1 Friday, 22 September 2023

2 (10.00 am)

3 LADY SMITH: Good morning, and welcome back to the evidence

4 in relation to our Phase 8 case study.

5 As we said last night, Dr Derek Chiswick is due to

6 give evidence this morning and I am told he is here,

7 Mr Peoples.

8 MR PEOPLES: Yes, he is, my Lady.

9 LADY SMITH: Are you ready to call him?

10 MR PEOPLES: Yes, if I could call Dr Chiswick.

11 LADY SMITH: Thank you.

12 Dr Derek Chiswick (affirmed)

13 LADY SMITH: Good morning.

14 A. Good morning.

15 LADY SMITH: Could we begin by you raising your right hand,

16 please, and repeat after me.

17 (The witness affirmed)

18 LADY SMITH: Do sit down --

19 A. Thank you.

20 LADY SMITH: -- and make yourself comfortable.

21 A. Thank you.

22 LADY SMITH: Dr Chiswick, thank you for agreeing to come

23 along this morning to help us with the evidence in this

24 case study. In the red folder you will find your

25 statement, but you may have brought your own copy,

1 marked, I don't know. Feel free to use whatever is
2 helpful to you. We may put some documents on screen
3 which may also assist you. If you want to take notes,
4 do, but there is a running transcript being made if you
5 need to look back at it at any stage.
6 Ask me if you have any questions as we go along.
7 Our mission is to make it as easy as we can for you to
8 give the evidence that we are asking you to give today.
9 Let me know if you want a break at all. I will normally
10 break at about 11.30 am for the mid-morning break, but
11 if you need a break before then, just let me know, will
12 you?
13 A. Okay, thank you.
14 LADY SMITH: If you you are ready, I will hand over to
15 Mr Peoples and he will take it from there.
16 A. Okay, thank you.
17 Questions from Mr Peoples
18 MR PEOPLES: Good morning, Dr Chiswick.
19 To begin with, perhaps I could just say for the
20 benefit of the transcript that you have provided
21 a statement to the Inquiry in advance of giving evidence
22 today. The main reason you are here today is, I think,
23 to speak to a report that you prepared with others in
24 1985 in relation to a particular establishment,
25 Glenochil.

1 A. That's correct, yes.
2 Q. I will come to that report in due course, and most of my
3 questions will relate to that period of time, but I may
4 ask you to look at certain other documents, or comment
5 on certain other matters in the course of giving
6 evidence.
7 I propose to start with the statement that you have
8 provided, so that we see how you became involved in the
9 preparation of the report. Can I first of all take you
10 to your statement, which is WIT-1-000001031, which
11 should be on the screen but you do have a copy in front
12 of you if you wish to look at that.
13 A. I do, yes.
14 Q. Your own copy.
15 Just for the record, can I just take from you that
16 the statement that you have in front of you was signed
17 by you on 4 July 2022?
18 A. Yes, that's correct.
19 Q. Can you confirm that you have no objection to this
20 statement being published as part of the evidence to
21 this Inquiry and that you believe the facts which are
22 stated in this statement are true?
23 A. Yes, I can confirm that.
24 Q. If I can start, hopefully briefly, with your
25 professional background and experience, which is set out

1 at the beginning of your signed statement. You are
2 a retired consultant forensic psychiatrist --
3 A. Correct.
4 Q. -- as you tell us in paragraph 2. You have provided
5 a full CV, and quite a lengthy CV, to the Inquiry. So
6 you have had quite a lot of appointments in the past in
7 various capacities, and you have been quite an extensive
8 writer of articles in journals of all descriptions in
9 relation to matters pertaining to your area of
10 expertise, is that correct?
11 A. That's correct, yes.
12 Q. In particular, can you just tell us when you first of
13 all qualified?
14 A. Yes, I qualified in medicine in 1969 at the University
15 of Liverpool. I did my house jobs in Liverpool, as they
16 were then called, and became fully registered in 1970.
17 Q. I think then after you did become a member of the Royal
18 College of Psychiatrists in 1976 I think; is that
19 correct?
20 A. That's correct, yes.
21 Q. Indeed you became a fellow of the Royal College of
22 Psychiatrists in 1989?
23 A. That's correct, yes.
24 Q. As far as your registration with the GMC is concerned,
25 you are a registered medical practitioner with

1 specialist registration in forensic psychiatry?
2 A. That's correct, I no longer have a licence to practise,
3 but I am registered with the GMC, yes.
4 Q. I think to some extent -- I am not suggesting that you
5 have kept up entirely with matters pertaining to your
6 areas -- you have kept abreast of, to some extent,
7 developments in your field?
8 A. I have kept abreast, that's a correct phrase to use.
9 I haven't engaged in any further research or anything
10 like that.
11 Q. Yes, so if I do ask you questions about more recent
12 times, and I may ask you the odd one, please feel free
13 to explain the extent to which you are able to assist
14 the Inquiry with those matters.
15 A. Okay, thank you.
16 Q. Although you are retired and you are no longer in
17 clinical practice, you do currently serve on the Mental
18 Health Tribunal for Scotland as a medical member, is
19 that correct?
20 A. That's correct, yes.
21 Q. You have done so since 2005?
22 A. That's correct, yes.
23 Q. If we go back to perhaps the sort of period during which
24 you prepared the report that we are going to look at and
25 discuss today, between 1980 and 1988 I think you were a

1 Senior Lecturer in Forensic Psychiatry at the University
2 of Edinburgh and an Honorary Consultant Forensic
3 Psychiatrist at the State Hospital in Carstairs and the
4 Royal Edinburgh Hospital?
5 A. That's correct, yes.
6 Q. I think in 1988 you became a Consultant Forensic
7 Psychiatrist with NHS Lothian and an Honorary Senior
8 Clinical Lecturer in Psychiatry at the University of
9 Edinburgh?
10 A. Yes, that's correct.
11 Q. Can you confirm that among the clinical responsibilities
12 you had, they included a role as lead clinician for the
13 Orchard Clinic, which I think you tell us in your CV was
14 Scotland's first medium-secure unit, which provided
15 a forensic psychiatric service for south-east Scotland
16 and HM Prison Edinburgh?
17 A. That's correct, yes.
18 Q. Of course you tell us within your CV, among the many
19 appointments you have had over the years, that in the
20 period 1984 to 1985 you were the chairman of a working
21 group to review suicide precautions at HM Detention
22 Centre and HM Young Offenders Institution, Glenochil,
23 having been appointed by the Secretary of State for
24 Scotland?
25 A. That's correct, yes.

1 Q. Your group published a report in 1985, I think, around
2 24 July?
3 A. That's correct, yes.
4 Q. In your CV you have listed many publications that you
5 have written in your field. I just picked out one, and
6 I don't know whether it is of any relevance to what we
7 are going to discuss today, but one article I noted was
8 that you published a leading article in the British
9 Medical Journal in 1992, "What mentally ill offenders
10 need"?
11 A. Yes, that's correct.
12 Q. Does that have any bearing on the matters with which
13 your report was concerned?
14 A. I think that was at the time when there were changes in
15 legislation relating to mentally disordered offenders,
16 and the way in which those changes might affect current
17 services.
18 Q. Yes. You retired as a Consultant Forensic Psychiatrist
19 I think in 2006; is that correct?
20 A. That's correct, yes.
21 Q. Can I go back to your statement. You tell us a bit in
22 the statement about the background to the working group
23 that you were appointed to in 1984 in relation to
24 suicide precautions at Glenochil. Can we just look at
25 that. It is paragraph 7 on page 2 of your statement.

1 You deal with it there. I can take this fairly short,
2 I hope. The background was that between 1981 and 1984,
3 when your working group was set up, there were five
4 deaths, self-inflicted deaths, at Glenochil detention
5 centre and young offenders institution?
6 A. Yes, that's correct.
7 Q. I think, as you say, these gave rise to significant
8 concern. I think it was a matter of public and
9 political concern at the time?
10 A. That's correct, yes.
11 Q. I think just by way of broad background, we are dealing
12 with the mid 1980s, we had a Conservative government?
13 A. Correct, yes.
14 Q. We had certain types of options available to the courts,
15 including short periods in a type of institution called
16 a detention centre?
17 A. That's correct, yes.
18 Q. Which was an alternative to perhaps the only other
19 option, which was then a young offenders institution?
20 A. Yes, that's correct.
21 Q. In broad terms, am I right in thinking that the
22 detention centre was intended for young offenders
23 serving relatively short sentences?
24 A. Yes, I think it was up to four months.
25 Q. Yes. I think historically it had had been a fixed

1 period of three months, but legislation had changed that
2 to allow up to around four months --
3 A. That's correct, yes.
4 Q. -- for offenders? It was colloquially described,
5 I think, at the time, as short, sharp, shock treatment?
6 A. That's right, yes.
7 Q. That expression may have owed its origins, at least, to
8 statements that were made by prominent politicians at
9 Conservative party conferences. I think in the papers
10 you provided one of these statements was by
11 William Whitelaw in 1981, where he spoke about these and
12 how they would not be holiday camps?
13 A. That's correct, yes.
14 Q. You may not recall exactly, but I think that was
15 certainly one example --
16 A. Yes.
17 Q. -- of when that expression was used?
18 A. That's correct, yes.
19 Q. By a senior minister --
20 A. Indeed.
21 Q. -- of the Government?
22 A. Indeed.
23 Q. And said publicly?
24 A. Yes, that's correct.
25 Q. Now --

1 A. Can I just say, when you mentioned five deaths at
2 Glenochil, there were of course a further two --
3 LADY SMITH: That was during the period of your review,
4 wasn't it?
5 A. Correct, yes.
6 MR PEOPLES: Sorry, I was going to come -- when you were
7 appointed, yes, there had been five deaths during that
8 period --
9 A. That's right.
10 Q. -- but subsequently during your working group's activity
11 there were a further two deaths?
12 A. That's correct, yes.
13 Q. Which I don't think you dealt with specifically in your
14 report, but you were clearly aware of, and I think at
15 the stage of your report there were still to be fatal
16 accident inquiries into those particular deaths, is that
17 correct?
18 A. We were aware of the outcome in relation to Angus Boyd,
19 and that is mentioned in the report, but the fatal
20 incident inquiry into Derek Harris was awaited, yes.
21 Q. Yes, I am grateful.
22 A. Yes.
23 Q. Before I look at these particular cases, can I perhaps
24 take you to one of the documents, another document, just
25 to get some idea of what Glenochil was like at that

1 time, because you have already told us it was both
2 a detention centre and in another part of the same site
3 a young offenders institution?
4 A. That's correct, yes.
5 Q. Just for the record, I think that we did establish,
6 I think earlier this week, that detention centres at
7 least as a specific setting disappeared around 1988?
8 A. That's correct.
9 Q. Although I may come back to the effect of that, because
10 I think things were written around the time about
11 whether that changed anything.
12 It was reclassified as simply a young offenders
13 institution, is that your understanding?
14 A. That's my understanding, yes.
15 Q. Yes. I think we were doing a little bit of homework,
16 just, and no doubt we can confirm this, but I think that
17 it remained a young offenders institution until around
18 2003, when essentially, I think, most young offenders
19 were sent initially at least to Polmont Young Offenders
20 Institution, although they might then thereafter be sent
21 to different places depending on how they were assessed,
22 does that accord in broad terms with --
23 A. I think so, yes, I can't be sure, but --
24 Q. Don't worry, I am probably telling you this, but I think
25 that is a reasonably accurate thing. Thereafter it

1 became an adult prison?
2 A. That's right.
3 Q. Indeed, I think it is still an adult prison today?
4 A. Yes, it has been completely rebuilt.
5 Q. Yes, there have been changes in relation to the site --
6 A. Yes.
7 Q. -- but it still remains in existence, but it doesn't
8 deal with young offenders any more?
9 A. No, it is an adult prison.
10 Q. I think we heard from Professor Norrie earlier this week
11 that both young offenders institutions and detention
12 centres would deal with young people who would be
13 categorised for the purpose of our Inquiry as children
14 or young persons under 18?
15 A. Yes, that's correct.
16 Q. Although they would also cater for young adults, if
17 I could use that expression, between the ages of 18 and
18 21?
19 A. That's correct, yes.
20 Q. I think in the case of a detention centre at any rate,
21 the young person could be as young as 14?
22 A. Yes, I understand that was the case. I am not sure that
23 there were any children as young as that --
24 Q. No.
25 A. -- when we did our inquiry, but it was possible, yes.

1 Q. If I could take you to another document just for the
2 moment, and move away from your statement. It is
3 WIT-3-000001184, which hopefully will come on screen.
4 A. Yes.
5 Q. Do we have it?
6 A. Yes, I have my report, I have the report in front of me
7 as well.
8 Q. Can I go to page 49, please. Sorry. Yes, I think it is
9 a document with which you are familiar, indeed we will
10 understand why in due course.
11 A. Yes.
12 Q. This document was a Scottish Office press release, or
13 news release, at the time that the report of your
14 working group was published, around 24 July 1985, is
15 that correct?
16 A. Yes, that's correct.
17 Q. This was by way of background briefing note to give the
18 media some idea of the background to the institutions,
19 or the institution that was being reported on?
20 A. That's correct.
21 Q. Can I just ask you this, before I look at the release
22 itself. Your report was published on 24 July 1985.
23 When was it completed?
24 A. We submitted the report to the -- give me --
25 Q. To the Scottish Home and Health Department?

1 A. Yes.
2 Q. I don't need a precise date, I was just trying to work
3 out relative to the publication, because it was always
4 intended that your report would be published, I think?
5 A. Yes, oh indeed. I submitted the report on 28 June 1985.
6 Q. So this was just short of a month later --
7 A. Yes.
8 Q. -- that it was published?
9 A. Yes.
10 Q. If I go to the news release itself, I will just pick out
11 some things, and if there is anything in that that
12 doesn't accord with what you think is an accurate
13 description based on what was in your report, please let
14 me know.
15 I think in broad terms what I am going to read out
16 is probably the situation as we could glean it from your
17 report as well.
18 A. Right.
19 LADY SMITH: Before we look at the content of the press
20 release, can you tell me, Dr Chiswick, whether you were
21 invited to provide any input for the press release, or
22 even just allowed to see it in draft beforehand?
23 A. The answer to both of those questions, my Lady, is no,
24 and no.
25 LADY SMITH: Thank you.

1 Mr Peoples.

2 MR PEOPLES: Thank you very much.

3 So this was all the work of the Scottish Office?

4 A. That's correct, yes.

5 Q. Unaided by your input?

6 A. Unaided by any input from me, yes.

7 Q. Yes. With that information, can we just look at what's

8 said. I will come back to your report itself and the

9 composition of the group, but what we learn is that

10 in overall charge of the Glenochil complex, which

11 included the young offenders institution and the

12 detention centre, the Governor was a Mr Bill McVey, and

13 the detention centre Governor was a Mr Alec Spencer?

14 A. Correct, yes.

15 Q. I will just pause there and say -- we will come back to

16 this -- that he actually sat on the working group?

17 A. He did, yes.

18 Q. As did two other persons who had had a connection,

19 a direct connection, with Glenochil?

20 A. That's correct, a nurse and a social worker, yes.

21 Q. Just in passing, do you happen to know what the thinking

22 behind that was, or were you presented with these names?

23 A. I was presented with those names and I think, as I have

24 indicated in my report, initially the composition of the

25 working group was all male, and I requested that we had

1 some female members appointed, and the membership was
2 modified at my request and my suggestion.
3 Q. We can look at the composition when we go back to the
4 statement, but that's the situation, that's how it came
5 about?
6 A. Yes.
7 Q. You weren't instrumental in asking for anyone connected
8 with Glenochil to sit on your working group?
9 A. No, I wasn't instrumental in that at all.
10 Q. Because in an inquiry context that would be a little
11 unusual, to say the least, if you are looking at
12 an institution critically and reviewing its practices,
13 policies and procedures?
14 A. Yes, I would agree, but you used the word "inquiry".
15 Q. Yes.
16 A. And we weren't an inquiry in the way that we have become
17 accustomed to that term being used, indeed the sort of
18 inquiry that we are here at today. It was a review --
19 it was a working group, so by definition the members
20 were people with working knowledge of the relevant
21 areas.
22 Q. I think you may have said this in your report, and if
23 you didn't, you probably said it in your statement, that
24 you found it valuable to have access to the individuals
25 who sat on the working group who had direct knowledge of

1 Glenochil, is that correct?

2 A. That is correct. I don't think we would have been able

3 to ascertain working practices in the way that we were

4 able to without their assistance, and membership of the

5 group.

6 Q. I take it that although on one matter there was

7 a division of opinion about whether Glenochil, as

8 a result of your findings, should close, there was

9 a division of opinion among the members of the group,

10 your broad conclusions were unanimous, and certainly

11 were the Glenochil members, if you like, in agreement

12 with them?

13 A. Oh yes, yes. We were all in agreement with the broad

14 conclusions that we reached: it was a unanimously

15 delivered report. We were all in agreement with the

16 conclusions that we reached. There had been a division

17 of view in relation to the possibility of closure, or

18 the possibility of recommending closure.

19 Q. Yes. Yes. But that was really only the point of

20 difference?

21 A. Yes, yes, absolutely.

22 Q. As far as the detention centre is concerned, if we look

23 at the press release we see that Glenochil detention

24 centre opened in July 1966 and was one of two in

25 Scotland, the other being located at Friarton near

1 Perth, with a capacity of 76 places.
2 The press release itself, I think, goes on to say,
3 "Provide what is referred to colloquially as the short,
4 sharp, shock". So that was the way it was characterised
5 by the department and the Scottish Office?
6 A. Exactly, yes.
7 Q. It says that at the time the centre provided
8 accommodation for 182 inmates in three wings, two
9 containing 61 rooms and the other 60 rooms.
10 Then I think there is an attempt in the press
11 release, because I think this is something that perhaps
12 many people found difficult to work out what the purpose
13 of a detention centre was, I think that was a matter you
14 may have commented on in your report?
15 A. That's correct. What the purpose of it was, and how it
16 was intended to achieve that purpose.
17 Q. Yes.
18 Well, what the press release says, and presumably
19 this was approved by ministers and officials before it
20 was released, is:
21 "The centre receives inmates most likely to benefit
22 from a short period of disciplined living under a regime
23 comprising a general alertness of response, and a high
24 standard of personal conduct, cleanliness, physical
25 fitness and work effort. All inmates are given

1 a medical examination to ensure that they are medically
2 fit for the regime. If unfit the medical officer either
3 places the youth on a modified programme or has them
4 transferred to a young offenders institution."
5 That could include transfer from Glenochil detention
6 centre to the young offenders in the same place?
7 A. Correct, yes.
8 Q. It says:
9 "Inmates who were medically fit have a period in the
10 gymnasium and on the running track each day."
11 You see that.
12 If we go over to page 50, it goes on:
13 "Apart from drill and physical exercise, employment
14 in gardening, workshop, cookhouse and domestic chores is
15 provided in a fully organised day."
16 Then it goes on to the issue of education to say:
17 "Basic education, on a limited scale, is also
18 provided during the day. Evening classes in educational
19 and other subjects form part of the evening programme
20 during the winter months."
21 It is not saying too much about the quality of the
22 education, is it, even in the official statement?
23 A. No, indeed. I think we found that a number of the
24 detention centre trainees, as they called them, I think
25 we were told that a third required remedial education.

1 Q. Yes.

2 Just pausing, if I may, just to ask a question:

3 would it be fair to say that a significant proportion of

4 those who were both in the detention centre at that time

5 and in the young offenders institution would have had

6 a care background?

7 A. Yes, we didn't do a -- we didn't do a survey of the

8 general --

9 Q. No, no.

10 A. -- population, so I can't speak with certain knowledge,

11 but certainly a large number of the either young

12 offenders or trainees, as they called them, had, you

13 know, experienced adverse childhood

14 experiences/childhood events.

15 Q. I can perhaps tell you that certainly a number of people

16 have come forward to this Inquiry to give us evidence

17 about where they were, and their experiences in various

18 places, care settings, have been on a journey which has

19 often included children's homes, foster care, List D or

20 Approved Schools, as well as young offenders

21 institutions, borstals, detention centres, remand homes,

22 remand institutions and so forth?

23 LADY SMITH: And assessment centres.

24 MR PEOPLES: And assessment centres.

25 LADY SMITH: Yes.

1 MR PEOPLES: That I can tell you is certainly what we are
2 hearing from people that have come to assist the
3 Inquiry.
4 A. Yes. I am absolutely sure, aware of that and I am sure
5 that is the case. I can only say that it wasn't --
6 Q. No, no.
7 A. -- part of our job, we didn't sort of research that
8 aspect of the institution population.
9 Q. If we go back to the press release, it just gives us
10 some assistance on the sentencing provisions at the
11 time. It said:
12 "Prior to the implementation of section 45 of the
13 Criminal Justice (Scotland) Act 1980 ... on
14 15 November 1983, the sentence to a DC was a fixed one
15 of three months. Section 45 provides that a sentence of
16 detention of between 28 days and four months passed on
17 a male aged between 16 and 21 will normally be served in
18 a DC otherwise committal will be to a YOI. The courts
19 have discretion to order that a sentence which falls
20 within the normal range for a DC may be served in
21 a YOI."
22 That gives the basic choices and the general type of
23 sentence that will lead to committal to a detention
24 centre?
25 A. That's correct, yes.

1 Q. It does say that by way of facilities in this centre, at
2 Glenochil:
3 "Indoor recreation facilities consist of television,
4 darts, table tennis, pool and table games. There are
5 two reconciliation rooms."
6 Did that generally accord with what you found?
7 A. Yes, there was limited availability of those
8 recreational facilities during the day, and I think we
9 describe in our report a day at the detention centre.
10 So those facilities were available for limited periods
11 of the day.
12 Q. Yes. Then one matter which I think you did comment on
13 in the report, in a sort of critical way, I suspect, is
14 that at the time that you carried out the review, visits
15 lasted between 30 minutes and 60 minutes and took place
16 at weekends twice a month. Is that --
17 A. That's correct. But as we indicated in the report, the
18 inmate, the detainee, the trainee, had to earn increased
19 visiting. It was awarded on the basis of so-called
20 performance targets and things like that.
21 Q. Could they lose the right to a visit if they lost marks?
22 A. Yes, they could, yes.
23 Q. So there was no entitlement to visits at all, or no
24 right to a visit? Maybe you can't answer that.
25 A. I can't say. I couldn't answer with certainty whether

1 there was an entitlement to any visit or not, I don't
2 know what the legal situation was.
3 Q. It seems to have been based on a system of privileges
4 and the length of the visits certainly depended on
5 performance, if you like?
6 A. Absolutely.
7 Q. On the face of it, I suppose, judging by maybe what
8 happens today, these are not long visits, are they?
9 A. No, they are not long visits, and by the time you take
10 into account the travelling that family members had to
11 do to get to Glenochil, which was at that time really
12 very distant from anywhere, not accessible by public
13 transport, making long journeys from the central belt,
14 the actual amount of time they had with their son would
15 have been very limited, really.
16 Q. Yes, it wasn't an easy place to visit in terms of --
17 A. Very difficult.
18 Q. -- in a practical sense of trying to get there?
19 A. Yes, we drew attention to the difficulties in visiting
20 arrangements.
21 Q. Yes. We will maybe come back to that in due course.
22 A. Yes.
23 Q. But that was the situation at the time --
24 A. Yes.
25 Q. -- in terms of visits?

