropriately discontinued the following day, it having by then served its primary purpose of monitoring Jack's physical health while he was under the influence of drugs. It is no doubt good practice to look at a prisoner's VISION records when conducting a review in accordance with a MORS care plan - as Nurse Forrester did in Jack's case. It might also be good practice to do so at time of initial assessment, if time permitted, although when that might be is perhaps hard to envisage given the inherent urgency of such assessments. But there are no good grounds to make a formal recommendation about this in the context of the present inquiry.

[253] This is quite distinct from the question of whether a healthcare professional should consult VISION when carrying out a suicide risk assessment for the purpose

of TTM. If, in accordance with Recommendation 4 above, TTM were to be amended to require a healthcare professional to carry out such an assessment when a prisoner is removed from MORS, then it would clearly be appropriate - indeed necessary - for them to acquaint themselves with all material relevant to the prisoner's suicide risk. This would include reviewing the prisoner's VISION notes as well as any previous TTM history or documentation. But the statutory recommendation as proposed by the Crown is not appropriate and I do not make it.

[254] The Crown next proposed that the inquiry recommend that SPS should include chronic drug use within the risk factors identified in TTM guidance and training. Dr Alcock in particular had given evidence about the increased risk of suicide in young drug users. There were particular concerns arising from increased use of synthetic cannabinoids such as Spice since 2019, and from changing patterns of abuse during the COVID lockdown. Overall, the available evidence showed that the link between chronic drug abuse and an increased risk of suicidality was well established. SPS response to this proposal was qualified. TTM policy and training already identified a history of substance misuse as a suicide risk factor. Whether "chronic drug abuse" should be specifically included in TTM as a risk factor was a matter which should be informed by expert advice in the context of the ongoing review. There might be a risks, substantive and practical, in appearing to differentiate between drug use and "chronic" drug use, where both required to be taken into account.

[255] TTM is currently subject to long term review, and as SPS submit, it will be informed by consultation with relevant experts and academic literature reviews, including in relation to the links between drug use and suicide. However that does not absolve this inquiry from making recommendations where they appear appropriate based on the evidence available to it. Regard should be had to any such recommendations, but they are not binding, and do not preclude SPS from also taking account of expert views and materials not placed before the inquiry in formulating policy going forward.

[256] The relationship between drug abuse and suicide by young prisoners was put at the heart of this inquiry, because Jack was a drug abuser who died by suicide. But as already noted, because the reasons for his suicide are unknown, it is not ultimately possible to say what role his drug use played in it - or indeed whether it played any role at all. Therefore his is a case which adds to the evidence of association, without clarifying the issue of causation.

[257] Understanding of the relationship between drug use and suicide in prisons is evolving, and will no doubt continue to evolve, in the light of a number of factors. These include the nature and effects of particular drugs, including new illicit drugs coming onto the market. It also includes the ability of SPS to respond to this and other changes in its attempts to prevent the flow of drugs into prisons. For example, at the time of Jack's death Spice and Etizolam had relatively recently become available for widespread abuse. Letters to prisoners could and would be impregnated with these drugs when reduced to liquid form. When this became

known, SPS sought to counter it by photocopying prisoners' letters in their presence, and then giving them the photocopy rather than the original documents. The success of this change may lead to further changes in the way these drugs are brought into prison, or as regards the types and quantities of drugs which are brought in, and the consequent effects of them on prisoners in the context of suicide prevention. It is a moving target. But sadly it can be assumed that drugs will continue to find their way into Polmont, and that a significant number of young prisoners will continue to abuse them.

[258] Dr Alcock said that in general terms there is an increased risk of suicide among drug users, and that this risk appeared to increase in relation to young people. One population study suggested that the suicide risk might be as high as six times greater for young drug addicts (15 to 24 years of age) when compared with young persons who did not take drugs. But again this is evidence of association, not cause. And as FVHB submitted, there was some uncertainty in the evidence as to the scope of the research, or what conclusions could be drawn from it relative to the present case. The studies were, as already noted, not specifically prison based. Siobhan Taylor spoke about cases where prisoners had attempted death by suicide after taking Spice where there was no evidence of previous suicidal ideation. But this is anecdotal, and it remains unclear, for example, whether young persons with traits predisposing them towards suicide are more likely to abuse drugs, or that abuse of drugs - or particular drugs - causes or exacerbates suicidal ideation, or both.

[259] TTM policy and training materials, as SPS submit, do already make some reference to drug use. In particular section 3 of Part 1 of the TTM Guidance, revised in June 2021, under the heading "Assessment", notes that "the majority [of prisoners] are from the following high risk categories … history of substance misuse including alcohol…" However that is the only reference to drug abuse in the more than forty pages of the TTM guidance. And in context, it is more a reference to prisoners' backgrounds prior to entering prison, than an alert for assessors in relation to the increased risk of suicide resulting from ongoing drug abuse in prison. There is no express reference in the non-verbal cues and clues to ongoing drug abuse - although it may sometimes amount to "self harm behaviour".

[260] The TTM training materials for staff also make similar passing references to drug abuse. These materials require staff to seek to identify "key indicators" identifying a prisoner who is at additional risk of suicide, which includes those "suffering from withdrawals (drug or alcohol)". Trainers are also directed to tell staff that another key indicator may be identified from a prisoner's healthcare background, including a "history of drug/alcohol abuse". Again, these references can easily be seen as historical background against which the assessor is to look for verbal and non-verbal cues and clues, none of which make express reference to drug abuse or its effects.

[261] In the light of all this, I consider that TTM Guidance and training materials should be amended to give staff greater awareness of the risk of suicide by prisoners who abuse drugs, and further information to better enable them to assess it. While a

history of drug abuse prior to entering prison is relevant to risk assessment, it should be made clearer that ongoing abuse of drugs within prison places a prisoner into a group with an higher statistical risk of suicide, particularly if they are a young prisoner. If a drug using prisoner chooses to withdraw from drug use – or is forced to by a lack of supply - then this may indeed be a key indicator that they are at heightened suicide risk. But it should also be made clearer that prisoners who are not in withdrawal but are engaged in continuing drug use - particularly if there is a pattern of such behaviour - are also at heightened risk. Finally, some express reference to drug use should be included as one of the non-verbal cues or clues for staff to consider when assessing suicide risk. For example, staff might be encouraged to consider whether the nature, frequency and extent of the prisoner's drug abuse is such that it should be recognised as an act of self-harm, and taken into account for suicide assessment purposes on this basis.

[262] Ultimately, as SPS points out, risk assessment under TTM is person centred, not a tick box exercise based on risk categories into which the prisoner may fall. But if a prisoner does fall into such a category, the statistical significance of this should be recognised, and should inform the person-centred assessment. Put another way, and for example, where a young prisoner is known to be a chronic or habitual drug user like Jack, this will likely suggest a need for heightened sensitivity to individualised signs of a risk of suicide, and may point towards a lowering of the threshold for TTM intervention in their case. But I also accept the point made by

SPS that this will have to be informed by expert advice in the context of the ongoing review of TTM.

[263] Accordingly I will make the following recommendation:

Recommendation 5: TTM Guidance and training materials should be amended to make express reference to, and greater emphasise, the heightened risk of suicide by a young prisoner who abuses drugs whilst in Polmont. In particular these materials should be amended so as to direct staff of the need to take account of chronic or habitual drug use by a young prisoner in assessment of their suicide risk.

[264] The Crown submitted that a visual hatch check, at the end of the night shift, should be reinstated in Polmont in order to ensure that prisoners are safe and well within their cells. Such a hatch check was instructed at the time of Jack's death, but has since been discontinued. This submission was supported by Jack's next of kin, who also invited the inquiry to recommend that the officer conducting the check should be required to take notice of the state and condition of the cell, and whether it was damaged or in disarray.

[265] SPS opposed the Crown submission. It submitted that the check took place only 60 minutes before the morning numbers check when cell doors are opened, and so was of little utility as a welfare check. The disruption and encroachment on a prisoner's privacy and dignity was unnecessary and inconsistent with a trauma informed approach. The procedure had been unique to Polmont, and this in itself made it inappropriate as there should be a single standard of service. There was no

evidential basis for reintroducing the check. The inquiry should go no further than recommending a review.

[266] When an individual is sent to prison, they do not surrender all their fundamental rights at the gate. They retain those rights, in full or attenuated form, which are not removed as a necessary concomitant of the deprivation of liberty. The right to respect for privacy is inevitably and severely curtailed, but it is not wholly removed. Measures imposed which amount to a further infringement of this right must therefore pursue a legitimate aim and be proportionate to it. A balance has to be struck between respecting what remains of a prisoner's privacy, and the interests to be served by interfering with it. The question is where exactly to strike that balance.