1 Then there is also something said about the young
2 offenders institution, and perhaps if I can just make
3 this point. Is it correct to say -- you deal with this
4 in your report -- that the respective regimes at the
5 detention centre and the young offenders, that they were
6 in a sense quite materially different?
7 A. Oh, they were very different, yes, very different. Yes,
8 the detention centre was characterised by what we have
9 seen referred to as the short, sharp shock, a rigidly
10 structured day, I don't know if we are going to come on
11 to that, but a rigidly structured day, silence except at
12 specific times, no smoking anywhere in the detention
13 centre. Which was very different from what was going on
14 in the young offenders institution, where there were
15 work opportunities, better educational opportunities and
16 a more relaxed atmosphere. I wouldn't say -- it was
17 still a prison, but it was a more relaxed atmosphere
18 than in the detention centre.
19 Q. And they could speak?
20 A. And people could speak, yes, people could speak, yes.
21 Q. I will come back to this --
22 A. Okay.
23 Q. -- because I do want to look at what your report says on
24 some of these matters, but I just want to get the
25 general picture at this stage.

1 The other point I wanted to just maybe confirm with
2 you at this stage is that in terms of movement between
3 the two types of regime, I think, as you found, it
4 wasn't uncommon for staff to move between the two
5 settings for a variety of reasons?
6 A. Absolutely.
7 Q. They weren't simply administering the same regime all
8 the time?
9 A. No. I think it was almost staffing depending on
10 overtime shifts and all of that sort of thing. It was
11 pretty chance as to where any individual officers were
12 allocated, whether it was the DC or the young offenders
13 institution.
14 Q. As I think we said earlier, and I think as your report
15 probably identifies, quite a significant number of boys
16 who might start in a detention centre could end up in
17 the young offenders part for one reason or another?
18 A. Yes, there is a section of our report that deals with
19 a sample of trainees who were transferred to young
20 offender institutions, either at Glenochil or to other
21 young offender institutions.
22 Q. It wouldn't work the other way round, would it, then?
23 A. No, because I think the sentence of detention was one
24 imposed by the court.
25 Q. Yes. That would constrain movement in the other

1 direction. But what it would mean is that someone who
2 was serving a short sentence could end up in a place
3 which was largely designed to accommodate inmates
4 serving quite lengthy sentences?
5 A. Absolutely so, yes.
6 Q. Indeed if we see -- if we go back to the press release
7 on page 50, under "Young Offenders Institution", do we
8 see that the young offenders institution opened in 1976,
9 that's about ten years after the detention centre?
10 A. Yes.
11 Q. "It adjoined the detention centre and was then one of
12 four young offenders institutions in Scotland."
13 Inmates were described as:
14 "Youths between 16 and 21, serving sentences of over
15 nine months and those serving shorter sentences who are
16 assessed as high security risks."
17 Then it says:
18 "It provides accommodation for 496 inmates in four
19 blocks, each containing 124 single rooms with access to
20 night sanitation."
21 A. That's correct.
22 Q. I think at the time you carried out your review, there
23 certainly wasn't 496 inmates, or anything like that, was
24 there? It was a bit less?
25 A. I can't remember the detail.

1 Q. We can maybe come to that, then. We can read it back,
2 I don't think it was full to capacity?
3 A. Right, no, I don't think it was either.
4 Q. In terms of facilities, it says:
5 "Dining and recreation facilities have been provided
6 as part of each wing of the inmates' accommodation, food
7 being supplied from a central kitchen. Other facilities
8 included education, classrooms, extensive playing
9 fields, well equipped games hall and a hairdressing shop
10 which also served to train inmates in hairdressing. On
11 the industrial front, the planning of workshop
12 employment in the young offenders institution at
13 Glenochil took account of the recommendations of the
14 1961 Anson Committee, which stressed the importance of
15 providing inmates employment conditions comparable to
16 those found in outside industry. Accordingly [if I go
17 to page 51] relatively large workshops are provided
18 equipped for finishing and assembly of panel furniture
19 (the components being manufactured at Dungavel) for the
20 manufacture of upholstered furniture and for work in
21 metal fabrication.
22 "Vocational training courses are also run in the YOI
23 on domestic appliance servicing, painting and
24 decorating, radio and TV servicing and hairdressing."
25 Perhaps in a similar fashion to the detention

1 centre:

2 "The Young Offenders Institution provides classes in
3 basic education, general studies and certificate work.
4 Evening classes mainly in leisure activities are also
5 available."

6 So there is a heavy emphasis in the regime on
7 vocational training?

8 A. Yes, indeed.

9 Q. I don't want to read all of this, but I think it then
10 goes on to say that in relation to the young offenders
11 institution there was a process of assessment on
12 admission, which involved an inmate being placed in the
13 assessment block for a period of four weeks. That
14 really determined their future, did it, because they
15 could either go to one of four blocks, or thereabouts,
16 in Glenochil, or to some other place, some other
17 offenders' institution, depending on the assessment
18 results?

19 A. Yes, that is correct. There was an assessment period,
20 yes.

21 Q. Yes. So the possibility existed, depending on
22 assessment, that you could either end up staying in
23 Glenochil, or you could perhaps end up in an open
24 institution such as Castle Huntly, or Noranside?

25 A. Correct, yes, that's right.

1 Q. Where presumably, although I don't know if you have
2 familiarity with those places, the regime would be a bit
3 more relaxed?
4 A. Yes, they are open prisons, the equivalent of open
5 prisons, yes.
6 Q. We mentioned this earlier, that there was a sort of
7 promotion scheme and inmates could move up grades and
8 earn increased privileges, including I think longer
9 visiting times, it would appear?
10 A. That's correct, yes.
11 Q. It says, halfway down that page:
12 "Assessment for each grade was based on the
13 condition of the inmates' rooms, their personal
14 appearance, their attitude to their peers, to staff and
15 to their work."
16 A. That's correct, yes.
17 Q. Then there is a bit about the daily programme, or
18 regime, in the young offenders institution. It began at
19 6.10 am. There was room cleaning. Then breakfast. And
20 then work from 8.00 am until 11.45 am, followed by lunch
21 and a period of recreation and work resumed at 1.00 pm
22 until 4.00 pm in the afternoon. And there was, from
23 Monday to Friday, the evening programme was one of
24 recreation and evening classes which was from 6.15 pm
25 until 8.30 pm, with a lock up at 8.45 pm. At weekends

1 the programme began at 7.40 am, with recreation and
2 visits during the afternoons and evening recreation for
3 those in promoted grades.
4 So you only had recreation at the weekends if you
5 were in a particular grade?
6 A. Correct, yes.
7 Q. It says:
8 "Inspection of rooms of inmates by the Governor
9 grades took place on Saturday forenoons and church
10 services, at which attendance is voluntary, were held on
11 Sunday forenoons."
12 We get to hear a bit about recreation facilities:
13 "... colour television, record player, snooker, pool
14 table, table tennis, darts and a selection of board
15 games and the institution had a football team which took
16 part, it is said successfully, in a local league and
17 that inmates were participating in other sports,
18 including badminton, basketball, and selected inmates
19 were taken hillwalking to the Ochil Hills."
20 Did that appear to be what was going on at the time,
21 do you recall?
22 A. Yes, I think so. I mean I don't think we enquired in
23 detail so much about the recreational facilities. Our
24 concern was particularly with the access that inmates at
25 the YOI had with staff if they wanted to discuss

1 personal problems, or whether they felt able to discuss
2 those problems. So we were concerned with the
3 relationships between individual young offenders and
4 staff members.
5 Q. Am I right in thinking that whatever facilities were
6 available for work or recreation, that your broad
7 conclusion was that there was limited opportunity to
8 have the sort of relationship that would allow someone
9 to speak to a member of staff about any problems they
10 might have?
11 A. That is correct. That is correct. I don't know whether
12 we will come on to it, but the sort of culture seemed to
13 militate against close relationships between a prisoner
14 and a staff member in terms of confiding information
15 about themselves.
16 Q. Yes. I will look a little bit --
17 A. Yes, okay.
18 Q. -- at the report, but I just wanted by way of looking at
19 this generally.
20 A. Okay.
21 Q. Going to page 52, we see that I think visiting was --
22 A. Yes.
23 Q. -- very much similar to the detention centre.
24 A. That's correct.
25 Q. Then we are given some information about the prison

1 population at Glenochil --

2 A. Yes.

3 Q. -- in the next part of the release. This was the

4 situation, I think, it says, at lock up time on Sunday

5 night on 21 July 1985.

6 A. Yes.

7 Q. This will give us the figures, I think I mentioned

8 earlier.

9 A. Yes.

10 Q. That there was a total in the young offenders

11 institution of 269, against I think a capacity of 496.

12 A. Yes.

13 Q. In the detention centre there were 145 inmates at that

14 time?

15 A. That's correct, yes.

16 Q. Then we get a breakdown of just exactly what type of

17 inmate and what type of sentence they were serving in

18 the young offenders institution, and I will just read

19 on:

20 "Of the 269 inmates in the YOI 25 are serving life

21 sentences for murder and 122 are serving sentences of

22 three years and over for crimes such as [and it gives

23 examples] rape (six inmates), attempted murder (three

24 inmates), culpable homicide (six inmates), assault with

25 intent to rape (seven inmates), serious assault (30

1 inmates), assault and robbery (44 inmates), the other
2 26 inmates are serving sentences for a range of crimes
3 such as wilful fire raising, theft by house breaking,
4 conspiracy, wilful and malicious damage. The remaining
5 inmates have been sentenced to periods of under
6 three years for a variety of crimes and offences ranging
7 from rape, assault and robbery to theft and reset."
8 So that's the population, the general population?
9 A. That's correct, yes.
10 Q. Then it says:
11 "In the detention centre [this is for the short
12 sentences] the 145 inmates were serving sentences of
13 between 28 days and four months, for such crimes as:
14 theft, road traffic offences, assault ..."
15 I take it that would be probably more minor
16 assaults?
17 A. Yes, absolutely so.
18 Q. "... breach of the peace and vandalism."
19 A. Yes.
20 Q. So there is quite a difference between the prisoner
21 profile?
22 A. There is a significant difference between the offending
23 profile of the detention centre trainees and the young
24 offender institution inmates, yes.
25 Q. Yet the detention centre inmates could be transferred

1 over to the young offenders?

2 A. That's correct, yes.

3 Q. And would then mix with the other population?

4 A. That's correct, yes.

5 Q. Also, by the same token, staff would mix with both types

6 of population?

7 A. Yes.

8 Q. Depending on where they were assigned on the particular

9 day?

10 A. Yes, that's correct.

11 Q. They wouldn't necessarily be always tailoring their day

12 to a particular type of prisoner, a short-term prisoner

13 or a long-term prisoner and so forth. They could be

14 confronted on a daily basis with quite different types

15 of prisoner population?

16 A. They could indeed, yes.

17 Q. They go on to deal, I think, with the matter with which

18 your review was particularly concerned, suicide

19 observation, because I think that ultimately, and we

20 will look, was the remit --

21 A. Yes.

22 Q. -- that you were asked to report on.

23 It says:

24 "Between January 1984 and 30 June 1985, 123 inmates

25 at Glenochil Detention Centre had been placed on strict

1 suicide observation (SSO), out of a total admission of
2 1,370 inmates."
3 A little bit under 10 per cent, is it, if I do my
4 arithmetic?
5 A. Correct, yes.
6 Q. Then as far as the young offenders institution was
7 concerned, I think it is in the same period, is it:
8 "132 inmates were placed on SSO out of a total
9 admission of 1,908."
10 So it is a bit less than --
11 A. Yes.
12 Q. -- the detention centre, but a significant number,
13 nonetheless?
14 A. Indeed, yes.
15 Q. It says:
16 "The strict suicide observation of the 123 detention
17 centre inmates varied from two to 60 days. The YOI
18 inmates were observed for periods of between two and 365
19 days."
20 Do we have a situation there where someone on strict
21 suicide observation in a detention centre could spend as
22 much as 60 days in a particular regime --
23 A. That --
24 Q. -- the SSO regime?
25 A. That's correct, yes. Yes. Within the -- yes, that's

1 correct, yes.

2 Q. And in the young offenders, perhaps the situation was

3 that a person could spend up to a whole year in the SSO

4 regime?

5 A. Correct, yes.

6 Q. Was the SSO regime for both places the same,

7 essentially?

8 A. The regime was the same, the location of it there was --

9 the greater number were in the young offender

10 facilities, there were facilities for strict suicide

11 observation within the detention centre as well.

12 Q. But the nature of the management was essentially the

13 same?

14 A. The nature of the management was the same, yes.

15 Q. Perhaps the clue is in the name: observation?

16 A. Yes. The nature of the management and the nature of the

17 location was the same.

18 Q. Yes. If we go over to page 53 of the release, we are

19 told:

20 "Prior to admission to the detention centre

21 73 inmates had admitted to self-inflicted injuries."

22 Examples are given of self-inflicted cuts being

23 quite a significant proportion: 63 in number. Drug

24 overdoses, nine, and one attempted hanging is described.

25 Is this coming from things that you found or is this

1 something that is being put out by the Scottish Office
2 separately?
3 A. We didn't report on the whole -- we didn't report on any
4 survey of the whole population. We confined our remarks
5 to the prisoners that we saw that were under strict
6 suicide observation and gave an account of their
7 individual histories.
8 Q. I will come to that, then, because I think your report
9 does deal with it.
10 A. Yes.
11 Q. So this is more general information?
12 A. Yes, and this would have been obtained from the initial
13 information given by the detainee, or the young offender
14 at the time of their reception.
15 Q. That would possibly be information listed at the
16 admission process assessment?
17 A. Yes.
18 Q. The initial assessment?
19 A. Correct.
20 Q. Because presumably they are asked, or they were asked at
21 that time the question whether they had any history of
22 self-inflicted injury?
23 A. Yes, they were asked. We made comments about the nature
24 of the assessment on arrival, and we considered it very
25 unsatisfactory in many ways. But that is where this

1 information would have been elicited.
2 Q. And that's self reporting?
3 A. It is self reporting.
4 Q. At the time, was there any attempt to cross-check the
5 information with medical records, or other parties, or
6 organisations, do you know? Can you recall?
7 A. I would be very, very surprised if there was. I don't
8 think that happened.
9 Q. Well, indeed when the assessment was carried out,
10 I don't know if you can help us, was it the practice for
11 the assessors, if you like, to have access to medical
12 records?
13 A. Do you mean their NHS medical records?
14 Q. Yes.
15 A. No, they wouldn't have had access to NHS records.
16 Q. As far as before your report, the assessors themselves,
17 who were they?
18 A. The initial assessment would have been done by a nurse
19 employed at the prison, at the institution. That would
20 be the initial assessment. Subsequently there would be
21 an examination by the doctor who was the visiting --
22 a local General Practitioner who was the visiting
23 Medical Officer.
24 Q. Would the nurse be employed by the prison service at
25 that stage?

1 A. Correct, yes.
2 Q. I know that that changed, and you will probably tell us
3 about that --
4 A. Yes.
5 Q. -- but at that time the nurse would be an employee of
6 the prison service?
7 A. The nurse would be an employee of the prison service.
8 Q. The nurse who was assessing, would she have any
9 particular qualifications to assess mental health needs?
10 A. No, I suspect -- I don't know if there was any training.
11 I would be surprised if there had been any significant
12 training. At that time they were largely state enrolled
13 nurses, not state registered nurses, but state enrolled
14 nurses, and they were known at "nurse officers" and they
15 were employed by the prison.
16 Q. The doctor, the visiting doctor, would that be a local
17 GP?
18 A. It was a local GP who came in before he did his own
19 morning surgery in his general practice. But that was
20 a local GP, yes.
21 Q. He wouldn't necessarily have any special qualifications
22 either in assessing mental health needs?
23 A. No, he would be a standard local general practitioner.
24 Q. Yes.
25 At that stage, if you can help us, was there any

1 process whereby there was continuing assessment after
2 this initial assessment, or was that not developed at
3 that time?
4 A. That hadn't been developed. It was one of our
5 recommendations --
6 Q. Yes.
7 A. -- that there should be, but there wasn't any standard
8 procedure for that.
9 Q. Yes.
10 I suppose there were basically two basic decisions.
11 One would be you are someone that should be subject to
12 the suicide observation regime --
13 A. Yes.
14 Q. -- or not, as the case may be?
15 A. That's correct, yes.
16 Q. Then if we go to, again, the information in the press
17 release at page 53, dealing with self-inflicted injuries
18 prior to admission, the release tells us that the
19 figures for the young offenders showed that 49 inmates
20 had admitted self-inflicted injuries prior to admission.
21 The large majority of those being self-inflicted cuts.
22 Six overdoses, 41 self-inflicted cuts and attempted
23 hanging, there was two within that number. It says:
24 "After admission to the institution 20 inmates
25 sustained self-inflicted injuries and one attempted

1 hanging."

2 I'm not sure, did I take from you the same thing for

3 detention? I may not have done so. Can I just say that

4 in relation to the detention centre, 19 inmates had

5 suffered self-inflicted injuries during their period of

6 detention, and again it was mainly self-inflicted

7 cuts --

8 A. That's correct, yes.

9 Q. -- and one attempted hanging?

10 A. That's correct.

11 Q. Some of the ones that are being referred to there had

12 a history of self-inflicted injury, mainly

13 self-inflicted cuts, but a proportion of them also had

14 a history of self-inflicted injuries after admission?

15 A. Yes, that's correct, yes. We do deal in our report, in

16 chapter 5 of our report, on the reception procedure.

17 Q. Yes.

18 A. What goes on in reception --

19 Q. Yes.

20 A. -- as far as eliciting any medical information.

21 Q. Broadly, again, and I will come to it, I assure you, you

22 weren't particularly satisfied by the assessment

23 arrangements?

24 A. No, we thought it was poor, it was hurried, because of

25 the pressure of the number of people coming through, and

1 the facilities in which it took place.

2 Q. What the release does say is that it was a matter of

3 normal practice at the time for inmates who were serving

4 life, or were on long-term sentences, does that mean

5 sentences over three years?

6 A. I would think so, yes.

7 Q. To be placed on strict observation for one or two nights

8 on admission. The explanation or thinking behind this

9 seemed to be, according to the release:

10 "This is a vulnerable period requiring observation

11 of the inmate's response to the sentence imposed by the

12 court."

13 A. Yes.

14 Q. So they had a special arrangement for some of the people

15 who were admitted?

16 A. That's right, yes.

17 Q. But if, say, for example someone was a young offender

18 for the first time entering the institution, perhaps

19 with no great history of experience of this type of

20 setting, there was no special arrangement for that

21 category?

22 A. No, no, there was no special arrangements, no. I am

23 just looking at our report:

24 "Some inmates are accompanied by a special risk form

25 which, if present, will have been completed by the

1 police. This may denote a variety of special risks,
2 including suicide risk. If this form is present then
3 a yellow label is attached to the inmate's record file
4 in the general office. The length of time an inmate
5 spends in reception depends on the numbers going
6 through. It is principally a time for completing forms
7 and only a few minutes are spent in face-to-face contact
8 or in assimilating information from various documents."
9 Q. Can you just give us the section of the chapter that you
10 are reading from?
11 A. That is paragraph 5.2.2.
12 Q. That is maybe what happened in practice?
13 A. Yes.
14 Q. In some cases the person being transferred after
15 sentence might, because of information known to the
16 police or perhaps to the court itself, might well, or
17 could have accompanying them information about risks or
18 concerns that are being highlighted. But it wasn't
19 invariable that that happened?
20 A. Yes, that is correct. I should point -- in fact that
21 continues, that paragraph I referred to, we wrote:
22 "Two procedures have developed in the wake of recent
23 events."
24 This again is 5.2.2:
25 "Inmates for the young offenders institution sign

1 a declaration that they have been warned of the harmful
2 effects of sniffing solvents within the institution and,
3 secondly, a nurse officer sees each inmate briefly and
4 a form is completed with five questions, asking the
5 inmate if he has ever sniffed glue, misused drugs,
6 attempted suicide, been in a mental hospital or injured
7 himself deliberately. The inmate signs the form
8 indicating that he has been asked the questions and the
9 interview is conducted in a room that is rather cramped
10 and is principally used for other purposes."
11 That was in the wake of the events that we were
12 reviewing.
13 Q. Was that a sort of an interim measure after the events,
14 the spate of deaths, was that introduced, this
15 procedure?
16 A. Yes, well, I think it was reactive to the series of
17 deaths, yes.
18 Q. Yes, it wasn't something that was happening for a long
19 period prior to your review?
20 A. No, that is correct, yes.
21 LADY SMITH: Am I to take from the tenor of 5.2.2 that
22 although you accept something was done by way of
23 reaction, you weren't hugely impressed by it?
24 A. That's correct, yes, yes.
25 LADY SMITH: Thank you.

1 MR PEOPLES: Perhaps leave the press release there for the
2 moment, and go back to your statement, if I may, which
3 is at page 2, I think, we had been looking at,
4 WIT-1-000001031, at the background to the working group.
5 You tell us in paragraph 7:
6 "... there were five self-inflicted deaths ..."
7 But there was a further two, as you told us, during
8 the currency of your working group.
9 You tell us a little bit about the deaths, and the
10 ones that you were aware of prior to your review
11 beginning, of these four had occurred in the young
12 offenders institution and one in the detention centre.
13 A. That's correct.
14 Q. So the majority were actually in the regime that on one
15 view was perhaps, I hesitate to use the word "liberal",
16 but certainly less strict and militaristic than the
17 other one?
18 A. That's correct, yes.
19 Q. If we look at the people, and the lengths of their
20 sentence, they were quite varied, were they?
21 A. They were varied, yes.
22 Q. Because if we take the individuals concerned,
23 Edward Herron, the death in 1981, had served six months
24 of a 15-month sentence at time of his death. So that
25 would be a young offender case?