[267] As already noted, in 2021 the Patrol Orders required prison officers to carry out a hatch check prior to the end of the night shift "to ensure all YP [young prisoners] / YW [young women] / W [women] are safe and well." In 2023, when women prisoners were moved to HMP Stirling, the Patrol Orders were revised. The purpose of the night shift hatch check was now to "ensure all people in our care are safe and well." In practice this would have meant young male prisoners. Even within a general prison population which has many vulnerabilities, young male prisoners are recognised to be particularly vulnerable for a number of reasons.

[268] Although the requirement to carry out the nightshift hatch check had the principal purpose and benefit of monitoring the health and safety of certain prisoners, it also had the function of providing an end of shift numbers check.

Sue McAllister's evidence was that a hatch check for these two purposes at the end of the night shift was standard practice in prisons in England and Wales, including in young offenders' institutions.

[269] Such a check involves a minimal interference with prisoners' residual privacy. In Polmont in 2021 it involved a visual check only. Officers were not required by the Patrol Orders to wake the prisoner up in order to get a verbal response. In purely practical terms, as regards suicide prevention, the principal but unspoken aim was to check that the prisoner was not hanging themselves or apparently preparing to do so. In any event the check served the legitimate aim of seeking to secure the welfare of particularly vulnerable groups of prisoners, and was proportionate to that aim. Seeking to further this aim was and is consistent with a trauma informed approach, not contrary to it.

[270] That no other prison in Scotland did such a check and that it was not required by the Prison Rules did not therefore mean that it was not appropriate in Polmont. As noted in the DIPLAR report in relation to Jack's death (lodged as Crown Production 10) the end of night shift hatch check was instituted at Polmont following the deaths in custody of other young prisoners[22]. That suggests the making of a recommendation in an earlier DIPLAR, or FAI.

[271] In any event the utility of such a check for welfare purposes is well illustrated by Jack's case. Had Officer Nelson carried out the check at Jack's cell

[22] See also GMA/016A/16, 28 March 2016, Crown Production 8.

properly in the early morning of 3 September 2021 there is at least a theoretical possibility that his death might have been avoided. Overall, the balance should be struck in favour of young prisoners' safety, rather than removing the minimal interference with their residual privacy involved in a visual hatch check likely to last a second or two, all being well.

[272] As to Caroline Wright's further submission, that the hatch check procedures should specifically include a requirement for the officer to take notice of the state of the cell, I do not consider that this is necessary or appropriate. The instruction in the Patrol Orders in 2021 was, and should be, teleological - it is for the purpose of ensuring that the prisoner is safe and well. The observed state of the cell may or may not play a part in assessing this, but it is not a matter which requires to be the subject of prescription in Patrol Orders.

[273] As to SPS' submission that this inquiry should recommend no more than a review in relation to the end of shift hatch check, I disagree. The check was previously in place, likely as a result of a previous recommendation following the death of a young prisoner or prisoners at Polmont, and no good operational, logistical or resources based objection to reinstating it was apparent. I will make the following recommendation, and it will be for SPS to decide whether to accept it or not:

Recommendation 6: A visual hatch check, around one hour before the end of the night shift, should be reintroduced at Polmont in order to seek to ensure that all young prisoners are safe and well within their cells at this time.

[274] The Crown submitted that SPS and NHS staff should receive regular training on the MORS policy ensure that it is properly understood and applied in practice. In response SPS submitted that training requirements would be considered as part of the ongoing MORS review. FVHB submitted that it was not clear how such additional training might realistically prevent deaths in similar circumstances to Jack. FVHB staff were made familiar with MORS and the relevant NHS standard operating procedure prior to working in Polmont, and would then have training on the job. Any inconsistences or misunderstandings of the policy were not material. Once Dr Sayers' updated policy was in place FVHB staff would be trained on it.

[275] As the Crown submitted, the evidence of the various prison officers and healthcare staff disclosed inconsistencies in understandings of MORS. These related to (i) whether the Appendix A form should be completed by a prison officer or the nurse; (ii) how exactly the checks carried out pursuant to the care plan should be recorded in the Appendix D form; (iii) whether the prisoner should be woken up on each occasion when they were checked during the night in order to obtain a verbal response; (iv) whether the nurse should check the prisoner's VISION records when assessing or reviewing the prisoner; (v) whether it was mandatory that a prisoner remain subject to MORS for 24 hours, or could be removed from it before this period had expired; and (vi) whether there was an automatic requirement that a prisoner subject to MORS should be removed from association pursuant to an order under rule 95 of the Prison Rules.