1 A. Indeed, yes.
2 Q. His death was attributed to solvent use, I think that
3 was one of the few exceptions to the normal method,
4 which was hanging?
5 A. Yes, that's correct.
6 Q. In their cells?
7 A. Yes. I think the solvent had been obtained from
8 a prison workshop.
9 Q. Yes. We are getting in to the era, are we not, where
10 solvent abuse had become a serious problem --
11 A. Oh yes.
12 Q. -- in prison environments?
13 A. Very much so.
14 Q. Is that correct? And in the community?
15 A. Yes indeed, yes.
16 Q. This was almost a -- not a new phenomenon, but it was
17 certainly something different to what you would smuggle
18 in in the past, historically?
19 A. Indeed, yes.
20 Q. That was starting to change, and present problems?
21 A. I think so. I think whatever was going on in the
22 community generally would be reflected in what was going
23 on in young offender institutions.
24 Q. Yes. So if you are abusing solvents in the community,
25 as soon as you got in to prison you weren't going to

1 stop if you could get your access to it, is that the
2 reality?
3 A. I think the reason people use solvents are very varied,
4 and I think it is difficult to generalise.
5 Q. If you had an addiction, though, you would certainly
6 want to continue the habit, if it was possible to do so?
7 A. Indeed, yes.
8 Q. I think we know from just general awareness that it is
9 still a real problem, what is brought into prisons
10 today, and they are now trying to take more
11 sophisticated measures by way of searching to ensure
12 that certain articles or substances are not introduced
13 into the prison environment, is that correct?
14 A. Well, yes. My understanding from just reading what
15 I read is that it is still a very major problem.
16 Q. Yes. If we take the next death in 1982 of
17 Richard MacPhie, he had served three days of
18 a three-month sentence. It is difficult to tell where
19 he was, and whether he was a -- perhaps you can tell us:
20 was he a young offender case or a detention centre case?
21 A. He was in the young offenders institution.
22 Q. Yes. So he was an example of someone who was serving
23 a short sentence but had found his way into the young
24 offenders institution?
25 A. Yes, correct.

1 Q. Then we have Allan Malley, another death in 1982, who
2 had served ten days of a three-month sentence. Again,
3 can you help me, which part of Glenochil was he in?
4 A. Allan Malley was in the young offenders institution.
5 Q. Another example of someone that, on the face of it, was
6 a short sentence, but for whatever reason had been
7 transferred to the young offenders?
8 A. Yes.
9 Q. Or has found himself in the young offenders?
10 A. Yes. I mean you could be sentenced -- my understanding
11 is that the court had to actually, it was the Sheriff
12 that actually had to sentence the person to detention
13 centre training.
14 Q. Yes, it might just be a three-month sentence in a young
15 offenders?
16 A. Yes, I think if they had already done a detention centre
17 sentence, they would be unlikely to get it again. It
18 did happen, but I think the preference was for first
19 custodial experience, as it were, for minor offences.
20 Q. Yes, you were supposed to see if it would work as
21 a short, sharp shock --
22 A. Indeed.
23 Q. -- to prevent re-offending, but if you appeared in court
24 again the chances were you wouldn't go back to that, you
25 would go to a young offenders?

1 A. That is my understanding.
2 Q. Even if it was a relatively short sentence?
3 A. That is my understanding, yes.
4 Q. I think some of the statements at the time in Parliament
5 were to the effect that that may have been the theory,
6 but until legislation stepped in it wasn't uncommon for
7 people to find themselves in detention centres several
8 times?
9 A. I think that's true, yes.
10 Q. I think some of the material you have provided us --
11 A. Yes.
12 Q. -- was to that effect, from people who had reason to
13 know. I think Donald Dewar for example had been
14 a solicitor in practice, before he became much more
15 prominent in the political field, and he I think said
16 something along those lines?
17 A. Yes.
18 Q. That that could happen?
19 A. That's correct.
20 Q. I think they were trying to take steps to say well, if
21 you are going to have this form of detention, which
22 I think he opposed, you have it once, and if it doesn't
23 work and they come back you should really be looking at
24 some other form of disposal?
25 A. One would imagine so, yes.

1 Q. Then the fourth death that you mention, paragraph 7 in
2 your statement on page 2, Robert King, was in 1983 and
3 he was ten months into a three-year sentence, so he was
4 definitely someone that would have been a young offender
5 case?
6 A. Yes.
7 Q. Then William MacDonald had served eight weeks of
8 a three-month sentence. He was in 1984, is that right?
9 A. That's correct, yes.
10 Q. Was he in the young offenders, or not?
11 A. William MacDonald was the first detention centre.
12 Q. I see.
13 A. Yes.
14 Q. So he was a detention centre case of the -- he was the
15 one detention centre case of the five?
16 A. Of the five, yes. And then --
17 Q. There were two other deaths that you mentioned.
18 A. Yes.
19 Q. Were they young offenders?
20 A. Of the subsequent, Angus Boyd was detention centre and
21 Derek Harris was initially detention centre, transferred
22 to YOI.
23 Q. So we have a range of prisoners?
24 A. Yes, that's right.
25 Q. Including one that we know started off life in

1 a detention centre, but ended up in a young offenders?
2 A. Yes.
3 Q. That's Derek Harris?
4 A. That's right.
5 Q. William MacDonald, do we know, he was a detention
6 centre, so presumably that is where he was sentenced to,
7 he had simply served the eight weeks of his three-month
8 sentence, so he was relatively early into the sentence?
9 A. That's right. Three months detention, convicted for the
10 theft of a tin of glue from Woolworths, and two charges
11 of assault, yes.
12 Q. That is what he got sentenced for?
13 A. That is what he was sentenced for, yes.
14 Perhaps, I mean we might come on to it later, but
15 I mean in terms of the determinations from the fatal
16 accident inquiries, three of the seven were determined
17 as suicide. But, you know, that's according to the
18 fatal accident inquiry.
19 Q. Can I just be clear, are we to understand that the
20 determination in recording that as the cause of death
21 took a view that the individual had intended to take
22 their life, whereas in other cases where death had
23 occurred through some form of self-inflicted method it
24 wasn't necessarily an attempt to end the person's life?
25 A. That's my understanding.

1 Q. That is how the Sheriff would tend to analyse it in
2 terms of whether it would be characterised as a suicide
3 on the one hand or something else?
4 A. That's my understanding, yes.
5 Q. I think Sheriffs were saying things along those lines,
6 to say well, did they mean it or was it just
7 unfortunately an experiment, or something that went
8 wrong as a cri de coeur, a cry for help whatever, that
9 unfortunately went further than the person intended?
10 A. That's my understanding, yes.
11 Q. And that was sometimes what was searched for in these
12 types of inquiries?
13 A. Yes. That is my understanding. I mean I have been
14 giving evidence at FAIs, but ...
15 Q. I think having seen a number that have been provided by
16 others --
17 A. Yes.
18 Q. -- that I think your understanding is perfectly sound on
19 that one.
20 A. Yes, the establishment of intent, which is I think
21 a very --
22 Q. Yes, it is the issue of intent. What they intended to
23 do by the actions they took on the day, was it intended
24 to actually bring their life to an end --
25 A. That's correct.

1 Q. -- or was it intended to be for some other purpose?
2 A. Yes.
3 Q. By using a means to draw attention to a problem of some
4 description?
5 A. Yes.
6 Q. Okay.
7 A. So this, I mean just for -- the three that were
8 determined as suicide was Allan Malley, Angus Boyd and
9 Derek Harris.
10 Q. Okay.
11 I don't know whether this is a good time to just ask
12 you, if you have the material in front of you about the
13 individuals, how many of the seven individuals that we
14 have discussed were under 18?
15 A. Um, at the time of their death, just giving you the ages
16 at the time of their death.
17 Q. Yes.
18 A. They were 18 --
19 Q. Sorry, Edward Heron?
20 A. Edward Heron was 18.
21 Richard MacPhie was 19.
22 Allan Malley was 18.
23 Robert King was 18.
24 William MacDonald was 17.
25 Angus Boyd was 17.

1 Derek Harris was 16.
2 Q. If we are making a broad distinction between children
3 and young adults, there were three there that would
4 classify as children because they were under the age of
5 18?
6 A. Yes, at the time --
7 Q. If that was our definition of child, and it is for our
8 purposes in this Inquiry, that's why I am just asking
9 their respective ages --
10 LADY SMITH: Angus Boyd was?
11 A. Angus Boyd was 17.
12 LADY SMITH: 17.
13 A. Yes. With regard to precise, whether they were under
14 18, any of the others, when they entered the
15 institution.
16 Q. Yes.
17 A. I don't know, I don't have dates of birth.
18 Q. At the time of their deaths --
19 A. At the time of their death.
20 Q. It didn't matter to the institution, because it held
21 them to 21.
22 A. Yes.
23 Q. It was at 21 they had to do something with them, if they
24 were serving a sentence that they might then have to go
25 to an adult prison?

1 A. That's right.

2 Q. But at that time, although I think we are getting

3 towards a possible change --

4 A. Yes.

5 Q. -- there wasn't the distinction made between 16 to under

6 18, and 18 to 21?

7 A. No, as far as I know there wasn't.

8 I have to say, when we were doing the review it

9 wasn't something that we, you know, we didn't know what

10 would be taking place 40 years later, but it wasn't

11 something, you know, concentrating specifically on under

12 18s wasn't part of our, I have to say, wasn't part of

13 our thinking. The people who were in Glenochil and who

14 were at risk of suicide, that was what our concern was.

15 Obviously it was disturbing to note the young ages, but

16 we didn't sort of do a separate review for --

17 Q. No.

18 A. -- people under 18 and people over.

19 Q. But all of the things you looked at in terms of regimes

20 and strict suicide observation management applied across

21 the board?

22 A. Across the board, yes.

23 Q. Irrespective of the age. There was no distinction

24 drawn --

25 A. That's correct.

1 Q. -- whether you were under 18 or over 18?
2 A. That's correct, yes.
3 Q. At that time?
4 A. That's correct.
5 Q. Can I say this: am I right in thinking, again looking at
6 the wider context at that time, that certainly in some
7 of the debates that may have raised the issue of your
8 report and the problem at Glenochil, there was
9 a movement, and quite a considerable body of opinion,
10 that felt that there needed to be a wholesale
11 examination of the management of young offenders under
12 21. They weren't making the distinction between 16 to
13 18 and 18 to 21, but they were saying that those who
14 were under 21, there should be a much wider review of
15 how they are managed, not just the ones with mental
16 health needs.
17 A. Yes.
18 Q. Was that not, at the time, at least --
19 A. That was reflected in a lot of those parliamentary
20 debates.
21 Q. Debates, yes.
22 A. Indeed, I am sure we will come to it, but as indeed it
23 was one of our recommendations that another body, a body
24 properly constituted to look at this, should do so. But
25 ...

1 Q. Yes, to look at the bigger or wider issues?
2 A. Of sentencing, yes.
3 Q. We will come back to --
4 A. Yes, okay.
5 Q. -- how that played out in due course.
6 A. Okay, yes.
7 Q. As far as the setting up of the working group is
8 concerned, and how that came about, in paragraph 8
9 I think you say that really it flowed from the
10 proceedings, the fatal accident inquiry proceedings,
11 relating to the death of William MacDonald in 1984, when
12 Sheriff Principal Taylor conducted that inquiry, and
13 among the people who gave evidence was
14 Dr Norman Kreitman, and he suggested in the course of
15 his evidence that a working group be established, and
16 the Sheriff Principal Taylor, as you say on page 3 of
17 the statement:
18 "... recommended that a working group be established
19 to review suicide precaution measures at Glenochil."
20 And that that recommendation was implemented by the
21 Secretary of State. That's how you came to be appointed
22 in November 1984 as the chair of the working group?
23 A. That's correct, yes.
24 Q. Although, I mean the Sheriff Principal wasn't saying
25 there must be a review, in the nature of these things it

1 was a recommendation.

2 A. Yes.

3 Q. But it was one that was taken up?

4 A. Indeed, yes.

5 Q. As you say at paragraph 9, during the course of your

6 review there were two further deaths.

7 One in February 1985, Angus Boyd, one of the younger

8 inmates, and you tell us that he had served two months

9 of a three-month sentence, and he died in the detention

10 centre.

11 Then in April 1985, Derek Harris had took his own

12 life, having served two months of a three-month sentence

13 in the young offenders institution?

14 A. That's correct, yes.

15 LADY SMITH: And he was the youngest of this group?

16 A. He was the youngest, yes.

17 LADY SMITH: Just 16.

18 A. Yes.

19 MR PEOPLES: But he was the one that had been transferred,

20 originally he had been in a detention centre

21 environment, but for whatever reason he was moved to the

22 young offenders?

23 A. Yes. In all fairness I don't think we were -- we didn't

24 know that.

25 Q. No.

1 A. We didn't have detailed information. I have
2 subsequently found that to be the case.
3 LADY SMITH: I think you note, Dr Chiswick, that at the time
4 you delivered your report the FAI outcome wasn't known.
5 A. That's right.
6 LADY SMITH: It sounds as though the FAI had taken place,
7 but the Sheriff's findings, determination and
8 recommendations hadn't been published.
9 A. That's correct, thank you, yes.
10 MR PEOPLES: If I can move on to paragraph 10 on page 3, you
11 give us a little bit about, obviously, as you make clear
12 in 1984 there was no devolved government, and that the
13 Prime Minister of the day was Mrs Margaret Thatcher, and
14 that the Secretary of State for Scotland, who appointed
15 you, was Mr George Younger. Mr Michael Ancram was the
16 Minister of State and that Donald Dewar was the shadow
17 Secretary of State. Another person whose names features
18 in some of these debates that you have mentioned
19 prominently was Martin O'Neill, who was the Member of
20 Parliament for Clackmannan constituency, in which
21 Glenochil was located, so he had perhaps a very direct
22 interest in the matter --
23 A. Yes.
24 Q. -- as the local MP.
25 In terms of governance and responsibility for young

1 offenders institutions, you tell us at paragraph 11 that
2 this rested with the Scottish Home and Health Department
3 within the Scottish Office, which, as you say, was
4 a department of the UK Government. And that at that
5 time the Scottish Prison Service, you tell us, had its
6 headquarters at St Margaret's House, London Road,
7 Edinburgh, and was the civil service department
8 responsible for administering all aspects of the
9 Scottish Prison Service. I think we know that even
10 today, although it was rebranded the Scottish Prison
11 Service from I think about 1993 or thereabouts, that it
12 is still an executive agency for which now the Scottish
13 Ministers are responsible?
14 A. Yes, that's my understanding, yes.
15 Q. Yes, it is not an independent agency?
16 A. Oh, no.
17 Q. It is not like a private prison, for example?
18 A. No, that's correct.
19 Q. Of which we have some?
20 A. Of which we have some, yes.
21 Q. As far as the review itself is concerned, at
22 paragraph 12 on page 3 of your statement you tell us
23 that the group was established in November 1984 and the
24 remit was set by the Secretary of State for Scotland.
25 I am taking it from how you put that matter that you had

1 no input into the terms of the remit?
2 A. No, I had no input into the terms of the remit.
3 Q. Can you just read out what the remit was?
4 A. The remit was:
5 "To review the precautionary procedures adopted at
6 Glenochil Young Offenders Institution and Glenochil
7 Detention Centre to identify and supervise inmates who
8 might be regarded as suicide risks and to make
9 recommendations."
10 Q. Passing on to page 4 of your statement, your letter of
11 appointment was issued on 26 September 1984, from the
12 Deputy Director of the Scottish Prison Service. You
13 quote from that letter, I don't think we need to go to
14 it, but can you just quote what's actually said as part
15 of that letter.
16 A. Yes, it says:
17 "These broad terms of reference should, we feel,
18 give the group scope to consider all the relevant
19 factors identified in the Sheriff Principal's
20 determination, and also any other factors that it may
21 consider relevant."
22 Q. You go on to tell us, and maybe you can tell us today,
23 what you considered the significance of the final part
24 of that quote that you just read out about also any
25 other factors that it may consider relevant. What was

1 the significance at the time for you and the members of
2 your group? I think you deal with this in paragraph 14
3 of your statement --
4 A. Yes.
5 Q. -- but you may want to refer to your report as well.
6 A. Let me just have a look at my report.
7 Q. Sorry, I can say, if you want -- do you want it up on
8 the screen?
9 A. No, I will use the one that's in front of me.
10 Q. Can I just say for the record, because I am not sure --
11 LADY SMITH: We need the reference to the report.
12 MR PEOPLES: The actual reference for our purposes is
13 SGV-000084067, and that's what I termed the Chiswick
14 report of 1985.
15 A. Yes, I think why I considered that statement important
16 was because we as a group, and we mentioned, we stated
17 in our report, that we have carefully considered whether
18 specific measures that we have described in the report
19 are in themselves a satisfactory answer to the problems
20 at Glenochil, and we concluded that they were not.
21 It goes on in that section to speak about the
22 possible view of recommending closure, which we didn't
23 do.
24 But we said that we felt that there needed to be
25 a change of approach in both the detention centre and in

1 the young offenders institution, and that we were unable
2 to recommend specific measures with any degree of
3 confidence, unless there were such changes. And these
4 refer to a variety of general measures about the way
5 Glenochil was run, the opportunities for ...
6 particularly the opportunities for inmates to be able to
7 confide in prison officers, the structure of the
8 building, particularly the young offenders institution,
9 the lack of contact between prison officers and inmates,
10 and all the other issues about visiting, contact with
11 relatives, information that's obtained and the care --
12 the major emphasis that we wanted to see was the
13 introduction of some sort of caring element to the
14 institution.
15 Q. Some of these issues, which maybe we could call the
16 wider issues, weren't just relevant to Glenochil,
17 because some of the issues such as the frequency of
18 visits was probably a more general feature of the system
19 at that stage in any young offenders institution or
20 detention centre at the time?
21 A. Yes.
22 Q. Therefore they had perhaps a wider significance?
23 A. That's right, yes. I'm sure that a lot of them had
24 wider significance, but we were looking at, we didn't
25 want to say that if you adopt these measures everything,

1 you know, that's the best we can do. We felt it was our
2 duty to draw attention to the wider issues.
3 Q. Can I just in that vein, I will take you to one of the
4 documents I said I might refer you to, I think you made
5 that point before your report was completed. Can I just
6 take one example of that. If we could take
7 WIT-3-000001184 at page 23. If I could refer you to
8 a document, a letter.
9 That's a letter of 1 May 1985, to the Secretary of
10 State for Scotland. The background to it was that you
11 I think had some concerns about statements that were
12 being made during the currency of your work in
13 Parliament by ministers. What you say in the second
14 paragraph is, and I will just read:
15 "We are aware of the wide public concern in relation
16 to the remit you gave our working group last year. From
17 an early stage in our work we recognised that a broad
18 interpretation of the terms of reference would be
19 essential if we were to make recommendations with
20 confidence."
21 You go on:
22 "Our view has been reinforced by the evidence so far
23 presented to us by individuals and organisations. We
24 are unable to examine, in isolation, the matter of
25 suicide precautions without considering the types of

1 inmates admitted to Glenochil, the conditions in which
2 they live and their daily activities within the complex.
3 Consequently our group has deliberated on these wider
4 issues, and in our report we shall comment on a number
5 of subjects which have immediate relevance to our task."
6 It says:
7 "We propose to make recommendations, where
8 appropriate, concerning aspects of the criminal justice
9 system as it applies to those aged under 21 years."
10 A. That's it.
11 Q. You were setting out clearly the approach your committee
12 or your working group was taking?
13 A. Yes.
14 Q. You felt that that approach had already been effectively
15 endorsed by those who set up the working group. Was
16 that your understanding?
17 A. That was my understanding, and partly the letter of
18 appointment, which we have already referred to, and the
19 statements that were made at various times by ministers.
20 Of course at that time the Glenochil situation acquired,
21 you know, political importance, and it was an important
22 and topical agenda. We didn't want to pretend that
23 there was some easy answer that we could give that
24 would, you know, deal with the situation without wider
25 issues being taken into account.

1 Q. Sometimes politicians with hot potatoes like easy
2 answers, but you were making it clear that that wasn't
3 the approach that your working group was proposing to
4 take?
5 A. That's right, and I didn't think we were doing it in any
6 sort of opposition to what we had been asked to do in
7 the first place.
8 Q. Can I just take you to another document before we
9 perhaps have -- I am conscious we are getting near to
10 11.30 am --
11 LADY SMITH: Yes.
12 MR PEOPLES: I would just like, while we are on the topic,
13 to take you to another page in this document at page 35.
14 I know you may have had some concerns about what
15 Mr Ancram was saying in Parliament around the time of
16 your letter. But one thing he did say, and perhaps we
17 can just bring it out, is in the left-hand column --
18 LADY SMITH: Is this Hansard?
19 MR PEOPLES: Hansard, yes, it is to do, I think, with
20 a discussion about the Law Reform (Miscellaneous
21 Provisions) (Scotland) Bill at the time, but I don't
22 want to get drawn into that.
23 If you look halfway down column 1, Michael Ancram
24 says this, halfway down, in a paragraph that begins --
25 I think we will have to go a bit further down, I think.

1 Yes:

2 "There has been criticism of the scope and nature of
3 the investigations by Dr Chiswick's working group on
4 suicide precautions at Glenochil. I emphasise that the
5 working group is independent and that it has taken
6 a great deal of evidence from within the prison service
7 and from other bodies and individuals. The working
8 group is free to examine and comment upon the wider
9 issues arising from its remit."

10 It sounds like he is certainly giving you the green
11 light and he is not in any way trying to challenge the
12 broad approach that you took, and indeed is reaffirming
13 that that's a perfectly proper way to approach your
14 task?

15 A. That's what I take from those statements in the House of
16 Commons, yes.

17 LADY SMITH: That's, as far as timeframe is concerned,
18 2 May 1985. Your letter was dated 1 May 1985.

19 A. Yes.

20 MR PEOPLES: Because I think, as we will come to find out,
21 perhaps that attitude changed somewhat in the months
22 ahead. I don't want to go into it too much at this
23 stage, but there was perhaps a shift in the way that the
24 approach your remit was looked at, at least publicly.