[276] As was further highlighted in evidence, there are inconsistences and deficiencies in relation to formal training for prison officers in relation to MORS. The policy was introduced by way of GMA 079A/14 in 2014. Officers in post at that time were expected to read the GMA and otherwise to learn on the job. MORS is included in training given to new recruits since 2014 at SPS College. Nurses in post in 2014 also learned on the job. MORS training is part of new nurses' induction programme, and they too are thereafter taught on the job, but with the assistance of a mentor.

[277] Given the sheer number of prisoners who are put on MORS in any given week in any given prison, there is clearly much opportunity to learn about the policy on the job. But I agree with the Crown that the nature and number of the misunderstandings and inconsistencies of MORS revealed in the evidence indicates a need for more formal training, both for prison and healthcare staff. The policy appears to work reasonably well in substance, but this does not remove the need for correct and consistent understanding of its terms by staff. The need for this will increase when and if a revised MORS policy, being drafted by Dr Sayers at the time of the hearing of the inquiry, is brought into effect. The precise nature and extent of such training is likely to depend on the nature and extent of the changes, but in principle it should be classroom based, and not merely consist of an instruction to read the new policy documents and thereafter learn on the job.

[278] But that said, like FVHB, I struggle to see the basis for a statutory recommendation to this effect in the present case. The evidence does not support

the proposition that Jack's death was a result of staff misunderstandings or inconsistencies in understanding MORS. He was appropriately placed on MORS when under the influence of drugs on 1 September 2021, and he was appropriately removed from it the following day when he was no longer under the influence. He was kept under observation in the intervening period during which his physical health was preserved. He died by suicide 12 hours later after he had again taken drugs, but had his renewed drug use been known about there is nothing to suggest that he would not again have been place on MORS due to staff misunderstandings of the policy. And in any event it is not established that Jack's death was causally linked to his drug use. Therefore I cannot see that more formal staff training on MORS - a good idea though it no doubt is - might realistically avoid deaths in similar circumstances to those in which Jack died. Accordingly no recommendation is appropriate in relation to this matter under section 26(1)(b) of 2016 Act.

[279] Finally, the Crown submitted that SPS should revisit the guidance provided to staff carrying out patrol and night shift duties, such that, where possible, there should be one member of patrol or night shift staff actively patrolling at all times. The evidence suggested that patrol officers were, somewhat counter-intuitively, not required to patrol during their shifts, but rather to respond to intercom buzzers. The two night shift officers on duty in Monro hall were required to patrol once per hour, but they could do so alternately, and the evidence suggested that a patrol of the four floors of the hall might only take around 20 minutes. Accordingly the Crown submitted that increased levels of patrol at night might realistically afford staff a

better chance of identifying distressed prisoners and intervene to prevent further suicide.

[280] Like Jack, the great majority of suicides in prison in Scotland take place at night when the prisoner is alone in their cell, and not subject to observations whether under TTM or MORS. In Monro Hall, a prison officer might walk past any given cell as little as once per hour during the night shift, taking a few seconds to do so. If an officer did so more frequently, because there was a continuous patrol, is there a realistic possibility that deaths by suicide similar to that suffered by Jack might be avoided?

[281] There are perhaps reasons why it might. Night is a time for prisoners at Polmont to shout from their cells, and sometimes to abuse or threaten other prisoners - the so called "window warriors"[23]. Andrew Elliot said that this happened to Jack on the night of 2 September 2021, and SPS submitted that it was possible that such threats had played some part in Jack's decision to end his life[24]. Night time is also a time for drugs to be passed between cells, whether via lines swung outside the windows or slid under the cell doors - again as Andrew Brolly said took place on the night Jack died. And if there is a disturbance from within a cell, for example where a prisoner is damaging fixtures or fittings, or throwing personal belongings about, this may indicate that they are in a state of distress.

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[23] See *Allan & Brown* [2025] FAI 1 at paragraph 66.