25 A. Yes, indeed, yes. Well, there was further

1 correspondence, as you are aware, yes.
2 Q. Well, we will come to some of that --
3 A. Yes.
4 Q. -- but maybe this is as convenient a time as any to stop
5 the story.
6 LADY SMITH: I promised you a mid-morning break,
7 Dr Chiswick.
8 A. Thank you.
9 LADY SMITH: You have refrained from asking for an earlier
10 one, so I think I can award you one now, if that would
11 work for you.
12 A. Thank you, my Lady.
13 LADY SMITH: Let's take a break and I will sit again in
14 about a quarter of an hour.
15 Thank you.
16 (11.30 am)
17 (A short break)
18 (11.45 am)
19 LADY SMITH: Dr Chiswick, are you ready for us to carry on?
20 A. Yes, my Lady, thank you.
21 LADY SMITH: Thank you.
22 Mr Peoples.
23 MR PEOPLES: My Lady.
24 We had looked at some documents. Can I take you
25 back to your statement for the moment at page 4, where

1 you tell us at paragraph 16 a little bit about the
2 composition of the working group. I will just take that
3 hopefully fairly briefly. You have told us a little bit
4 about what you wanted in terms of some sort of gender
5 representation from at least one person who would be --
6 no, I think you have, did you end up achieving --
7 LADY SMITH: Two women.
8 MR PEOPLES: Two out of eight, is that right?
9 A. That's right, yes.
10 Q. We have mentioned that another member was the Governor
11 of the detention centre at that time.
12 Dr Pamela Baldwin, Clinical Psychologist at Douglas
13 Inch Centre.
14 Davina Drummond, if I go to page 5 of your
15 statement, who was an Assistant Director of Nursing
16 Services with a clinical background and experience of
17 psychiatric nursing care. I suppose that might be
18 relevant based on what you told us about the nursing
19 care and qualifications of those on site at Glenochil at
20 the time?
21 A. Yes, precisely, yes.
22 Q. You also had someone who was a Principal Nurse Officer
23 at Glenochil, Alan Henderson, who was based at the
24 health centre in the young offenders institution, and,
25 as you said, you had the benefit, therefore, of direct

1 knowledge.

2 Can I just be clear, then, so that I understand this

3 correctly, at that time in Glenochil there was what's

4 described as a health centre, or healthcare facility?

5 A. Yes.

6 Q. I mean would it equate in any sense to a health centre

7 in the community?

8 A. Oh, no, no. It was the place where medication was

9 dispensed, given to prisoners. It was a place where

10 people could come and see ... the facility for the

11 doctor to see people.

12 Q. As part of the assessment process, for example?

13 A. No.

14 Q. No?

15 A. I don't think the assessments took there, it took

16 place --

17 Q. In the reception.

18 A. -- in the reception. Well, I am not quite sure.

19 I think those that were required to see -- the doctor

20 would see as a routine, which was in the detention

21 centre, I think he attended in the detention centre to

22 do that. I think there was a small inpatient facility

23 there, I think for people with physical illnesses.

24 That's what the health centre was.

25 Q. Yes.

1 Then the next member you tell us about on page 5 is
2 Doctor, later Professor, Norman Kreitman, who of course
3 was the person who gave evidence at the FAI that led to
4 the establishment of the working group?
5 A. Correct.
6 Q. He was then a director of the -- can you help us with
7 the acronym?
8 A. Medical Research Council.
9 Q. Unit for epidemiological studies in psychiatry at
10 Edinburgh University. You tell us there that he was
11 an international expert on suicide, and indeed, as we
12 have learned, gave evidence at the FAI of
13 William MacDonald.
14 Then another member was a social worker with Central
15 Region, Robert Stark --
16 A. Yes.
17 Q. -- who had been seconded to Glenochil. Was he
18 effectively an on site social worker for the authority?
19 A. Yes, he was an on site social worker seconded from the
20 Local Authority.
21 Q. In terms of the individuals who, apart from the Governor
22 of the detention centre, Alec Spencer, Alan Henderson
23 and Robert Stark, did they perform functions in relation
24 to both the detention centre and the young offenders
25 centre?

1 A. Yes, as far as I know, yes.
2 Q. Yes.
3 A. Certainly Alan Henderson did.
4 I'm not sure how much social work involvement there
5 really was with the detention centre trainees, so
6 I can't answer that for certain.
7 Q. No.
8 Then Paul Youngjohns was the final member that you
9 tell us about, a senior nurse at the adolescent unit at
10 the Crichton Royal Hospital in Dumfries. He had long
11 experience, you tell us, in the management of
12 adolescents in the psychiatric inpatient unit at
13 Crichton Royal Hospital, Dumfries?
14 A. Correct, yes.
15 Q. But apart from making representations about having women
16 on the group, the actual choice of these individuals was
17 the decision of others?
18 A. Yes, correct, yes.
19 Q. At paragraph 17 and subsequent paragraphs you tell us
20 a bit about the work of the inquiry. You mention there
21 the death of Derek Harris during the currency of the
22 inquiry and that his death was raised in Parliament by
23 Mr O'Neill, the Member of Parliament for Glenochil, or
24 in whose constituency Glenochil was located. And that
25 there seems to have been statements made in the currency

1 of the inquiry by the Secretary of State, including one
2 which emphasised, and you quote:
3 "None of the inquiries [into the deaths] have
4 suggested that the nature of the regime had anything to
5 do with any of these tragic deaths."
6 Can we perhaps just look at a document, just to get
7 the sequence, which if we go back to the document we
8 looked at earlier today at WIT-3-000001184, and could we
9 go to page 15 and what we have here is an extract from
10 Hansard for 16 April 1985, so you are still doing your
11 work?
12 A. Yes.
13 Q. Of course the occasion of this discussion was the death
14 of Derek Harris. Martin O'Neill had raised this matter
15 and sought a statement from the Secretary of State in
16 relation to that death. I am not going to go through
17 this at length. What I am going to do is direct you to
18 perhaps I think at least four occasions when a statement
19 along the lines of what you have repeated in your
20 statement to the Inquiry is made by Mr Younger, the
21 Secretary of State.
22 If we start with page 15, second column, final
23 paragraph, he does mention the setting up of your
24 working group, and that you had started work. In fact,
25 I think there was pressure to accelerate the work,

1 because you were originally given I think a longer
2 timescale, but because of the way events were
3 developing, and there were further deaths, I think there
4 was a certain degree of pressure to get something
5 completed and published, is that the background?
6 A. That's -- quite, it was following the death of
7 Derek Harris --
8 Q. Yes, yes.
9 A. -- that it was expedited.
10 Q. That prompted --
11 A. Yes.
12 Q. -- calls of, "Can we quicken the process up?"
13 But what George Younger said, the Secretary of State
14 said, is:
15 "I must again make the point that in the cases that
16 have happened so far, I exclude the two for which fatal
17 accident inquiries have not yet been held, there has
18 been no evidence that any of the tragic deaths were due
19 to the nature of the regime, none of them had any
20 connection whatever with the so-called "short, sharp,
21 shock" regime, which is a separate matter."
22 That was one statement he made at the time.
23 Then if we go over to page 16 of the same document,
24 in the second column, just towards the top, the second
25 paragraph -- sorry, just take the first paragraph

1 briefly, it records there, through the words of the
2 Secretary of State:
3 "Derek Harris was found not to be fit for the
4 original regime to which he was sentenced and was
5 therefore transferred."
6 This is the individual who moved from the detention
7 centre regime to a young offenders regime?
8 A. Correct, yes.
9 Q. Then he goes on, almost a mantra by now:
10 "As to the nature of the regime, I should not like
11 to prejudice any conclusions that may come out of the
12 fatal accident inquiries or the study that is in
13 progress about the precautions against suicide. My mind
14 is open to suggestions or recommendations, none of the
15 inquiries [I think he means inquiries to date] into the
16 fatal accidents have suggested that the nature of the
17 regime had anything to do with any of these tragic
18 deaths."
19 He is getting his message in in advance before you
20 even reported, during the currency of your review. That
21 is twice he has made that point?
22 A. Absolutely, yes.
23 Q. Then if we go on to --
24 LADY SMITH: I suppose strictly he is correct, but the
25 problem is he is not saying, "However, I do accept

1 I have yet to hear the outcome of this review".
2 MR PEOPLES: Yes, you are perfectly correct, the inquiries
3 were saying things to that effect, I think, but you had
4 a review and you may well have something to say on the
5 regime --
6 A. Yes.
7 Q. -- or something about it, and to what extent it may have
8 played a part?
9 A. Yes.
10 Q. And he was preempting anything you might say on that
11 subject?
12 A. Yes. I will let you carry on to your next point.
13 Q. If I could carry on, just to complete what he was saying
14 at this stage.
15 At page 17, as if it hadn't already been said,
16 perhaps, enough in the first column halfway down, in
17 fact he may have actually got the heads up to be very
18 careful of what you say on these occasions, because
19 Bill Walker, just before the bit I am about to read out,
20 asks the question of the Secretary of State:
21 "Does my right honourable friend agree that it is
22 unwise to make statements about matters that are
23 currently under investigation."
24 That seems quite a wise piece of advice, I would
25 have thought, from Mr Walker, but if we go on,

1 Mr Younger says:

2 "I appreciate the point made by my honourable

3 Friend, I would like to express my appreciation to the

4 prison service of Scotland for doing a difficult job so

5 well. In the service's defence I should add that all

6 the reports and inquiries on these tragic deaths have

7 been clear on one point: none of the deaths have been

8 due to ill treatment or to the nature of the regime."

9 He seems to have widened it not just to the nature

10 of the regime, but that the deaths had nothing to do

11 with any form of ill treatment, whether by staff or

12 others.

13 That seems to be the message that he is trying to

14 convey time after time on this occasion.

15 Then if we just finish off on page 18 of the same,

16 it is the same proceedings, a report of the same

17 proceedings in Parliament, he says in concluding, this

18 is the final paragraph on that page, on the left-hand

19 column, the last five lines or so:

20 "In fairness to those who operate there now, we must

21 make it clear that there is no evidence of any kind yet

22 [maybe at least he has started to be careful with his

23 choice of language] that the nature of the way in which

24 people are looked after there, or the regime and so on,

25 had any bearing on the fatal accidents."

1 So four times he has made this point, in slightly
2 different language, and this is before you have
3 reported. He has every right to say what he thinks he
4 wants to say, but some might think that it was unwise
5 and perhaps Bill Walker had it right; that you are
6 better to stay silent --
7 A. Yes.
8 Q. -- until you see what the report says?
9 A. Yes, I agree. I think, I don't know whether in --
10 I mean I can understand that there are political reasons
11 why he has said what he said. I fully understand that.
12 But I do wonder whether there is a sort of
13 hair-splitting exercise going on in relation to what is
14 "the regime". Is the regime simply square bashing,
15 standing to attention, having a clean bed area, folding
16 your blanket and everything properly. Is that the
17 regime? And you could say well, nobody has died because
18 of the regime.
19 If by the regime you mean everything that happens to
20 you once you enter the doors, I think that's an entirely
21 different matter, and I think the assumption, I suppose,
22 there is that the regime, the military type regime, of
23 itself hasn't killed, nobody has killed themselves or
24 harmed themselves because of that. But I am not saying
25 that in his defence.

1 Q. He does introduce the words "ill treatment" --
2 A. Yes.
3 Q. -- which is not confined to saying -- maybe the
4 implication is that he is talking about ill treatment by
5 staff, rather than the possibility of ill treatment by
6 other inmates, but --
7 A. Yes.
8 Q. -- the message is out there that he is trying to convey
9 perhaps in Parliament, his own party are listening and
10 so forth, and in a climate where there is a particular
11 policy towards young offenders that the Government of
12 the day is promoting, that these are no doubt things
13 that perhaps the majority might wish to hear, and he
14 might wish to say to keep them happy.
15 A. That's --
16 Q. Maybe you could say "I couldn't possibly comment" is
17 maybe the answer, so maybe I shouldn't ask you to
18 comment on my suggestion, but --
19 LADY SMITH: I think what I do take from what you are
20 saying, Dr Chiswick, is that as you see it, the regime
21 must be more than the simple facts of having rules that
22 you have to make your bed properly, you have to turn
23 yourself out properly, you have to be on time. It has
24 to encompass matters such as what will the young person
25 feel is the attitude towards them, for example, when

1 they go into the place. Will they feel that they are
2 being supported through this strict regime, or not?
3 A. Yes, I absolutely agree.
4 In the case histories of the 24 inmates that we
5 interviewed who were on strict suicide observation,
6 a number of them were, you know, didn't want to do it or
7 found difficulties doing it. Perhaps we will come to
8 it, but many of the most common themes was to escape
9 bullying, the intimidation that they felt from other
10 inmates.
11 LADY SMITH: Yes.
12 A. And their inability to talk about that, or complain
13 about that, or have anything done about it, which was
14 a huge issue.
15 Whether that is the regime, I mean in my opinion it
16 is the environment, it is the milieu, it is what it's
17 like inside that institution and the way that the young
18 person perceives it.
19 LADY SMITH: Yes.
20 A. His perception of his safety is, I think, crucial.
21 LADY SMITH: Safety being a critically important word here.
22 A. Absolutely, yes.
23 LADY SMITH: Mr Peoples.
24 MR PEOPLES: This is a good time to go to your report, if
25 I may. I just wanted to, to some extent -- could I look

1 at some bits of your report now --
2 A. Indeed.
3 Q. -- and pull together some of the things I think you have
4 been telling us about, and perhaps hoping that we can
5 relate to that what's in the report. You have a copy,
6 but for the transcript it is SGV-000084067 is the
7 report. I am going to be selective. We can all read it
8 and it is there, but I will perhaps just focus on
9 certain passages that caught my eye and maybe ask you to
10 comment.
11 LADY SMITH: Let me interject, Dr Chiswick, we are not
12 trying to close you down --
13 MR PEOPLES: No.
14 LADY SMITH: -- if there is anything you want to refer to in
15 relation to any part that Mr Peoples is telling us
16 about, please speak up.
17 A. Okay, thank you, my Lady.
18 LADY SMITH: Thank you.
19 Mr Peoples.
20 MR PEOPLES: Yes, absolutely, I should have made that clear.
21 I am trying to pick up some of the things I think you
22 told us about, but by all means add anything that you
23 feel important to say.
24 Just turning briefly to page 5, the contents, just
25 so we know what the structure of the report is about.

1 You have an introductory chapter, chapter 1, and then
2 you have various chapters, 11 in all, where you deal
3 with various matters.
4 Chapter 2 being self-inflicted deaths, which I think
5 is an attempt to give a working definition of what you
6 mean by that expression, I will come to examples.
7 A. Yes.
8 Q. Chapter 3 is information about the Glenochil complex,
9 and to some extent we have covered that this morning.
10 Then you deal with, I think, 4 and 5 are probably
11 concerned with, well, chapter 3 has some information
12 about the regimes and daily routine, I should say --
13 A. Yes.
14 Q. -- and the assessment process that you spoke about
15 earlier today.
16 I will come to some parts of what your report says.
17 Chapters 4 and 5 are concerned largely with perhaps
18 the direct issue, or subject matter of your remit, the
19 suicide precautions and the strict suicide observation
20 regime.
21 Then, chapter 6, you identify key issues, and key
22 recommendations are made.
23 You then, in chapters 7 and 8, develop what you are
24 recommending in terms of both specific measures --
25 that's chapter 7 -- and more general measures which you

1 are recommending or suggesting.

2 You also then deal with, I think, what for your

3 group was an important issue in chapter 9, which was the

4 prior question of fitness, of all, to be placed in the

5 detention centre regime.

6 You follow that up in chapter 10 with a chapter on

7 what are characterised as broader issues.

8 Chapter 11 is the summary of recommendations and

9 suggestions that you have made during the course of your

10 review.

11 And there are various appendices, which at the

12 moment I don't probably plan to spend too much time on,

13 but if you feel that there are any we should look at,

14 feel free to tell us. I think we can probably take what

15 I want to ask you about from the report itself.

16 Against that introduction to the report, can I take

17 you to chapter 1, the introductory chapter, and just

18 identify some of the things that you have said already

19 today and some other things that I want to discuss more

20 fully.

21 Can I go to page 11, and there is a section, 1.8,

22 "How we worked". At 1.8.1 you record:

23 "Our approach to this task has been to take a broad

24 view of our remit."

25 We have discussed that.

1 A. Yes.

2 Q. I don't want to go over it again, but you make that

3 point in the report, and we see that.

4 The next part of chapter 1 I would just like to look

5 at is 1.9.1, on page 12. You make clear what you have

6 done and what you are not doing in this particular

7 report, which is perhaps quite important, because

8 perhaps this is lost sight of. You say:

9 "In chapter 3 we described the daily routines in the

10 detention centre and in the young offenders institution.

11 It was not our task, and we have not tried, to analyse

12 the reasons for each of the deaths."

13 So you weren't in this report looking at what may

14 have triggered the deaths?

15 A. No, that is correct, we weren't looking at what might

16 have triggered each of the deaths, we weren't a body

17 that could do that. We didn't have access to the

18 appropriate information. We couldn't have witnesses to

19 appear before us. It is a very -- I suppose that's what

20 a fatal accident inquiry is for. We certainly couldn't

21 do that.

22 Q. Well, to an extent perhaps -- I am not actually sure

23 sometimes that fatal accident inquiries do look at it in

24 that way, but you didn't, that's the main point we are

25 making, and therefore it cannot be said that your report

1 would shed any light on whether or not abuse, ill
2 treatment, or regime -- no, abuse or ill treatment were
3 a contributing factor to any of the individual deaths
4 that you were looking at. You didn't look at that in
5 that way?
6 A. No, we didn't. You mean for individual acts of abuse --
7 Q. Yes.
8 A. -- against people that died?
9 Q. Against these individuals, yes.
10 A. No, we didn't look at that, no.
11 Q. We can't learn from your report whether any of these
12 individuals took their own lives because of something
13 related to the way they were treated by other inmates,
14 or prison staff, or both. I will develop, but, strictly
15 you are not really going into that, you are not making
16 findings on that?
17 A. We are not making findings on that, no.
18 Q. You make findings in a broader sense, and I will come to
19 that.
20 A. Yes, absolutely, yes.
21 No, we didn't make individual findings about those
22 individual cases.
23 Q. But you did make findings or observations expressly and
24 implicitly on the regime?
25 A. Yes, we did, yes.

1 Q. We will come to that.
2 A. Okay.
3 LADY SMITH: Dr Chiswick, I noticed you were careful in the
4 first paragraph of your letter to the Secretary of State
5 of 28 June 1985, which is reproduced at page 3 of the
6 report, that you referred to having completed your work
7 within "the expedited timetable discussed earlier this
8 year", and you thought that had been accomplished
9 "without any neglect of any major issues".
10 I have two questions.
11 Was that discussion about the expedited timetable
12 one that took place between you, or you and other
13 members and the Secretary of State?
14 A. Officials, civil service officials, yes.
15 LADY SMITH: They wanted a quick response, did they?
16 A. After Derek Harris's death they wanted the -- I think we
17 had originally planned for about later in the year, sort
18 of October/November, something like that, and they
19 wanted it brought forward to be able to put it into
20 Parliament before the summer recess.
21 LADY SMITH: Yes.
22 Secondly, you are careful to say you feel you didn't
23 neglect any major issues. If you hadn't had
24 an expedited timetable, were there any particular
25 matters that, looking back, you think that you would

1 have investigated and reported on?

2 A. I don't think so, to be honest. I don't really think

3 so. I mean having said that we weren't going to -- we

4 weren't constituted to look into and find a cause for

5 each death, I think we gained, we had sufficient time to

6 gather the information that we had, that we wanted, and

7 to frame our recommendations in the context of

8 information from witnesses, visiting other institutions,

9 et cetera.

10 So I don't think there was anything else that we

11 would have done if we had had longer.

12 LADY SMITH: Thank you.

13 Mr Peoples.

14 MR PEOPLES: But you were satisfied when you did submit your

15 report that you knew enough from the evidence you had

16 gathered from a range of sources, including staff and

17 inmates and ex inmates, that you knew enough about the

18 regime, as you defined it, in terms of the environment,

19 milieu and attitude of young people and perceptions to

20 be able to make the recommendations and suggestions and

21 to reach the conclusions you did? You were satisfied,

22 as were the whole of your group?

23 A. Yes, indeed, yes.

24 Q. I mean it couldn't be said that you reached the

25 conclusions and made the recommendations and suggestions

1 without evidence or without sufficient basis, evidential
2 basis?
3 A. Well, I don't think so, no.
4 Q. No, I'm not suggesting so. I just want to bring it out
5 that that is how you saw things?
6 A. Yes, it was how we saw things on the basis of what we
7 witnessed, what people told us and what we saw happening
8 elsewhere.
9 Q. You had taken considerable efforts to gather information
10 in a variety of ways?
11 A. Yes, they are all listed in one of the appendices, yes.
12 Q. Yes. I think you mentioned that in your statement.
13 I am not going to go through the whole process of
14 gathering information, but it is clear from the
15 description you give that you sought information from
16 a lot of sources, including those that had direct
17 experience of the complex?
18 A. Indeed, yes. And of course we spent time, whole days,
19 in the complex seeing, observing, speaking with people,
20 and we were able to interview the 23 inmates that were
21 on strict suicide observation in private, individually.
22 Q. The members of the group who were the Glenochil members,
23 if I could put it that way, including the Governor, they
24 weren't saying to you in your private deliberations,
25 having gathered this information, "Well, I wouldn't pay

1 any attention to what these people are saying, it's not
2 the way it happened in my experience"? They weren't
3 telling you anything along those lines?
4 A. Absolutely not, no. Absolutely not. They fully took
5 part in and were open about all the matters we were
6 reviewing.
7 Q. In a sense would that have confirmed to you at least
8 that they had a very good idea of what the regime, as
9 you have defined it, was all about?
10 A. The broad term regime.
11 Q. The broad term regime, yes, if we use your description.
12 A. Yes, I am satisfied on that point, absolutely.
13 Q. Yes.
14 Just on another point, just following that up, there
15 wasn't any attempt on their part when you were
16 deliberating about how to express your report or
17 conclusions, that they in any way were seeking to defend
18 the regime, as you have described it, or characterised
19 it?
20 A. Er, no. I mean we didn't make comments about the regime
21 in general --
22 Q. No.
23 A. -- we made very strong comments about the suicide,
24 so-called suicide precaution regime. We all agreed, you
25 know, at the end of the day we said what was going on

1 was inhumane and unacceptable. And we were all a party,
2 all agreed on that choice of words.
3 Q. I will come to that in your report.
4 A. Yes.
5 Q. If I can go back to the report then, if I may. Page 14,
6 there is a chapter headed "Self-inflicted deaths". This
7 is more to assist those reading the report of how one
8 defines suicide as opposed to parasuicide, and you tell
9 us at 2.2.1:
10 "The legal definition of suicide requires that the
11 deceased has died by his own hand and that this outcome
12 was fully intended."
13 This introduces the stricter definition of suicide:
14 it involves some form of intention to take one's life?
15 A. That's right, yes.
16 Q. That, to some extent, since you can't look into the mind
17 of the deceased, you have to try and look at all
18 available evidence and draw such reasonable inferences
19 as you can, although it is not a perfect science?
20 A. That's right, yes.
21 Q. Indeed that's what you say in that sentence:
22 "This second component [looking at the issue of
23 intention] is often difficult."
24 A. Indeed, yes.
25 Q. The other term that you use or define is "parasuicide",

1 and you say at 2.3.1 on page 14:

2 "In the community, non-fatal acts of self poisoning

3 or self injury are common. Such behaviour is now

4 described as 'parasuicide'. This avoids the assumption

5 in the old-fashioned term 'attempted suicide', that the

6 individual actually intended to die."

7 You follow up:

8 "An act of parasuicide may occur for various

9 reasons."

10 This is the point, this is just simply to

11 distinguish suicide and parasuicide by reference to

12 intention?

13 A. Yes, parasuicide is the behaviour that mimics an act of

14 suicide. It does not address reasons, or circumstances,

15 it is simply an act that resembles an act of suicide.

16 Q. It is not necessarily an act where the individual

17 intended to take their life. It might be --

18 A. It doesn't -- the old-fashioned term "attempted suicide"

19 signifies that there was some intention to die.

20 Q. Which failed?

21 A. Which failed.

22 Parasuicide is a term used to describe a behaviour.

23 Behaviour being something that mimics an act of suicide,

24 without any reference to the underlying motivation,

25 reasons, circumstances. We list a number of --

1 Q. Examples.

2 A. -- examples. Exactly.

3 Q. If I could take you on to page 15, just on this point at

4 2.4.2. Your report says:

5 "In describing any kind of suicidal activity, it is

6 preferable to avoid the terms 'manipulative' or

7 'pretend' suicides. These tend to imply criticism, and

8 fail to do justice to the desperation that may underlie

9 the behaviour."

10 Then you go on to say, or your report says:

11 "Every parasuicide should be assessed to determine

12 the underlying causes and to plan the appropriate

13 treatment. In an institutional setting, such as

14 a prison, it is important to look at the act in context

15 and to consider to what extent it may be a product of

16 group influences and difficulties."

17 You are not shying away from looking at the possible

18 causal connection sometimes between a parasuicide and

19 whether it is something to do with what is, in your

20 definition, the regime?

21 A. No, I think it requires every -- it is as we say: every

22 parasuicide should be assessed to determine the

23 underlying causes, and they are varied. And on that

24 basis treatment is planned. So that in an institutional

25 setting, like a prison, you do have to look at the

1 context, and that includes all the things that we
2 mentioned. To what extent it may be a product of group
3 influences and difficulties.
4 It requires a careful examination of all aspects.
5 That's what we set out to do.
6 Q. Then you have a section that starts on page 16 headed
7 "Identifying a person at risk of suicide". I just want
8 to look at 2.5.3, which is at the foot of page 16 and on
9 to page 17. It starts, this is to do with there has to
10 be some sort of screening or initial assessment of
11 whether there is a risk. You say in the second line,
12 your report states:
13 "Isolated individuals are at greater risk, not only
14 because of their own sense of isolation, but because
15 those who are responsible for them are unaware of their
16 state of mind: young people are particularly prone to
17 changes in mood. In addition, being in a closed
18 institution, away from home, friends and family, can
19 alter the inmate's perception of events. What might
20 seem [this is on page 17] a trivial happening in the
21 outside world can appear to be a major upset within the
22 confines of a closed institution. For this reason, it
23 is important that those in charge of young people are in
24 close touch with their thoughts, feelings and behaviour
25 so that they can observe and monitor any changes."

1 I think that's part of the background to what you
2 were suggesting had to be radically changed in terms of
3 the process and management at Glenochil?
4 A. That is, yes, that is correct.
5 Q. Yes.
6 A. It was an attempt -- what we suggested was trying to
7 introduce the sort of measures that would take place in
8 a healthcare setting for somebody who had committed
9 an act of parasuicide, or was taking about it, or was
10 deemed to be of that degree, in that degree of distress.
11 Q. Is that therefore trying to state that basically what
12 you should be applying as a minimum is the principle of
13 equivalence? That you get the same care and the same
14 approach in prison as you get in a healthcare setting,
15 or in the community?
16 A. That's exactly what we were aiming for. I don't think
17 the word "equivalence" had been invented in 1980 --
18 Q. No, I am using modern language but I am trying to see
19 what you were getting for --
20 A. Yes.
21 Q. -- because I think in fact you have actually drawn
22 attention, and it is not a document before us and I am
23 not going to go to it, but the Scottish Government last
24 year -- you have drawn our attention to this -- issued
25 a publication that was based on research called

1 "Understanding the mental health needs of Scotland's
2 prison population". It was published, I think, late
3 last year, and it was by a number of authors,
4 Lindsey McIntosh and others.
5 Can I just at this point say that the executive
6 summary says this, and I will just take a few passages,
7 just to see where we are on this. The executive summary
8 begins:
9 "People in prison experience numerous and often
10 complex mental health and behavioural difficulties at
11 a higher rate than people in the community. Mental
12 health services in prison should be equivalent to those
13 in the community in terms of accessibility, quality, and
14 the types and range of interventions available."
15 That's very much echoing what you were saying in
16 1985, is it?
17 A. It is indeed, yes.
18 Q. I will just go on just briefly to say what is being said
19 at this stage in 2022, in the summary:
20 "As part of a wider health needs assessment
21 programme, the Scottish Government commissioned
22 a national assessment of mental health needs among
23 Scotland's prison population to ensure that future
24 changes to prison mental health services are
25 evidence-based and person-centred."

1 One might add the expression that is in currency,
2 a trauma-informed approach, as well?
3 A. Yes, indeed, yes.
4 Q. Just if I could just briefly continue with that.
5 One important factor is understanding the scale of
6 mental health needs in the prison population, and this
7 report says:
8 "Robust data on the mental health needs of
9 Scotland's prison population are required to develop
10 services designed to meet the particular needs of this
11 group. However, data on mental health needs of people
12 living in Scotland's prisons are not routinely collected
13 at the national level."
14 Now, if that's being said in 2022, I suspect that
15 you didn't have much data to go on in 1985?
16 A. No, zero.
17 Q. What it also says, and I can just read this to you as
18 well, and put it into the transcript:
19 "People with lived experience of having mental
20 health needs while in prison recalled [because I think
21 they did obviously seek the views] a reluctance to share
22 their mental health concerns with prison officers due to
23 a general lack of dignity and respect from officers, or
24 perceived lack of training to provide sought after
25 support."

1 The summary contains what's said to be the
2 conclusions and recommendations, and it goes on:
3 "This needs assessment found that current service
4 provision to support the mental health and wellbeing of
5 people in prison places too much responsibility on the
6 individual to engage and choose to share information
7 with mental health services to gain necessary support.
8 Mental health services in prison are not equivalent to
9 care available to people in the community, and do not
10 adequately address the high levels of need in this
11 population. A fundamental change in the approach to
12 prison care and prison mental health services is
13 required."
14 That kind of echoes what you were saying in 1985?
15 A. Yes, indeed, yes.
16 Q. I mean it is a long time since 1985 for all of us, but
17 that's quite a long time, and yet we are seeing the same
18 sentiments being said?
19 A. We are. And that report -- I am not up to date, I don't
20 practise in prisons any more --
21 Q. No.
22 A. -- I don't have contact with the prisons. But reading
23 this report, it does draw attention to the difficulties
24 of trying to obtain equivalence. The difficulties in
25 trying to provide healthcare within a prison setting.

1 Because they are two systems that have different
2 priorities, work in different ways and it is very
3 difficult to sort of inject that healthcare approach
4 within a custodial setting of a prison.
5 Q. Can I just lastly say from the summary, if I may, that
6 on the issue of training, because it is an issue you
7 raised in your report also in 1985, it says:
8 "Relevant mental health training should be mandatory
9 for all staff who work with people in prison, in keeping
10 with the whole-prison approach to supporting
11 individuals' mental health and wellbeing."
12 We have heard about the need for training in other
13 contexts, where vulnerable children have been cared for,
14 and how this has been said for many decades, and we are
15 seeing this being said in 2022 in the context of
16 a setting for children and young people under 18. This
17 training is still needed, therefore it is not there
18 already, at least to the extent required?
19 A. Yes, I mean it does require trained staff to carry out
20 this sort of work. I mean, one of our first general
21 principle recommendations was that in the prevention of
22 suicide the aim should be to achieve a proper balance
23 between procedures that reduce risks to a minimum yet
24 are compatible with an acceptable way of life within
25 a penal establishment.

1 It is easy to say that, and I acknowledge that, we
2 said it. The evidence is that it is extremely difficult
3 to bring that about, to strike that balance between
4 proper healthcare that reduces risk to a minimum, but is
5 compatible with the way of life and the way penal
6 institutions function.
7 Q. And can I --
8 A. I don't underestimate it.
9 Q. No. Can I just -- because I was going to bring
10 attention to that principle and another, but if we go to
11 page 73 of your report, which was chapter 11
12 "Summarising recommendations and suggestions", the first
13 two that are listed are described as general principles,
14 which I take it you might feel hold good as much today
15 as they did in 1985.
16 The first one, as you have just read out, the first
17 general principle that the report stated was:
18 "In the prevention of suicide [I will read it again]
19 the aim should be to achieve a proper balance between
20 procedures that reduce risk to a minimum yet are
21 compatible with an acceptable way of life within a penal
22 establishment."
23 The second general principle that you set out in
24 your report:
25 "There should be an appropriate balance between the

1 prison officer's concern for discipline and his interest
2 in the welfare of inmates."
3 I suspect, as you have just said, striking the right
4 balance to apply these principles in practice is not
5 an easy matter, but these are the principles, aren't
6 they? Whatever the detail might be in how you apply
7 them, these, you say, are cardinal principles?
8 A. Yes, I would say so. We were struck by the lack of
9 involvement in the welfare of detention centre trainees
10 and young offenders, with some exceptions in the young
11 offender institutions. There was some good social work
12 being done, but we were, as far as the prison officers,
13 who have the most contact on a day-to-day basis with the
14 prison population, there was very little sort of what
15 you might call evidence of welfare-type interest.
16 Q. It wasn't certainly a care and welfare regime?
17 A. It didn't strike us as a care and welfare regime, no.
18 Q. Was it best described as a punitive regime, even for
19 those with mental health needs?
20 A. Well, you know, who am I to -- you know, read the
21 description of a day in the life of a detention centre
22 trainee and come to your own conclusions. You know, it
23 was a highly disciplined, military regime for a group of
24 young boys, many with learning difficulties, many having
25 experienced, as we said before, adverse childhood events

1 and experiences, many of whom had never set foot -- most
2 of whom had not set foot in a penal institution before.
3 I mean, it is difficult to say it wasn't punitive.
4 Q. Just on chapter 3, if I could go back to your report to
5 page 19, we went through some of these issues earlier
6 today, and there is a part there about visiting, but
7 I am not going to repeat what we have already discussed
8 on that. You obviously raised this issue, but you also
9 say in relation to the daily routine, and this is
10 I think the detention centre regime, at the foot of
11 page 19, 3.2.6, you record:
12 "Trainees remain silent and are reprimanded for
13 talking. Commands are given in the style of a drill
14 sergeant."
15 That was the regime?
16 A. That was the regime, yes.
17 Q. 3.2.7, I don't want to go through it all, but the point
18 you are making is that to do anything involved
19 a marching process, almost as if you were in the
20 military?
21 A. That's right, yes.
22 Q. And marching in silence?
23 A. In silence, and going on parade, yes.
24 Q. And responding simply to commands?
25 A. Correct.

1 Q. Then if we turn to the young offenders institution,
2 I think it is at 3.3, starting at page 21, we have
3 already been through some of this in evidence earlier
4 today. The part about assessment at the time of your
5 review is at 3.3.6, where you describe the assessment
6 process. I will not repeat that, but that's where we
7 find what you have told us earlier, and there is more
8 information about what's called the grading and
9 progression systems at 3.3.7, and how that operated in
10 practice, is that right?
11 A. That's right, yes.
12 Q. Then can I come to something that is perhaps of
13 particular relevance for our purposes. When we go to --
14 in the next section on page 23, which is headed
15 "Pressure among inmates". I will just read out 3.3.8,
16 which is in your report:
17 "The grading and progression systems are designed to
18 be incentives for good behaviour within the institution.
19 The majority of the inmates make good use of the
20 facilities and serve their sentences in a purposeful
21 manner with few major difficulties."
22 Then you go on:
23 "We gathered much information, however, from
24 governors, discipline staff, inmates and ex-inmates on
25 the difficulties posed by the aggressive behaviour of

1 a minority. It was put to us that in addition to
2 individual cases of bullying, a number of alliances
3 existed within the institution that may exert
4 considerable pressure upon vulnerable inmates."
5 So that was what you were being told?
6 A. Yes.
7 Q. Presumably the members of your group were taking no
8 exception or saying that that's not the way things are?
9 A. I agree, what you have said is correct, yes.
10 Q. You say then, at 3.3.9:
11 "The more vulnerable young offenders may be
12 characterised by several features: those who have no
13 allies, those who have committed sexual offences ..."
14 There is quite a number in this institution at that
15 time that fell into that category?
16 A. Correct, yes.
17 Q. "... those who have committed crimes against the elderly
18 or the young, those who have an unusual physical
19 appearance, those who have any kind of handicap, mental
20 or physical, and those who just do not manage to assert
21 themselves from the beginning of their sentence. Such
22 individuals may be victimised in several ways. The most
23 common appeared to be that their tobacco was extorted,
24 some may be physically assaulted or verbally harassed
25 and teased during the day. A more subtle form is

1 a campaign of whispering, with implied threats of what
2 awaits the victim. At night there may be shouted taunts
3 by other inmates, these have included encouragement and
4 incitement of the inmate to hang himself."
5 So that is a flavour of prison life?
6 A. That is a flavour of prison life as reported to us, yes.
7 Q. In the mid 1980s.
8 A. In the mid 1980s.
9 Q. You then go on to explain some of the difficulties for
10 those that experienced that life, at 3.3.10:
11 "For those who cannot cope with these pressures,
12 there are limited remedies. Reporting it to the staff
13 brings the added stigma of being a grass, and of then
14 being in need of protection."
15 Again, you just don't grass is a prison norm?
16 A. It is a prison norm, yes.
17 Q. It was a prison norm and perhaps it is still today?
18 A. Absolutely, yes.
19 I mean perhaps, if I may just add, that because this
20 was what some prisoners, some young offenders
21 experienced, some of them opted for being placed in
22 an area where they felt safe, at least safe from attack
23 or victimisation by other inmates. One of those places
24 was strict suicide observation and --
25 Q. That was their place of safety?

1 A. For some of them it was their place of safety, yes.
2 Q. Because of the things that are described in that report?
3 A. Because of the things listed. It was the major -- it
4 was the most common feature in the 23 that we spoke to,
5 it was the most common feature.
6 Q. Yes. And then if I --
7 LADY SMITH: An example, I see, I think it is the ninth case
8 history on page 19, appendix E, that you refer to
9 a 21-year old who had been threatened physically, placed
10 on SSO a fortnight after admission. He tried to return
11 to the blocks. He couldn't withstand the intimidation.
12 He thought he would remain on SSO until liberation.
13 That seems to be quite typical.
14 There are others who told you they thought they just
15 wouldn't cope if they weren't on SSO.
16 A. Yes.
17 LADY SMITH: The last one, 24, aged 17 on SSO for six days.
18 He decided to opt out of the detention centre regime.
19 He was suicidal on admission, because he had heard about
20 deaths at Glenochil, and he thought if he tried to enter
21 it he would fail. So his best strategy was to remain on
22 SSO.
23 A. Yes. You didn't lose remission on SSO.
24 LADY SMITH: Yes.
25 MR PEOPLES: These pressures, as you call it, would be

1 applicable in both settings, the detention centre and
2 the young offenders, this isn't something that would be
3 unique to one rather than the other?
4 A. I think it was mainly in the young offenders that we --
5 because there was more opportunity to mix --
6 Q. Right.
7 A. For the prisoners to mix. So much of the day was
8 rigidly controlled within the detention centre, and
9 I think some of the references to not coping in the
10 detention centre may not just have been intimidation by
11 others, but also the ability, frankly, the ability to
12 comply with the rules and regulations, and the
13 structure, and be in the right place at the right time
14 with the right gear, et cetera.
15 Q. This is the fitness for the regime point?
16 A. The fitness, absolutely, which we addressed in our
17 report.
18 Q. Can I perhaps pass on, if I may, to page 26, which has,
19 at 3.5.1, under the heading of "Staffing", and this is
20 a point that I think you brought out earlier:
21 "It is the aim of Glenochil to maintain the same
22 staff on each block and on each wing."
23 That sounds very good in theory, but then you go on:
24 "Witnesses said that staff continuity was poor,
25 because many shifts were covered by staff working

1 overtime, as a result they may be allocated to any duty
2 within either part of the complex or outwith the
3 establishment on escort duties. The number of staff may
4 change between the two establishments on a day-to-day
5 basis."
6 That was the reality?
7 A. That was the reality, yes.
8 Q. Can I just take you then to 3.6.3 on page 27, you do say
9 this about the staff, you say:
10 "We also heard that the majority of staff were fair
11 and considerate in dealing with their charges. This was
12 widely reported from within and outside Glenochil.
13 However, as in many large institutions, there were
14 isolated reports of individual members of staff who were
15 described as having been too ready to resort to physical
16 sanctions when others failed. We recognise the
17 difficulty of investigating such incidents within
18 an institution. We are not in a position to adjudicate.
19 We saw no such behaviour, but it was a matter of concern
20 to a number of staff and inmates. The overall
21 impression given by inmates, ex-inmates and staff was
22 that although the enforcement of rules and discipline
23 was all pervasive, that the practice of physical force
24 was not. Such incidents were rare and taken very
25 seriously by management. They were investigated through

1 standard legal procedures for alleged assault."
2 That was your conclusion, based on what you were
3 being told --
4 A. Yes.
5 Q. -- but you do say the difficulty of investigating
6 incidents ... now, can I just try and drill down into
7 that. There is a difficulty for an inmate making
8 an allegation against staff, because I think we will
9 probably see this, and I am sure the Scottish Prison
10 Service will confirm, that very often there is
11 an investigation, and you will get two sides: the inmate
12 will say X and the officer and perhaps colleagues will
13 say Y, and therefore the case may not be found
14 established. I don't suppose that seems unduly
15 surprising to you, that that may happen in practice?
16 A. Yes, I am not surprised, yes.
17 Q. You can see the difficulties. If someone is being
18 subjected to unacceptable behaviour by staff, it is not
19 an easy matter (a) to say anything at all, because you
20 are seen as a grass even if you are complaining about
21 an officer.
22 A. Yes.
23 Q. But (b) you may well think your chances of being
24 believed and accepted are slim.
25 A. Yes.

1 Q. Also, it is a curious feature of the prison system as
2 I understand it that you can end up, if you make
3 an allegation that's not proved, you could be put on
4 a charge for making a false allegation. So it was a bit
5 of a disincentive to speak up?
6 A. Yes.
7 Q. In the past, at least?
8 A. Yes, yes, I absolutely acknowledge all of what you say.
9 I can only say what we have put in the report. We
10 didn't hear from, you know, former inmates who left the
11 institution that, you know, it was a place of regular
12 violence perpetrated upon the inmates by staff. We
13 didn't hear that.
14 Q. But did you hear at least it was a place of violence
15 because of the behaviour of inmates towards each other?
16 A. We did hear a lot about the behaviour of inmates towards
17 each other, yes.
18 Q. As you pointed out, the people you spoke to,
19 a significant proportion went to the strict suicide
20 observations regime because they wanted to escape --
21 A. Yes.
22 Q. -- some of the things that were going on in the main
23 block?
24 A. Absolutely, yes.
25 Q. Can I pass on, if I may, to -- in chapter 4, as

1 I outlined when we started looking at the report, you
2 started to deal with suicide precautions.
3 In chapter 5 you deal with the procedures for the
4 identification and management of inmates considered to
5 be at risk of suicide. You say you include the results
6 of a survey of 24 inmates under suicide observation,
7 interviewed in private. That is on page 32 of the
8 report.
9 I am not going to go through the reception process,
10 we have been through that, but at 5.4 you then deal with
11 what strict suicide observation is all about, I think,
12 is that right?
13 A. Yes, that's correct.
14 Q. And the sort of numbers that were on strict suicide
15 observation, and the lengths of time.
16 Again, we have been through that, so I am not going
17 to take too long over that.
18 At 5.5.1, page 34, you deal with accommodation, and
19 you say:
20 "The modified cells [which are used for strict
21 suicide observation] are the same size as other rooms in
22 the young offenders institution but washbasins and
23 fitted furniture have been removed. In addition, all
24 protruding fitments, for examples door handles and
25 window catches which might be used to support or suspend

1 a ligature have been removed. The window, made of
2 unbreakable polycarbonate, is fixed, ventilation is
3 provided through a grille, which cannot be closed, and
4 inmates and staff agree that in winter the rooms can be
5 extremely cold."
6 Then you go on at 5.5.2:
7 "The electric light is inoperable from within the
8 cell and remains on at all times. At night it is dim
9 but it is still light enough to allow an officer to
10 observe the cell through the spyhole in the door. Most
11 inmates sleep with the head end of the mattress under
12 the desk to afford some shade from the light at night."
13 5.5.3 goes on:
14 "The contents of the cell comprise by day a desk and
15 chair made from toughened cardboard painted with gloss
16 paint. A plastic chamberpot, one paperback book, or
17 alternatively comics for certain inmates, and a copy of
18 the Bible. By day, the inmate has one blanket made from
19 coarse canvas, reinforced by stitching to render it
20 virtually untearable. At night, the inmate is provided
21 with a second blanket of a similar type and mattress."
22 So that is strict suicide observation?
23 A. That is strict suicide observation, yes.
24 Q. Then you talk about the regime. There was a circular at
25 the time, which you refer to, but you say it doesn't

1 specify in that circular that inmates on SSO must wear
2 protective clothing, but it was customary for them to do
3 so. This comprised a canvas gown, a short-sleeve
4 knee-length garment shaped in similar style to
5 a pinafore dress, neither underpants nor any other
6 clothing is worn, slippers are worn on the feet."
7 Yes?
8 A. That's right, yes.
9 Q. You go on at 5.6.2, page 34:
10 "The regime consists essentially of the inmate
11 sitting in his room."
12 Basically most of the time they are just sitting in
13 their room?
14 A. Most of the time they are sitting in their room, yes.
15 Q. I think you say, effectively, that that really deprives
16 them of association?
17 A. Absolutely, yes.
18 Q. For most of the time?
19 A. Yes, there is a little bit of -- well, if you come on to
20 it later on, there is a little bit of mixing of inmates
21 after each meal.
22 Q. But it is fairly minimal?
23 A. It is minimal, yes.
24 Q. Because most things are done with the person in the
25 cell, or --

1 A. Or not done.
2 Q. Or not done, yes.
3 A. Yes.
4 Q. But even meals are taken --
5 A. Yes.
6 Q. -- are they not, because they are collected, are they
7 not, but they are put into the room?
8 A. The collecting of the meal allows a certain amount of
9 mixing, but the meal is taken in the room, yes.
10 Q. Indeed you say at 5.6.4, on page 35, there is no work,
11 other than basic cleaning task within the cell,
12 presumably?
13 A. Correct, yes.
14 Q. It is basically a sort of monotonous life?
15 A. Very monotonous, yes.
16 Q. You are sitting there with nothing to do half the time,
17 unless you want to read the Bible?
18 A. Exactly, yes.
19 Q. I don't suppose that many of the people who were
20 there -- if all they had was basic education and
21 learning difficulties -- would necessarily find that
22 an easy thing to do?
23 A. I absolutely agree with what you are saying, yes.
24 Q. If we go on to what strict suicide observation involves,
25 I think we have said already, as the name implies, it is

1 essentially observation and nothing more?