[24] For what it is worth, I think that this is unlikely. Jack was no stranger to violence. Even if he did have a drug debt to Andrew Brolly – which is unclear – the evidence does not suggest to me that this would have caused him great concern, or at least, sufficient concern to kill himself when he would otherwise not have done so.

Again, there has been evidence that Jack may have engaged in this sort of behaviour on the night he died.

[282] Such behaviour, if seen or heard by night shift prison officers, should call for intervention, at least by way of a hatch/welfare check. Yet neither Officer Nelson or Officer Afzal was aware of any of such behaviour by or relating to Jack's cell on the night of 2 September 2021. Accepting that all the relevant witnesses are telling the truth about their recollections of what happened, it might suggest that the officers' patrols were sufficiently infrequent as to allow it to take place unheard and unchecked. But as Andrew Elliot said, it might also be that as prisoners could hear the officers' footsteps when they patrolled the hall, they would simply modify their behaviour, and quieten down, until they had left.

[283] In any event, as SPS submitted, the precise duties of patrol and nightshift officers, and in particular the extent to which they should be actively on patrol, are operational matters which this inquiry is ill equipped to pass judgment on. What is proposed is not simply reinstating a requirement which was previously in operation, such as the end of shift hatch check, but introducing a new and as yet untested requirement. There are two members of staff on night shift for the whole four floors of Monro Hall. They will no doubt have a variety of duties. They will require to conduct periodic hatch check observations on prisoners who are on TTM or MORS. They will need to respond to prisoners who press their cell buzzer indicating a need for assistance. If one officer is always out in the hall patrolling, and the other is

answering a buzzer, then there is a risk that a further buzzer will go unnoticed or unanswered.

[284] There is therefore a balance to strike between pro-active and reactive patrolling. And where exactly that balance should be struck as a matter of policy is beyond the scope of this inquiry. The evidence of what happened on a single nightshift in September 2021 is not a sound basis to make recommendations about patrol practice in general. And if questions arise as to whether two officers are sufficient for supervising the whole hall at night, these cannot be divorced from questions about the allocation of sufficient resources to pay for any increase in staffing. The evidence before the inquiry did not enable it to properly answer such questions.

[285] Ultimately SPS submitted that it was content to review the patrol and night shift instructions in relation to active patrolling, but that the inquiry should not go beyond recommending such a review. I agree. Both in this inquiry and in *Allan & Brown* the evidence suggested that the sort of night time behaviour referred to above is common in Polmont and has at least formed part of the background for the deaths by suicide of the young prisoners involved. More active steps to seek to eradicate such behaviour is indicated, so as to try to better protect the interests of those young prisoners vulnerable to it, in particular those whose vulnerabilities manifests not only in distress and upset but also in self-harm and suicide. Whether and if so how that should be done should be a matter for SPS to review in the first instance.

[286] Accordingly I recommend:

Recommendation 7: SPS should review the instructions given to staff at Polmont regarding active patrolling of residential halls during patrol and night shifts. In the context of this review SPS should seek to identify ways to better reduce, at night, abusive and bullying verbal behaviour, drug dealing, and to respond to physical disturbances by prisoners within their cells. This review should also consider the adequacy of present staffing levels for this purpose. It should be completed within 6 months of the date of this determination, and a written report made to Scottish Ministers.

(H) POSTSCRIPT

[287] Like all other participants in the inquiry I offer my condolences to Jack's next of kin.

APPENDIX 1: TABLE OF ABBREVIATIONS

A2C	Act 2 Care suicide prevention policy
CAMHS	Child and Adolescent Mental Health Services
DIPLAR	Death In Prison Learning Audit Review
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
HMIPS	His Majesty's Inspectorate of Prisons for Scotland
IMU	Intelligence Management Unit
MORS	SPS Management of Offenders at Risk from any Substance policy
MTK	Manchester Took Kit
NSPM	National Suicide Prevention Manager
NSPMG	National Suicide Prevention Management Group
PER	Prisoner Escort Record
PHAS	FVHB Prisons Healthcare Addictions Service
PR2	SPS electronic prisoner record system

RRA	TTM Reception Risk Assessment
SOP	Standard Operating Procedure
SPOA	Scottish Prison Officers Association
SM	Scottish Ministers
SPS	Scottish Prison Service
SRU	Separation and Reintegration Unit
TTM	SPS Talk To Me suicide prevention policy
VISION	NHS electronic prison healthcare recording system