2 A. Absolutely. Passive observation.

3 Q. Passive observation.

4 I think we see that if we go to 5.9.1 on page 36, do

5 we?

6 Sorry, I have the wrong one there. That's the

7 interview. Sorry, I will come to that.

8 I think it's just, you may have said it earlier,

9 I think, but, well, I can take it from you in case

10 I have the wrong passage. It is a matter of they are

11 observed at regular intervals during the day?

12 A. And night.

13 Q. At 15-minute intervals --

14 A. Yes.

15 Q. -- if they are on strict observation?

16 A. That's right.

17 Q. And they are not in their normal place if they are on

18 strict observation, because they have been moved to this

19 special cell?

20 A. They have been moved to a special cell, mainly in the

21 young offenders institution, some in the detention

22 centre as well.

23 Q. Then, yes, sorry, I can go to 5.9.1 then, against that

24 explanation at page 36. It says as part of the working

25 group's review:

1 "We interviewed inmates under suicide observation on
2 three separate occasions."
3 You summarise what the outcome of that process was:
4 "We spoke to 24 inmates, of whom three had been on
5 ordinary observation."
6 I think that doesn't involve removal to this special
7 cell, if you like?
8 A. That's right, that's right.
9 Q. "But 21 had been on the strict suicide observation for
10 periods ranging from 3 to 395 days, the average being
11 about 70 days."
12 A. That's right.
13 Q. "All were interviewed in private and were willing to
14 talk about their experiences."
15 Therefore you were able to get some information
16 through that source.
17 At 5.9.2 on page 37, I think you make the point that
18 you made earlier, and this is where we find it, that
19 there were several different types that were on the
20 strict SSO regime:
21 "The largest group [comprising 13 of the inmates
22 that you interviewed] were there primarily for the
23 purposes of protection from other inmates. For some,
24 the nature of their offences, such as crimes of violence
25 or sexual offences against elderly people or children,

1 made it likely that they might be assaulted. For
2 others, there had been bullying by other inmates for
3 various reasons."
4 You said:
5 "Some were from country areas and were not
6 criminally sophisticated and others appeared to be
7 mentally handicapped and could not cope in the
8 mainstream. One had a speech impediment, which had made
9 him a target for bullying. Approximately half of this
10 group of inmates had been placed on SSO by staff who
11 feared for the safety of the inmate in the main blocks.
12 The others had effected their own removal, either by
13 saying they were suicidal or by injuring themselves. In
14 only one of these protection cases was there evidence of
15 any mental disorder or suicidal intent at the time of
16 our interviews."
17 So they were taking refuge.
18 A. They were taking refuge, yes.
19 Q. Because they felt unsafe in the main block for one
20 reason or another?
21 A. Correct, yes.
22 Q. Including because they may be bullied, assaulted and so
23 forth, victimised?
24 A. Yes.
25 Q. Then you comment on this situation at 5.10 on page 37,

1 and you divide the people into three distinct groups.

2 "Those who are mentally disturbed, either as

3 a result of mental illness or a temporary emotional

4 upset."

5 That is 5.10.1.

6 "Secondly, those who seek protection because of the

7 nature of their offence or because they cannot cope in

8 the mainstream, for example due to mental handicap.

9 "And thirdly those seeking a way out of the regime

10 [that is a detention centre] in which they find

11 themselves..."

12 For whatever reason.

13 A. For whatever reason, yes.

14 Q. Although you are dealing with people, and you are trying

15 to separate the mentally ill from others who subjected

16 themselves to this regime, you do say this, I think, at

17 5.10.2:

18 "Many would consider only the first category of

19 inmate to be at genuine risk of suicide, but we

20 emphasise that under the present circumstances all are

21 at risk since their only means of withdrawing from

22 circulation is by threatening suicide. It is

23 significant that many were willing to endure long

24 periods in conditions of gross deprivation on SSO rather

25 than return to the mainstream."

1 So that is making a clear point about --

2 A. Yes.

3 Q. -- they are prepared to put up with the conditions --

4 A. Yes.

5 Q. -- that you set out to get away from the mainstream?

6 A. Some, absolutely.

7 Q. Some are.

8 A. Yes, the majority, that's what we found. The problem is

9 that, well, perhaps we will come on to it, but one of

10 the problems, of course, is that the means for injuring

11 yourself in a prison are potentially lethal compared

12 with the means that are available to people in the

13 community, where survival is more likely. But for

14 a whole range of reasons attempting self harm in prison

15 is more dangerous than self harm outside.

16 Q. Can you just help. I mean obviously in the mainstream

17 they have access to things that can allow them to take

18 their life, but in what sense do you mean it is also

19 more dangerous?

20 A. Because hanging, putting anything, any form of putting

21 something round your neck, as we indicate in the

22 chapter 2, any form of putting something round your neck

23 can quickly become an irreversible step, whatever your

24 intention may be when you start. Whereas with overdoses

25 or cutting, you know, the likelihood is that you will

1 come to someone's attention, because these are not
2 happening in places where you do come to someone's
3 attention. You don't --
4 Q. You are alone, and if it's hanging it is going to be
5 very difficult to reverse what you do even if you don't
6 intend to take your life.
7 A. Exactly.
8 Q. That's why it is a heightened risk.
9 A. That's right, yes, it is a dangerous place to carry
10 out -- it is a more dangerous place to carry out acts of
11 self harm, self injury, than in a community, in another
12 setting.
13 LADY SMITH: Sorry, Dr Chiswick, I am not sure I am
14 following you, because people sadly hang themselves in
15 the community.
16 A. Yes, they do indeed. But the majority of acts of
17 self harm that don't lead to death are by other means.
18 LADY SMITH: I see.
19 A. If the person is signalling distress, the means
20 available to him in prison are very limited. And if the
21 choice is one of putting something round your neck and
22 tying it to a fixed point, it is very dangerous. It
23 sounds obvious, but it is much more dangerous, even
24 though the intent, the intent might be to signal, the
25 intent might be to register distress, the intent might

1 be to do something else, the intent might be to kill
2 oneself, but it is more likely to result in death than
3 a similar act carried out, an act with similar
4 motivation carried out in the community.
5 LADY SMITH: So you are saying the risk of death in for
6 example parasuicide is higher in prison because the
7 means adopted, that can be adopted, are so limited, is
8 that it?
9 A. The means are limited, and you are not in contact with
10 other people.
11 LADY SMITH: Of course.
12 A. Other people don't, they don't find you. Nobody knows.
13 If you are not in the place you are normally expected to
14 be in the community, people become worried and take
15 action. If they don't get any response from a phone or
16 something they take action. None of those things, you
17 know in a prison cell on your own when observations
18 aren't carried out, or whatever, it is a very dangerous
19 place.
20 LADY SMITH: Thank you.
21 MR PEOPLES: You have not got the range of ways you might
22 have in the community to be someone who wants to not
23 take their life, but to do something that will perhaps,
24 for whatever reason, draw attention to a situation that
25 they are in. There is less alternatives in prison.

1 Hanging is an obvious one if you are not in one of these
2 cells, it seems to be the common cause in prisons, or
3 the means.
4 A. Indeed.
5 Q. And presumably when you say those who are not intent on
6 taking their life, but use hanging as a parasuicide
7 activity, in general terms would not necessarily
8 understand that that can be the result. They don't come
9 into it thinking "if I do this it's okay". They may
10 think so, but they don't actually realise it is
11 irreversible, often, even if they suddenly have a change
12 of heart and think "oh gosh, this has gone too far". Is
13 that the reality, that they don't know they are taking
14 a risk that they are not going to just draw attention to
15 themselves but they are going to lose their life?
16 A. I don't know if they are aware of the risk, I really
17 don't know.
18 Q. If someone similarly doesn't have an intention to take
19 their life, and they use a means such as hanging, and
20 hanging can result in death, whatever they think will
21 happen, that suggests they don't have a true
22 appreciation of the risk.
23 A. That might well be the case. I think in chapter 2 we do
24 draw attention, once there is constriction of the neck,
25 the blood vessels are constricted and the blood supply

1 to the brain is affected you don't have any more control
2 over, whatever your intentions might be you don't have
3 any more control over it, and you can't simply stand up;
4 a lot of these are carried out in a sitting position.
5 The whole issue when we looked, and from what I read
6 probably still continuing, is that it is a dangerous
7 place because there is no equivalence of healthcare.
8 I know suicides do occasionally tragically happen in
9 psychiatric hospitals, but in general terms there isn't
10 the type of care, the type of observation, the type of
11 contact with others, that you would expect in a hospital
12 setting. Nothing like that is available, or was
13 available, in 1985.
14 MR PEOPLES: I am conscious of the time. I think it is
15 probably --
16 LADY SMITH: I think we should break.
17 We will stop now for the lunch break, Dr Chiswick --
18 A. Thank you.
19 LADY SMITH: -- and give you a rest.
20 We will sit again at 2 o'clock.
21 A. Thank you.
22 (1.02 pm)
23 (The luncheon adjournment)
24 (2.00 pm)
25 LADY SMITH: Good afternoon. Welcome back, Dr Chiswick.

1 A. Thank you.

2 LADY SMITH: Are you ready for us to carry on?

3 A. Yes, I am, thank you.

4 LADY SMITH: Thank you.

5 Mr Peoples.

6 MR PEOPLES: My Lady.

7 Dr Chiswick, when we broke for lunch I was looking

8 at chapter 5 of your report. I just want to go to one

9 more passage in that chapter, before we move on to the

10 sort of key issues and recommendations section, which

11 I would just like to look at.

12 A. Right.

13 Q. It is at page 38 of the report at 5.11.1. It is just

14 one of the sentences that is included in that section,

15 or paragraph, and it is just about six lines from the

16 bottom of that paragraph. The report states:

17 "In all institutions that we visited ..."

18 Because you had visited other institutions, I think?

19 A. Yes.

20 Q. "... the importance of keeping inmates at risk of

21 suicide in association with others was emphasised."

22 Is that something that -- you draw on that to some

23 extent when you talk about, obviously, things like close

24 relationships between staff and inmates, but is that

25 something that we have to keep in mind, the importance

1 of association rather than isolation?
2 A. Absolutely. As a response to suicidal behaviour, yes.
3 Q. Yes. It might be a general response, one might say that
4 any person in that environment who is isolated for any
5 period of time it could be injurious to their general
6 mental health, as a general proposition. But more so,
7 even more so with someone who perhaps has mental health
8 difficulties?
9 A. Yes. I mean here that paragraph deals with the way
10 other establishments dealt with the same problem.
11 Q. They recognised that you have to have association?
12 A. That's right, yes.
13 Q. But Glenochil --
14 LADY SMITH: When you said, Dr Chiswick, "All institutions
15 we visited", I understand that was other penal
16 institutions in Scotland, the State Hospital at
17 Carstairs, psychiatric hospitals and penal institutions
18 in England and Wales, is that correct?
19 A. That's right. They are listed in appendix A --
20 LADY SMITH: Yes.
21 A. -- the final page of appendix A. HM Remand Centre
22 Ashford, Youth Custody Centre Aylesbury, Youth Custody
23 Centre Feltham, Remand and Youth Custody Centre
24 Glen Parva, Junior Detention Centre at Send and Prison
25 and Youth Custody Centre Swansea.

1 LADY SMITH: Right. So a wide sweep of comparable
2 institutions?
3 A. That is correct, my Lady, yes.
4 LADY SMITH: And they were all saying the same thing?
5 A. They were all saying the same thing, yes.
6 LADY SMITH: Thank you.
7 MR PEOPLES: Can I move on to chapter 6 that starts on
8 page 39, it is headed up "Key issues and key
9 recommendations". To an extent you have foreshadowed
10 what we can look at here by telling us about the general
11 principles and some of the things that you describe
12 broadly were the result of this review. But if I could
13 just take you to some passages here.
14 You make the point, and it is at page 40, at 6.2.3:
15 "All penal institutions are required to have regard
16 for the safe care of their inmates. Where the inmates
17 are all young people the obligations upon the caring
18 institution become matters of even greater importance
19 and sensitivity."
20 I think this is how you introduce one of your
21 general principles:
22 "However, there can be no certainty in the
23 prediction of human affairs and even with the most
24 sophisticated methods of identifying and managing those
25 at risk, there can be no guarantee of prevention.

1 However, we think the aim should be to achieve a proper
2 balance between procedures, that reduce risk to
3 a minimum yet are compatible with an acceptable way of
4 life within a penal establishment."
5 That really explains the thinking?
6 A. That's right, yes.
7 Perhaps it just follows on from the previous
8 paragraph; that it is, you know, a difficult task in
9 an institution such as Glenochil. As we say, it is
10 asking much of staff to identify inmates at risk, given
11 the whole circumstances that we have been speaking about
12 this morning.
13 Q. Yes.
14 Even if you do, though, you still have this
15 difficult balance to strike --
16 A. Yes.
17 Q. -- of how you manage that situation?
18 A. Indeed.
19 Q. Then you deal with the suicide observation procedure,
20 6.3, a specific measure that you are introducing. Can
21 I just look at that, if I may, in short. At 6.3.1 this
22 really starts to draw together some of your conclusions
23 and views on what you consider of the regime for suicide
24 prevention. You say, in the final sentence of 6.3.1:
25 "A regime originally intended for those at risk of

1 suicide has become contaminated by its use for those who
2 seek a refuge and those who find conditions preferable
3 to mainstream."
4 You saw the distinction between those that use it --
5 A. Yes.
6 Q. -- but you explained why they sought refuge, it wasn't
7 just in some way a criticism of them, it was almost
8 something that the regime, or what was happening in the
9 broad sense, drove them to that place?
10 A. That is correct, yes. I suppose the follow on is it
11 then presented difficulties to those responsible for
12 running that unit into: how do we deal with this?
13 Q. Yes, are you managing people with mental health needs or
14 are you managing people who simply want to escape other
15 parts of the environment?
16 A. Exactly, yes.
17 Q. And do you treat them the same?
18 A. Exactly.
19 Q. And yet the regime was the same?
20 A. The regime was the same, yes.
21 Q. Yes. Indeed, I think you say, without trying to reach
22 a firm conclusion, at 6.3.2:
23 "The presence of those who find the mainstream
24 unacceptable for one reason or another, it may be due to
25 the presence of this latter group that the regime of

1 strict suicidal precautions contains, what is in our
2 view, highly punitive elements."
3 So you see the regime, albeit it was perhaps set up
4 for those with mental health needs, as having become
5 something that, perhaps because of the presence of
6 others, had become, in the group's view, a highly
7 punitive environment, or element ... it had that to it.
8 A. That's right. Well, it was a highly punitive element,
9 and we, you know, perhaps just thinking how it came
10 about, perhaps it was a sort of demonstration that if
11 you just chose to be here because you didn't like the
12 other condition, for whatever reason, but if you just
13 chose it, you know, maybe it shouldn't be too easy for
14 you. That was the sort of implication that we --
15 Q. Yes, it's not a soft option if you are there for the
16 wrong reason?
17 A. Yes, exactly.
18 Q. Or at least that might have been the mindset?
19 A. Yes.
20 Q. To an extent anyway?
21 A. Yes. But the one-size-fits-all type of procedure,
22 seriously -- well, (a) as we say it was highly punitive
23 and it seriously disadvantaged many people who were
24 there.
25 Q. Yes, it would be difficult to change the mindset because

1 you wouldn't necessarily be entirely sure whether those
2 that were assessed as a need were genuine suicide risks
3 or in some other category?
4 A. Yes. I mean we could see how it came about. You know,
5 it doesn't, we didn't intend, we didn't imply any
6 condoning of the regime, or anything like that.
7 Q. No, no.
8 A. But we could see how it had come about.
9 Q. Then if I can move to 6.3.3, your group say:
10 "We think that the methods of managing inmates
11 thought to be at risk of suicide are unsatisfactory. In
12 particular, we consider that the procedure whereby
13 an inmate, identified as suicidal, is secluded for
14 lengthy periods in a special cell to be inhumane and
15 unacceptable."
16 These are quite strong words, for the time?
17 A. Yes. For the time. That was our view, yes.
18 Q. Yes. You go on to explain, I think, your reasons for
19 that characterisation. You say:
20 "The procedural emphasis on passive observation, the
21 lack of opportunity for the inmate to engage in regular
22 conversation and the denial of human contact are
23 misplaced and contrary to modern notions of psychiatric
24 care."
25 Then you say:

1 "We think that this form of strict suicide
2 observation, which depends principally on physical
3 safeguards, is a form of gross deprivation rather than
4 treatment, and should be abolished. We recommend [going
5 to page 41] that alternative methods of management based
6 on the adoption of good standards of medical and nursing
7 care should be instituted. We also recommend that
8 because the system known as ordinary suicide observation
9 can have no possible therapeutic role it should be
10 abandoned."
11 You go on at 6.3.4 to say:
12 "We recommend that both these forms of observation
13 should be replaced by a range of procedures, their
14 implementation depending on assessment and regular
15 review of the inmate's circumstances and mental
16 condition. We recommend three levels of care, which we
17 designate extra care, close care and special care. The
18 latter two forms of care should be provided by nurse
19 officers under medical supervision in the institution
20 hospital."
21 Then you finally say:
22 "The essential component of each form of care, which
23 is described more fully in chapter 7 [that's the
24 detail], is contact between inmate and staff."
25 Does that really capture in a nutshell what was

1 wrong and what was needed?

2 A. That's exactly so. I mean when we were speaking just

3 earlier about the mixed population within the strict

4 suicide observation conditions, the fact that some were

5 there by choice, as it were, partly explains what we

6 would call the low key role of doctors in its

7 participation, because it wasn't really a medical -- for

8 many of the youngsters there, it wasn't seen as

9 a medical issue. It was apparent that they had chosen

10 to be there, for whatever reason.

11 Q. It was for some.

12 A. Pardon?

13 Q. It was for some, though.

14 A. It was for some.

15 Q. But they got denied the care they might have been

16 entitled to --

17 A. That's right.

18 Q. -- because they were lumped in with all of the

19 categories?

20 A. That's right, it was the one-size-fits-all approach that

21 failed.

22 Q. You have a section in chapter 6, starting on page 43,

23 which is headed "General measures". I think this is

24 maybe getting towards the territory of the wider issues

25 point that we discussed this morning, before lunch, that

1 to some extent seems to have caused a bit of concern
2 once the report came out.
3 A. Yes.
4 Q. You see this as fundamental and necessary to report on.
5 One of the things you say in your report is at
6 6.4.3, page 43, line 2:
7 "We are unanimous in our view that important changes
8 of a general nature are needed in both the detention
9 centre and in the young offenders institution."
10 That's not just confined, I suppose, to suicide
11 observations, it is a bit wider than that in terms of,
12 for example, relationships?
13 A. Absolutely, yes.
14 Q. And also the layout --
15 A. Yes.
16 Q. -- of the complex?
17 A. That's right.
18 Q. So there is quite a range of factors that you have in
19 mind there?
20 A. A range of factors, structural and sort of functional as
21 well.
22 Q. If we go on at 6.4.4, page 44, you say, four lines down,
23 we think, from what you have seen, there is
24 an indication that the range of options provided by the
25 young offenders institution is insufficient for the

1 needs of a widely varied inmate population.

2 You go on then to address some of the pressures that

3 we saw earlier in your report:

4 "The problem is most acute for those who are the

5 victims of bullying."

6 Then, just going on:

7 "We suggest that the young offenders institution be

8 modified into smaller units, each providing a different

9 regime, and we give examples in paragraph 8.2.8 of the

10 changes we have in mind. We think that this measure

11 will separate factions, meet the needs of individual

12 inmates and provide better opportunities for inmates to

13 relate to the staff and take them into their confidence.

14 In this way the bullying, which we regard as a malignant

15 aspect of inmates' culture, would be tackled, with

16 a consequent reduction in the need for vulnerable

17 inmates to threaten or resort to suicidal behaviour."

18 You go on, 6.4.5, on the same page:

19 "A further argument for this measure is that smaller

20 units would encourage the sort of staff-inmate

21 relationships that we think should be developed at

22 Glenochil."

23 Your proposal was that new modified units should be

24 designed in a manner that forced close contact between

25 staff and inmates. Then you go on, at 6.4.6:

1 "There are other measures that we recommend to
2 facilitate staff-inmate relationships. We think that
3 the personal officer scheme should be developed in the
4 young offenders institution and in the detention centre.
5 We consider that the skills of prison officers could be
6 developed further by incorporating welfare tasks into
7 what is predominantly a disciplinary function. It is
8 important that officers are properly motivated for this
9 work, and we recommend a review of their training so
10 they may acquire knowledge in counselling, aspects of
11 adolescent development and other matters which we
12 mention in 8.3.3."
13 You also go on at 6.4.7:
14 "We recognise that the detention centre has a fixed
15 and disciplined regime, but we feel there is scope
16 within it for change. We are concerned that so much of
17 the trainees' sentence is spent in silence. We feel
18 this to be an unnatural and for some and even harmful
19 experience."
20 So you make suggestions.
21 I am not going to go into all the detail of how you
22 said these could be addressed, these are measures that
23 we can read for ourselves, but that was what prompted
24 the inclusion of these passages, that you felt the need
25 to say that beyond the specifics of the strict suicide

1 observation regime?

2 A. Absolutely, they were general measures and we felt that

3 without adopting those general measures, purely relying

4 on changing the suicide observation, strict suicide

5 observation regime, by itself would not address the

6 issue satisfactorily.

7 Q. On page 45 you recognise the importance of continuing

8 contact with family of anyone, I suppose, in a prison

9 environment. Perhaps more so those who may be

10 experiencing some mental health problems, or

11 difficulties. You say at 6.6.1:

12 "Inmates need to be in contact with their families.

13 Such contact improves the inmates' spirits, helps to

14 defuse tensions and increases the likelihood of

15 successful reintegration upon release. Glenochil is

16 an extremely difficult place to reach by public

17 transport. Moreover, visitors may have no real

18 opportunity to talk to those staff who are most closely

19 involved with the inmate."

20 You make suggestions in chapter 8 for improving that

21 situation:

22 "Because [as it says here] we think visiting plays

23 a vital part in promoting the inmates' mental

24 wellbeing."

25 It is not just about the staff-inmate relationship,

1 it is also the importance of a continuing contact with
2 family, and making sure that they have proper access to
3 that contact?
4 A. Absolutely, yes, and that the visitors can speak to
5 significant staff involved in their son's care.
6 Q. In chapter 7 -- I am not going to go through this with
7 you today, but you can be assured we are aware of what
8 it says, it develops and goes into more detail of the
9 measures that you feel need to be put in place to
10 improve and give effect to your general conclusions and
11 recommendations.
12 If you want to say anything about chapter 7 before
13 I pass on to chapter 8, please feel free, because
14 I think we have covered the background to all of what
15 you say there, and no doubt it will be interesting to
16 see to what extent, even today, any of what was said
17 there has found its way into the system for managing
18 young offenders. But that's for other people and
19 another day --
20 A. Yes.
21 Q. -- but just if you have any points you want to say.
22 A. No, the chapter is largely a reflection of an attempt to
23 introduce, say, impose, if you like, I don't know,
24 import, a healthcare system of looking after people at
25 risk of suicide or self harm into the prison situation.

1 So they are detailed recommendations about how we
2 recommend that should be done.
3 Q. I think chapter 8 to some extent is doing the same
4 thing. You have said there is a need for specific
5 measures, radical change and a need for general measures
6 to address some of the wider issues. I think what you
7 seek to do in chapter 8, am I right, is that you are
8 indicating how these things can be addressed in various
9 ways, the issues of the contact with family, the
10 introduction of a personal officer scheme and things of
11 that nature. Is that correct?
12 A. Yes, in chapter 8?
13 LADY SMITH: 8, from page 56.
14 MR PEOPLES: Yes, sorry, page 56.
15 A. They were fairly radical suggestions, and I appreciate
16 that.
17 Q. For the time?
18 A. For the time. Restructuring -- I mean the buildings of
19 Glenochil young offenders institution, you know, wasn't
20 geared to contact, meaningful contact, between the young
21 offenders and staff. So there were recommendations
22 about the layout of the place, the sort of people that
23 could be prison officers with young people, female staff
24 working on the blocks and those sorts of things, yes.
25 Q. I suppose that the politicians that hold the purse

1 strings start looking in horror when they see things
2 like that, because they have serious cost implications
3 or resource implications, as it is sometimes said, and
4 were you conscious when you were doing that, that that
5 might present a practical or a political difficulty to
6 implementing your suggestions?
7 A. Um --
8 Q. Or did you just say, "Well, let the politicians sort
9 that out"?
10 A. I think the latter, I don't think we could concern
11 ourselves -- we were asked to do a job and we did it in
12 the way that we felt was appropriate. I don't think
13 I can say any more.
14 Q. I think in the event those considerations did play
15 a part in the aftermath?
16 A. In the aftermath, yes, you mean after the report was
17 submitted?
18 Q. Yes, and the response to it.
19 A. And the response to it, yes.
20 Q. While we are still on the report, chapter 9 is fitness
21 for detention centre. I don't want to diminish its
22 importance, because it was a big issue for you, but
23 I think you basically reached the conclusion, based on
24 what you were aware of, that perhaps the assessment of
25 fitness needed considerable overhaul and many people who

1 were in detention centres were in the wrong place, and
2 were not fit for that regime. Is that essentially in
3 essence what you conclude?
4 A. That's it in a nutshell.
5 I mean at appendix F we list the 32 inmates that
6 were transferred from the detention centre to a young
7 offenders institution during the time that we were --
8 from 1984 to 1985. There were a whole variety of
9 issues, but recurring issues were, "Could not cope
10 and/or mental disorder", but then there were physical
11 issues, as well. Somebody with an amputated foot,
12 somebody with a deformity of the right arm, deformed
13 foot, disability in the hip. These were people that had
14 been sent by the court for detention centre, for short,
15 sharp shock detention centre training.
16 We felt that the selection of offenders for
17 detention centres was severely flawed.
18 Q. I think you say because courts presumably to an extent
19 have to act on the background information they get on
20 the individual, that there was a need perhaps to tighten
21 up the guidance in Scotland --
22 A. Yes.
23 Q. -- in relation to the criteria for saying whether
24 someone could be assessed as fit --
25 A. Yes.

1 Q. -- or unfit. I think you compared it unfavourably with
2 the equivalent English guidance in your report; is that
3 correct?
4 A. Yes, it seemed to us the English guidance to social
5 workers contained much more information about the sort
6 of mental factors that would make a detention centre
7 unsuitable for the offender.
8 Q. Then in chapter 10 there is a short chapter headed
9 "Broader issues" on page 70. Again, I am not going to
10 take you through that in detail, but I think you were
11 trying to find sensible ways of trying to implement some
12 of the changes that you were advocating in your report.
13 I think one idea was the establishment -- at page 71 at
14 10.5 -- of a policy and development unit, which would
15 perhaps look at the matter globally and across the
16 board, and perhaps have a more strategic look at things,
17 and drive change?
18 A. That was our recommendation, yes.
19 Q. Yes. You were looking for a mechanism to effectively
20 see that what you were suggesting could actually happen
21 in practice?
22 A. Yes, and I suppose underlying it is the hope that
23 someone would recognise the failings of the broader
24 system as it was operating. We weren't qualified to do
25 that and recommended that other people should.

1 Q. Yes.

2 If I go on to chapter 11, this is a summary of all

3 of your recommendations, suggestions, including at the

4 start, as we spoke about before lunch, at page 73, the

5 general principles. Then you go through the various

6 matters that were of concern and how you felt that they

7 should be addressed, by way of either a recommendation

8 or a suggestion. There is a very large number of

9 recommendations at the end of the day. Is it 63 in all?

10 A. Yes.

11 Q. You were making a lot of recommendations for change?

12 A. We were, yes.

13 Q. I am not suggesting too many, I am just saying maybe it

14 was a sign of the scale of the problem?

15 A. Exactly, yes.

16 Q. Rather than that you were suggesting too many changes

17 for no great reason, it is not like, well, if the

18 system's not broken --

19 A. Yes.

20 Q. -- don't throw it out.

21 A. We gave very careful consideration to what should be

22 a recommendation, because we didn't want to say things,

23 as you say, just for the sake of it. So we tried to

24 make them brief and direct and address the particular

25 issue.

1 Q. At appendix A -- I am not going to go through this, we
2 can all look at it for ourselves -- at page 78 through
3 to page 80 you list the various organisations and
4 individuals who provided views to the working group,
5 either in writing or orally. I think one can certainly
6 say it is a pretty comprehensive list --
7 A. Yes.
8 Q. -- and quite a varied list to get an adequate range of
9 view on the issues that you were addressing?
10 A. Yes, well, we thought that that was an important thing
11 to do.
12 Q. Yes.
13 Can we perhaps go back to your statement now, at
14 page 17, I think it starts at paragraph 59, headed
15 "Publication of the report". I will perhaps take this
16 as short as we can, but I do want to capture what it is
17 that happened after publication.
18 You submitted the report on 28 June 1985, that is
19 paragraph 59. You tell us that prior to publication of
20 the report in July you were asked to come to a meeting
21 with -- I think was he known as Bill Reid, or
22 William Reid, is it?
23 A. William Reid.
24 Q. Later Sir William Reid, Secretary of the Scottish Home
25 and Health Department. That is a very high ranking

1 official?

2 A. Yes.

3 Q. And Alistair Thomson, who was then the director of the

4 Scottish Prison Service. You say:

5 "It was clear to me that there were parts of the

6 report that Alistair Thomson found difficult to accept."

7 But you say that you stuck to your guns, I think,

8 and you didn't make any adjustments to the report, as

9 I think in practice does happen from time to time in

10 these situations?

11 A. Yes, we made no adjustments. It was exactly as

12 submitted.

13 Q. Can we look at, the publication, as we have been told

14 earlier today, I think was it on 24 July --

15 A. Yes.

16 Q. -- 1985? Perhaps in that we can perhaps have a look at

17 what was said in the press release of the statement that

18 was issued, the Secretary of State's statement, which

19 I think was the statement which was read out in

20 Parliament. I think you provided us with a copy of it,

21 and I think you have given us the Hansard reference as

22 well. We can maybe just take this short. It is at

23 WIT-3-000001184, page 57.

24 A. Yes.

25 Q. I am sure it is a familiar one to you.

1 A. Yes.

2 Q. It is a Scottish Office news release. Page 57, sorry.

3 It is giving them advance notice of what the Secretary

4 of State was going to say at the time of publication of

5 the report; is that right?

6 A. Yes.

7 Q. Or at least it is released at the same time, I think,

8 rather.

9 This was the response of the Secretary of State. It

10 was a public response to your report; is that right?

11 A. That's correct, yes.

12 Q. This was said in Parliament. If we take page 57, the

13 final paragraph, he deals with his response to the

14 recommendations and he says:

15 "This is an important report on a subject which has

16 generated a good deal of understandable public concern.

17 It makes a considerable number of recommendations, the

18 majority of which I am ready to accept, although some

19 will require more detailed examination. There are,

20 however, a number of recommendations which I cannot

21 accept."

22 He then, if we go to page 58, we perhaps begin to

23 get a sense of where he is coming from when he speaks to

24 the politicians, when he says:

25 "I would remind the House [this is what he was

1 saying in Parliament] that procedures to identify care
2 for vulnerable and inadequate offenders, who may have
3 genuinely suicidal tendencies, must be a vitally
4 important feature of any penal institution.
5 Nevertheless, these are a tiny minority of the inmates.
6 We must not lose sight of the fact that the primary
7 purpose of custody is the deprivation of liberty as
8 a punishment. The inmates at Glenochil are there
9 because they have offended against society and require
10 custodial sentences and rehabilitation. They include
11 many hard and brutal offenders. About half of those in
12 the young offenders institution are serving sentences of
13 between 3 years and life for particularly serious
14 offences. The authorities at Glenochil have to manage
15 their custody, as well as that of a comparatively small
16 number of vulnerable youths."
17 He seems to be downplaying the problem, with great
18 respect to the Secretary of State at that stage, would
19 you agree?
20 A. Yes, I think it serves as his introduction to what then
21 follows.
22 Q. What's about to follow.
23 A. Yes.
24 Q. Then he says something that he has said before in the
25 next part of his statement, he says:

1 "The report's broad conclusions are, I am pleased to
2 note, in accordance with the recent finding by the
3 Sheriff Principal who conducted the fatal accident
4 inquiry into the death in April of Derek Harris, that
5 there is no evidence that the regime operated at
6 Glenochil or the actions staff were responsible for any
7 of the seven deaths which have taken place since 1981.
8 Only three of the seven deaths were determined as
9 deliberate suicides."
10 Then he refers to the fact that the group were
11 impressed by the dedication of the Governor, staff and
12 so forth, and that the recommendations implied no
13 criticism of the staff as such.
14 Did that come as news to you?
15 A. Yes. I mean we didn't say anywhere that there was no
16 evidence that the regimes operated at Glenochil or the
17 action of the staff were responsible or were not
18 responsible. That wasn't our role. So I don't know
19 where that came from. There is no --
20 Q. Probably a civil servant within the Scottish Office who
21 prepared a briefing note or a draft statement for the
22 minister.
23 I think we know from other case studies that that's
24 the way that the political system works in Scotland, and
25 no doubt elsewhere, but ...

1 I think I can maybe offer you that suggestion, that
2 it is not always written by the person who delivers the
3 statement, although he may well ultimately decide
4 whether it accords with what he wants to say. But is
5 a process that culminates in a statement, which is then
6 approved and is read out.
7 A. Yes, but I mean there are aspects of it which simply
8 don't tell -- aren't true --
9 Q. Yes.
10 A. -- they attribute to us findings that we didn't make.
11 Q. They got it wrong, if that is what they were suggesting,
12 that you gave a clean bill of health --
13 A. Yes.
14 Q. -- I think was one of the expressions used in one of the
15 debates or in Parliament. That wasn't what you did? As
16 you have explained, you have explained today, I think?
17 A. Yes, it certainly wasn't what we did and we have
18 discussed before, we weren't told to determine who was
19 responsible for the deaths.
20 Q. If we go to page 59, I am not going to read all of this
21 statement, we can all read it at our leisure, I suppose
22 one thing you did say, I don't know if I brought this
23 out when we were looking at the report earlier, but in
24 the second full paragraph on page 59 one thing he does
25 seem to be prepared to accept wholeheartedly is the

1 important recommendation of using a team approach when
2 you are making assessments and decisions on suicide
3 risk, is that -- because that was something, I think,
4 you --
5 A. Yes.
6 Q. -- to a large extent were suggesting?
7 A. Indeed we did.
8 Q. There should be a process, a collaborative process?
9 A. Exactly, yes.
10 Q. Including involving appropriately qualified
11 professionals?
12 A. Yes, indeed.
13 Q. Then perhaps we come to a more controversial statement
14 that he made, and I take it you never saw this speech
15 either in draft --
16 A. No.
17 Q. -- or had any input into it at all?
18 A. None at all, no.
19 Q. If we go to the second part, the last paragraph on that
20 page, the statement goes on:
21 "In a number of respects the working group have gone
22 beyond their remit and discussed issues affecting the
23 overall management of establishments in the prison
24 service as a whole, which as a small specifically
25 qualified group they were not constituted to comment

1 upon."

2 That doesn't seem to sit easily with some of the

3 things we saw earlier on being said by Michael Ancram,

4 and indeed your notification to the Secretary of State

5 by letter that you were taking a broad approach?

6 A. Yes, I think it is a direct contradiction of what was in

7 the other sources that you referenced just now.

8 Q. Then he goes on, perhaps to try and close this matter

9 down once and for all, to say:

10 "I trust that the working group's findings [as he

11 has explained them to be], together with the

12 determination of Sheriff Principal Taylor will be

13 accepted by honourable members and by the general public

14 as refuting any suggestion that the unfortunate deaths

15 which have taken place at Glenochil are attributable to

16 the regimes, particularly that of the detention centre,

17 or the behaviour of staff. There is not a shred of

18 evidence to support these allegations."

19 What did you make of that when you heard it?

20 A. By this stage I wasn't surprised.

21 Q. Well, no, I can tell. But on reading the statement?

22 A. Yes, I mean I think we have spoken about it. I think in

23 an effort to defend what the politicians thought was

24 an area of vulnerability, that is the safety of

25 detention centres, what they do and the whole system of

1 short, sharp shock, in their effort to ensure that no
2 blame would be attributed to the detention centre regime
3 you get statements like this, which completely don't do
4 justice to what we said and what we found.
5 Q. I suppose we have to remember context and the day, and
6 the situation, I said earlier that the Home Secretary,
7 or at least senior ministers in England, were talking
8 about, "No holiday camp, short, sharp shock"?
9 A. Yes.
10 Q. Which I presume was still a favoured policy.
11 I suppose that one might surmise that to have
12 a condemnation of a regime, in the way that you have
13 defined the term, would not have been one that the
14 Secretary of State may have wanted to state publicly?
15 A. No. I accept that, yes, I am sure that is the case.
16 Q. Political considerations came into play, it would
17 appear?
18 A. Very strongly, I think, yes.
19 LADY SMITH: It sounds rather as though they were terrified
20 of anything being read as saying that deaths in
21 Glenochil were caused by their very distinct choice of
22 policy.
23 A. Yes, I would agree, my Lady. I think that's exactly the
24 situation.
25 MR PEOPLES: If I could just briefly go on, not only were

1 you perhaps -- you reacted in the way you have
2 described, but you felt strongly enough to write to
3 Sir William Reid in August of the same year. If I can
4 ask you to look at page 73.
5 You exercised commendable restraint in terms of the
6 language used, but you certainly wanted to put on record
7 your feelings, having considered the statement made by
8 the Secretary of State on 24 July, and how matters were
9 reported in Hansard. You say, in the second paragraph:
10 "In relation to the latter statement, I must confess
11 disappointment with its general tone and surprise at
12 certain ..."
13 Is it "parts" or "of the responses", I think that is
14 the gist of what you were conveying to
15 Sir William Reid --
16 A. Yes, "Certain of the responses" .
17 Q. Sorry. So you were --
18 A. Yes.
19 Q. -- feeling strongly, strong enough to want to say
20 something. Was that something that you were writing on
21 behalf of the whole group?
22 A. Yes, we had an invitation to attend a meeting at
23 St Andrew's House in October, so it was by then I had
24 had the opportunity to look at the statement, which
25 I hadn't seen in detail before, and everything from

1 Hansard. Yes, that's just to lay down my view that
2 I didn't know why we were going to have a discussion
3 meeting in St Andrew's House on 22 October.
4 Q. Did much come of that meeting?
5 A. No, I don't think so, not a great deal.
6 Q. Well, they weren't going to retreat from their formal
7 position, or their public position?
8 A. No, no. I can't speak for the civil service at that
9 stage. Was it peacemaking, I don't know. Was it --
10 I don't know.
11 LADY SMITH: Did they want to be able to say they had met
12 with you?
13 A. Well, maybe, maybe. It turned a little sour later on,
14 as I am sure we will --
15 MR PEOPLES: I will perhaps now move on.
16 Whatever was said at this meeting that you
17 mentioned, can we move on to 7 November 1985, and
18 a debate in Parliament, at page 75 of the document we
19 have been looking at. The bit I am interested in is
20 that it seems to be a response to various questions, not
21 just about your report, but your report is one of the
22 matters that's dealt with in this debate on the address,
23 I think it's called. Do we see there that two
24 statements are made on the second column, the first one
25 about one-third of the way down:

1 "The majority of the report's 63 recommendations
2 were accepted and many are now in operation at the
3 institution."
4 I will come forward in a moment to what you tell us
5 in your statement, but that's what was being said to the
6 House --
7 A. Yes.
8 Q. -- by the Secretary of State?
9 Further down, well, it looks as if whatever you said
10 at the meeting, it didn't seem to shift the position,
11 because the Secretary of State says:
12 "I believe that further inquiries and investigations
13 at Glenochil would now seem inappropriate, given the
14 findings of the Chiswick report and the determinations
15 of recent fatal accident inquiries. They gave a clean
16 bill of health to the Glenochil complex. That
17 demonstrates that there is no evidence that there is
18 anything in the regimes or in the actions of staff at
19 either of the two institutions to which any of the
20 deaths could have been attributed."
21 So we have the same message --
22 A. Yes.
23 Q. -- as the central message from Government --
24 A. Indeed, yes.
25 Q. -- in response to the report, based on their

1 interpretation of your report, which you don't accept?
2 A. That's correct, yes.
3 Q. And didn't accept at the time?
4 A. That is correct, yes.
5 Q. Indeed, if we go on to page 76, having no doubt been
6 challenged to some extent then, and I think when the
7 report was published by Mr Dewar on behalf of the
8 opposition, who I think weren't accepting the Secretary
9 of State's interpretation, but was rather accepting the
10 interpretation you have told us about today, we get
11 a further statement by Mr Younger, in the first column,
12 about your report, Dr Chiswick:
13 "... and the fatal accident inquiries have given us
14 one thing that is satisfactory, although we must not be
15 complacent about it, that the tragic deaths which we all
16 deplore were not directly attributable to the
17 institutions, the regime or any of the staff. That is
18 the important thing that we should hang on to."
19 He was trying to, presumably, move on?
20 A. Yes, presumably, yes.
21 Q. Then if I could go back to your statement, which we were
22 looking at, you deal with the matters that we have been
23 just discussing. If we go to page 19 of your statement,
24 there is a section headed "Aftermath".
25 A. Yes.

1 Q. Paragraph 66 we have covered already, but you tell us at
2 paragraph 67 that following publication of the report
3 you returned to Glenochil in April 1986. What you tell
4 us there is that you were asked to see a young offender
5 there by a visiting psychiatrist. You were very
6 concerned about the individual you examined, who
7 disclosed he was under pressure from other inmates and
8 had sought the sanctuary of strict suicide observation.
9 You say:
10 "It seemed to me that almost a year after
11 publication of the report, the regime had not changed in
12 respect of strict suicide observation."
13 Is that what it appeared to be?
14 A. That's correct, yes.
15 Q. No doubt you were further disappointed?
16 A. Yes, yes, I mean I was disappointed. I was going to say
17 perhaps not surprised, but, yes, it was disappointing.
18 Q. You took the trouble to write a further letter to
19 Sir William Reid of the Scottish Home and Health
20 Department following that visit?
21 A. I did, yes.
22 Q. You deal with that at page 20, paragraph 68. You stated
23 to him:
24 "I was concerned to find that the institution
25 continues to be dominated by the problem of

1 self-injurious behaviour in its management. The inmate
2 whom I examined and staff to whom I spoke confirmed my
3 view that the major reason for acts of self injury at
4 Glenochil continues to be the bullying and the
5 victimisation carried out by certain inmates upon
6 others. I have no doubt that suicidal behaviour will
7 continue to be prevalent as long as a substantial number
8 of inmates perceive their environment as unsafe. It is
9 disappointing that there seems to have been so little
10 effective action to deal with this fundamental problem."
11 You did get a reply, but ultimately can I just take
12 it from you that you really didn't get any satisfactory
13 reply to that?
14 A. No, I did get a reply.
15 Q. I am not suggesting he didn't give you the courtesy of
16 a reply, but it didn't really address your concern?
17 A. It didn't address the concerns or give any indication
18 that things were going to be different in the future, or
19 that any changes were going to happen.
20 LADY SMITH: It almost sounds as though you were getting
21 a little rap on the knuckles?
22 A. Yes.
23 LADY SMITH: "Why are you coming to me? You should have
24 spoken to the Governor."
25 A. Exactly, my Lady, that is what --

1 MR PEOPLES: That's what you tell us in paragraph 69, you
2 have quoted from the reply:
3 "That it seems to me that it would have been
4 appropriate [said Sir William] for you to raise the
5 points you have put in your letter with the Governor
6 direct."
7 That does seem like a censure or a rap on the
8 knuckles, as my Lady said. It is maybe not that
9 response, having conducted this inquiry and spent a lot
10 of time doing all this, that you might have been
11 entitled to expect.
12 I am putting that to you, maybe it is not a question
13 you can answer, or maybe it isn't even a question, but
14 you might want to comment?
15 A. No, I think by then that's what I did expect, probably.
16 LADY SMITH: I see you received another letter a couple of
17 months later, saying, "By the way, we are urgently
18 repairing the plumbing, that's our priority".
19 A. Yes, yes, that was one of the problems that was
20 preventing things moving on.
21 LADY SMITH: Yes. No doubt necessary, but why is that the
22 only thing that gets prioritised --
23 A. Yes, indeed.
24 LADY SMITH: -- when young people's lives are at risk?
25 A. Yes, indeed.

1 MR PEOPLES: You have a section in your statement "Helping
2 the Inquiry". I am conscious of what you told me
3 earlier, that you are not obviously up to speed with
4 everything that is going on these days --
5 A. No.
6 Q. -- but you do tell us, obviously, that the system that
7 you reviewed, strict suicide observation, did disappear.
8 I think we will find out from other witnesses that
9 various suicide prevention strategies have been put in
10 place in more recent years. And that, as you say at
11 paragraph 71 on page 20, the current strategy is known
12 as "Talk To Me", which is the one used by the Scottish
13 Prison Service, which is the strategy in play, the sort
14 of modern-day equivalent of the SSO, I suppose?
15 A. That's right. It has been through "ACT and Care", "ACT
16 2 Care", now "Talk To Me".
17 Q. It has gone through a number of iterations --
18 A. Yes, yes.
19 Q. What you do say at paragraph 72 is having said all of
20 that about these developments, the suicide rate in
21 prisons has increased and increases every year,
22 particularly amongst youngsters. So whatever strategies
23 have been put in place, the problem continues to exist,
24 is that right?
25 A. They continue to exist and appear to be increasing, yes.

1 Q. Yes. You say in fact that -- you give us some
2 statistics, recent ones, which you say:
3 "Having said that, the suicide rate in prison has
4 increased and increases every year [this is
5 paragraph 72, page 21] particularly among youngsters;
6 indeed the most common cause of death among young people
7 in prisons is death by self harm. The Independent
8 Review of the Response to Deaths in Prison Custody was
9 published in November 2021 by then Her Majesty's
10 Inspectorate of Prisons in Scotland. It reported that
11 Scotland's prison mortality rate was at 47.6 per 10,000
12 ... well above the European average of 30.4 per 10,000
13 prisoners. The largest cause of death was natural
14 causes, reflecting an ageing prison population. The
15 second highest cause of death is self-inflicted death,
16 in particular the leading cause of death of young people
17 aged 21 or under in Scottish prisons is death by
18 suicide."
19 As you put it:
20 "It is a major and continuing issue."
21 A. Indeed, yes.
22 Q. So we have that?
23 LADY SMITH: That is suicide not parasuicide, that leads on
24 to death?
25 A. It is a good question, my Lady. I am not totally sure.

1 I would need to -- I don't know whether HMI's report is
2 based on FAI findings, or whether it is another
3 database. I don't know.
4 LADY SMITH: Thank you.
5 A. I am sure it is set out in the HMI's report.
6 LADY SMITH: Yes, and perhaps to use the language "self
7 inflicted" you may have lifted from the report?
8 A. Maybe, that's possible.
9 LADY SMITH: Which would then cover both?
10 A. Yes.
11 LADY SMITH: Thank you.
12 MR PEOPLES: Just really two matters I wanted to conclude
13 with. You have helpfully provided us with various
14 documentation.
15 A. Yes.
16 Q. Some of which was published around the same time.
17 I think it is fair to say, and I think you say this in
18 your signed statement, that what you were advocating and
19 saying in your report generally received favourable
20 feedback, and indeed was supported by I think the
21 opposition of the day, from what you are saying?
22 A. Yes.
23 Q. And indeed by Sacro, who I think agreed with you that
24 the regime for suicide, the SSO regime, was
25 dehumanising, I think was an expression they used?

1 A. Yes. I haven't put it in my statement, but there was
2 an editorial in the British Medical Journal as well,
3 I think headed "A book, a chamberpot and a Bible",
4 I think is how the editorial was headed, but it reported
5 favourably on our findings as well.
6 Q. It wasn't all favourable, I think, and I think you have
7 directed us to one article, which I can perhaps put up,
8 and I only want a very brief response, because we can
9 read it for ourselves, but I want to have your comment
10 on what perhaps the criticism is, because it seems to be
11 a criticism of the approach of your working group to
12 this matter. It is at page 94 of WIT-3-000001184. It
13 seems to be a paper that was presented in September 1985
14 by, is it Phil Scraton?
15 A. Scraton, I think his name has two Ts in it, actually.
16 Q. Yes, I was wondering, and Kathryn Chadwick. Can you
17 just tell us very briefly who Phil Scraton is?
18 A. I think he is now a professor of either criminology or
19 social science of some sort, I believe in Belfast,
20 I think that's the case, but he has long been involved
21 in issues of public concern. I think he took a major
22 role in the aftermath of getting some justice for
23 Hillsborough disaster families.
24 Q. Yes.
25 I think you have probably read this article at least

1 once, maybe more than once?

2 A. Yes.

3 Q. I don't want to go through it, because we can all read

4 it, but I don't think he is against what you were

5 advocating. I think what he maybe seems to be saying is

6 that you didn't tackle the issue in a way that looked at

7 the root causes of the problem of the regime.

8 You have told us today what you saw to be the

9 regime, and perhaps the Secretary of State saw it in

10 rather narrower terms, but I just wanted to know whether

11 you feel it is -- if we go to page 96, for example,

12 which deals with the Chiswick report, he is concerned

13 about the narrowness of the remit --

14 A. Yes.

15 Q. -- in the first column, page 96. He seems to think that

16 really you didn't really address, this is in the second

17 column, towards the penultimate paragraph, that

18 operational policies and regime practices were not

19 really considered or treated as relevant. You looked

20 more at the individual and the individual's

21 circumstances.

22 Is that fair comment?

23 A. No I don't think it is fair. I think the basis of his

24 criticism is that we sort of medicalised it and found

25 pathological youngsters who were the problem, and

1 I don't think we did, I don't think that was the tone of
2 our report. I think we paid a lot of attention to the
3 context, the environmental situation at Glenochil, and
4 a lot of things about the way the institution was
5 structured and the way that the regimes were operated.
6 I don't think it is fair to criticise us on the
7 basis of having taken a medical approach and found
8 pathological people as the cause. I think it is
9 a misrepresentation, really, of what we did.
10 Q. Lastly, I want to deal with one final matter very
11 briefly. The Inquiry has been provided with a statement
12 by the mother of a young woman who took her life at
13 Polmont young offenders institution in 2018, the young
14 woman being Katie Allan, this matter has received quite
15 a lot of publicity in the last few years.
16 A. Yes.
17 Q. But she has provided a statement to the Inquiry about
18 her daughter, who took her own life in her cell in
19 Polmont on around 4 June 2018, and it was a situation of
20 hanging in her own cell.
21 She was not assessed as a suicide risk, as her
22 mother tells us, and I don't want to go into the detail
23 of that case, but there are some things I would just
24 like to ask you about, based on what we have been told
25 about the situation at Polmont in 2018. The first is

1 that -- can I say, I think you have had the opportunity
2 to see the statement --
3 A. Yes.
4 Q. -- that I am referring to, so I am not sort of springing
5 this on you, if you like.
6 One matter I was interested in is that she tells us
7 that ... she tells us something about the suicide
8 strategy, Talk To Me, and I will just read out what she
9 says on that matter:
10 "As part of Talk To Me, prison officers ask
11 prisoners if they feel suicidal. The prison-wise
12 population will say no. They know that if they say yes
13 they will be put into a safer cell, which is simply
14 barbaric. For somebody who is suicidal, all of their
15 personal belongings are removed and anti-ligature
16 clothing and bedding is supplied. The person is
17 observed at 15-, 30- or 45-minute intervals, often by
18 putting a light on, it is torture. If someone is
19 suicidal what they need is a therapeutic environment.
20 Instead they are literally put into a torture cell.
21 That happens all over the prison estate. Prisoners talk
22 about it, so they all know that that happens. The SPS
23 [Scottish Prison Service] have carried out their own
24 research, which is quoted in FAIs, highlighting that
25 prisoners will not admit to suicidal ideation for fear

1 of being placed into a safe cell."

2 That seems to bear an uncanny resemblance to what

3 you saw at Glenochil -- that description at least -- in

4 1985, taking it at face value?

5 A. Yes. Can I say first of all I found Mrs Allan's

6 submission, her statement, very, you know, very moving,

7 and I think it is a tragic ... the events she describes

8 are absolutely tragic, and, you know, distressing to

9 read. But, yes, I agree that what she describes sounds

10 not very dissimilar from the strict suicide observation

11 regime. I am sure it is not exactly the same --

12 Q. No.

13 A. -- and I think there may be more periods of access, of

14 accessing other people and contact with other people,

15 and I think there is a sort of team approach that is

16 part of the Talk To Me routine, but I agree, in terms of

17 the description of the cell in which her daughter was --

18 Q. I don't think her daughter was placed in that cell, to

19 be absolutely clear --

20 A. Yes.

21 Q. -- but she describes that that could have faced her had

22 she been assessed --

23 A. It doesn't sound very different.

24 Q. If that was being used at all in 2018, does that, to use

25 your expression, disappoint you?

1 A. It is. I thought Talk To Me -- I am surprised that they
2 are still using isolation cells like that for people
3 that have mental symptoms.
4 Q. What might be said, though, and this is a curious
5 situation, is that in 1985, the equivalent of this type
6 of safe cell was being seen by prison-wise inmates as
7 a place of safety to get away from a place of violence,
8 or intimidation, or bullying. But it seems that in 2018
9 the safe cell has become a place that is to be feared.
10 A. Feared.
11 Q. And so you would rather stay where you are, and so you
12 do not admit to any -- the street-wise or the
13 prison-wise person will not admit to having suicidal
14 thoughts or feelings. That seems to be what's being
15 said --
16 A. Yes.
17 Q. -- and indicating that it is not a place that the
18 prison-wise inmate wants to go.
19 A. No. That's what comes out from this statement, I agree.
20 Q. I think she and others have carried out research into
21 deaths in custody, particularly young people, and
22 I think she says much the same as you do, that the
23 numbers are increasing?
24 A. That's right, yes.
25 Q. That she sought to identify, perhaps through this

1 research, and I think you will be aware that she gives
2 some facts and figures, but one of the things that she
3 seems to be suggesting from the research is that that
4 has uncovered what she describes as risk factors,
5 perhaps increased risk factors. She lists some of them,
6 I think, as: youth; first-time offenders, which Katie
7 was; weekends; history of previous suicide attempts or
8 mental ill health; and being on remand.
9 Is that saying anything that you would be unfamiliar
10 with, that these would be considerations that anyone
11 doing a proper assessment would need to have in mind, if
12 doing a proper assessment?
13 A. Yes, I mean I think those are, you know, well-identified
14 risk factors. I'm sure that's right.
15 Q. The only other thing I maybe want to just -- obviously
16 this is a different strategy to the one that you had to
17 review. Another thing that's mentioned, and I just want
18 to take this from you, is that Katie's mother says after
19 every death in custody there must be something called
20 a Death in Prison Learning, Audit & Review, DIPLAR
21 I think for short as it is called, and that the purpose
22 of this process is to assess what happened and see
23 whether any learning can occur.
24 I take it then that is a development, because it
25 wasn't necessarily something that was standard practice

1 in 1985?

2 A. No, I wasn't aware of it.

3 Q. No.

4 I think she also refers to the personal officer?

5 A. Yes.

6 Q. So that scheme was certainly embedded by 2018, albeit it

7 was something you were recommending in 1985?

8 A. Yes.

9 Q. We will no doubt find out when, perhaps, that scheme

10 took hold, but I think that has also been said, is that

11 correct?

12 A. That's right, yes.

13 Q. As you say, there have been changes, there is a new

14 strategy and so forth, but I think in fairness she is

15 quite critical of some aspects of the strategy --

16 A. Yes.

17 Q. -- as well?

18 A. That's correct, yes.

19 MR PEOPLES: Maybe that's something we can explore with

20 other witnesses, clearly.

21 These are all of my questions, Dr Chiswick, and can

22 I thank you for your patience, because it has been

23 a long day.

24 A. Can I just add one thing. I do accept everything that

25 Mrs Allan says about identifying risk factors. The

1 problem is what you then do afterwards, having
2 identified them. It does seem to me, as an observer
3 now, that trying to -- as I have said earlier this
4 morning -- introduce a health service style of practice
5 into a prison is difficult, and some of these ... the
6 difficulties are covered in the social Scottish
7 Government publication that we referred to earlier of
8 7 September 2022.
9 I mean it speaks, for example, of a need for
10 a cultural shift, a big sea change, it says, is
11 required. Prisoners' reluctance to share mental health
12 concerns, a fundamental change in approach, structural
13 changes, multi-factorial issues, as you indicated in
14 those risk factors, isolation, bullying. Serious
15 concerns at Polmont about young people and women
16 accessing appropriate mental healthcare.
17 They are huge issues, and I am not involved anymore,
18 but trying to introduce a system of care that can deal
19 with these issues and provide decent care in a humane
20 way, I think is an enormous task. A big sea change
21 I think is about the right way of describing what's
22 required.
23 MR PEOPLES: Thank you very much for that.
24 LADY SMITH: Dr Chiswick, thank you so much.
25 A. Thank you.

1 LADY SMITH: We have kept you for hours here, but everything
2 you have given us today, and before with your statement
3 and the documents you have helped us with, is enormously
4 valuable, we are really grateful to you for doing that.
5 A. Thank you very much, thank you.
6 LADY SMITH: Please go with my thanks. I hope you have
7 a restful weekend ahead, you have earned it.
8 A. Thank you.
9 MR PEOPLES: My Lady, this is maybe a time for a short
10 break, but there will be a read in of evidence after our
11 short break.
12 A. Say again? I'm sorry?
13 LADY SMITH: It is all right, I have one other bit of
14 business still to clear this afternoon, Dr Chiswick.
15 You are able to go.
16 Don't worry about tidying up, we can do that.
17 Thank you.
18 A. Okay, thank you.
19 (The witness withdrew)
20 (3.07 pm)
21 (A short break)
22 (3.13 pm)
23 LADY SMITH: Mr Peoples, you have said we are having a read
24 in and Ms Forbes is going to, is that right?
25 MR PEOPLES: Yes, my Lady.

1 LADY SMITH: Ms Forbes, when you are ready, thank you.
2 MS FORBES: Good afternoon, my Lady.
3 Professor Linda Allan (read)
4 MS FORBES: Professor Linda Allan has provided a statement
5 to the Inquiry, and I would now like to read in parts of
6 her statement.
7 LADY SMITH: Thank you.
8 MS FORBES: However, before doing so I would just like to
9 briefly address your Ladyship and summarise some
10 background information relating to Professor Allan --
11 LADY SMITH: Thank you.
12 MS FORBES: -- and provide some context as to the potential
13 relevance of her account.
14 Professor Allan's professional background was that
15 of a registered nurse in the NHS for adults with
16 learning disabilities, between 1985 and 2022.
17 Eventually working as a consultant nurse.
18 She was seconded to the Scottish Government for part
19 of her career to advise on policy for adults with
20 learning disabilities. The nurse consultant role she
21 undertook conferred honorary status with Glasgow
22 University, so first as an honorary lecturer, and
23 latterly as an honorary professor. Within that role she
24 became active in research on health inequalities and
25 amenable deaths for adults with learning disabilities.

1 Sadly, as your Ladyship has heard earlier in
2 evidence today, her daughter Katie took her own life in
3 2018, while serving a sentence of imprisonment within
4 Polmont. After that her research interest shifted, so
5 she is now part of a multi disciplinary team at Glasgow
6 University, along with criminology and health
7 colleagues, and their research has focused on deaths in
8 prison custody settings, as well as fatal accident
9 inquiries.
10 My Lady, part of her statement relates to the death
11 of her daughter in custody and part relates to her
12 research on deaths in prison custody settings, which
13 includes young persons under the age of 18.
14 LADY SMITH: Thank you.
15 MS FORBES: Whilst Professor Allan's daughter Katie was
16 20 years old when she was initially sentenced to
17 a period of detention, she was placed in the same part
18 of Polmont in which under 18s would be placed, which was
19 for 16 to 21-year olds.
20 LADY SMITH: Of course.
21 MS FORBES: I will now read in parts of her statement, which
22 can be found at WIT-1-000001325.
23 LADY SMITH: Thank you.
24 MS FORBES: "Before Katie's death we were just a normal
25 family. I lived in East Renfrewshire with my husband,

1 Katie and our son, Katie's younger brother. Both our
2 children did well at school and went on to study at
3 university, Katie attended the University of Glasgow,
4 studying human geography. Katie was a normal young
5 woman, studying at university and working part time to
6 help fund her studies and day-to-day living expenses in
7 a local cafe. Katie moved into student accommodation at
8 the beginning of her university career, and then moved
9 to a privately rented flat to begin her second year.
10 Although Katie had moved out of her parental home, she
11 often visited to spend time with us and her younger
12 brother with whom she was incredibly close.
13 Prior to Katie starting her third year at
14 university, Katie was arrested and charged with
15 dangerous driving and driving under the influence.
16 Katie had injured a 15-year old young men. Katie had
17 never committed any previous offences. Unfortunately,
18 despite a positive social work report, despite the
19 victim's parents writing to the Sheriff requesting
20 a non-custodial disposal (the victim made a full
21 recovery) and despite being told consistently by her
22 legal representative that it would be highly unlikely
23 that Katie would receive a custodial sentence, the
24 Sheriff sentenced Katie to 16 months for dangerous
25 driving and four months for the drink driving, to be

1 served concurrently.

2 "Katie wasn't psychologically prepared for

3 a custodial sentence. Before we went to the sentencing

4 hearing I asked Katie to prepare a bag to take to court

5 with some toiletries, a change of underwear, a book and

6 some money, just in case the worst happened. We tried

7 to prepare Katie for prison practically, but she wasn't

8 prepared mentally. I remember Katie going to the dock

9 in court, shaking and terrified. When she was

10 sentenced, Katie turned to me and mouthed, 'Help me,

11 mum". It was horrendous. Katie was sentenced on

12 5 March 2018. She was dead 12 weeks later.

13 Katie was initially taken to Corton Vale prison,

14 before being transferred to Polmont. We were not told

15 where Katie was. It wasn't until Katie was allowed to

16 call us that we found out where she was. I telephoned

17 an ex colleague, who was a prison nurse in Corton Vale.

18 I told him that I was really worried about Katie (Katie

19 has experienced an episode of self harming previously,

20 and also suffered from stress-induced eczema and

21 alopecia areata). He told me not to worry and that he

22 would let the health centre in Polmont know. He told me

23 Katie would be safe there. I think Katie was sentenced

24 on the Monday and it wasn't until the Saturday that we

25 got to see her. We were able to take her some underwear

1 and socks but nothing else.

2 Having previously worked in Lennox Castle hospital,
3 institutional behaviour was very familiar to me. This
4 is what I saw in Polmont. Initially, there was no
5 information given to families. Katie was also
6 constantly given conflicting information. Any
7 information we did manage to obtain was through our own
8 personal research. We found out that Polmont had
9 a number of 'family liaison officers'. Unfortunately
10 they all told us different information and gave us
11 different advice. Everything appeared to be about power
12 and control, with prisoners and with visitors/family
13 members. Visiting, which we did often, was a traumatic
14 experience.

15 Katie experienced bullying at Polmont. Early on in
16 her sentence, Katie told us about another adult female
17 prisoner who had been demanding items, such as coffee
18 and cigarettes, from Katie. Another female young
19 offender reported this woman to prison officers, and she
20 was apparently moved. This adult prisoner was allegedly
21 supplying drugs to the young offenders. When she was
22 moved it cut off the young offenders' drugs supply, and
23 some of the young offenders then turned on Katie.

24 All through her sentence, Katie referred to cliques
25 in the hall. Katie was quite mature for her age, so she

1 found this quite difficult. There seemed to be factions
2 within the cliques in the hall. Katie became friendly
3 with a few of the young women. One of those girls, like
4 Katie, was a first-time offender who had been sentenced
5 when she was 18. The other girls had been in and out of
6 prison and appeared to be 'prison-wise'.
7 We were really concerned, because we knew that
8 during Katie's sentence she would turn 21, and therefore
9 be moved to an adult prison. We initially thought that
10 she would be moved upstairs in Polmont, and we were
11 concerned about that. However, Katie's personal officer
12 told Katie that she wouldn't get moved, because she
13 wasn't 'prison-wise' and they could keep an eye on her
14 in the young offenders' hall. Unfortunately, on the
15 night Katie died, she was told that she would
16 potentially move upstairs in the prison.
17 "All young prisoners should have an assigned
18 personal officer. Katie had an assigned personal
19 officer. However, it seemed that when the personal
20 officer was on days off, or on leave, the prisoner was
21 left not knowing what was happening. This was important
22 for Katie, as initially she was going through an appeal
23 against her sentence, and towards the time of her death
24 she was being assessed for suitability for home
25 detention curfew (HDC). Prison officers gave us

1 conflicting information about the appeal and the HDC
2 process, advising that the HDC process could not start
3 whilst an appeal was ongoing. We had to instruct
4 a solicitor to write to the Governor to clarify that
5 this was not the case.
6 Katie was petrified of most of the prison officers.
7 When Katie was being bullied by the older prisoner,
8 I asked Katie to speak to the prison officers. She
9 refused. She appeared very frightened. She told me not
10 to tell the prison officers anything. Katie spoke
11 highly of her personal officer, as well as another
12 couple of officers that she named. However, even at the
13 last visit I had with Katie, she didn't want me to talk
14 to the prison officers. I did do so. I had to, given
15 how distressed Katie had been, but Katie didn't want me
16 to talk to the prison officers about anything.
17 Polmont reminded me of Lennox Castle hospital.
18 Despite its facade, it's what goes on behind locked
19 doors that is the most concerning. I can remember
20 thinking when I visited Katie, how do you change this?
21 Unlike Lennox Castle, Polmont isn't a long-stay
22 hospital, it is a prison. The punishment for
23 individuals is loss of liberty. You can't open the
24 doors and expose what's going on to the public, as
25 happened at Lennox Castle hospital. Media coverage

1 forced the doors of the hospital open and exposed what
2 was happening. How can that happen on a prison site?
3 How do you 'open the doors'?
4 Katie was in third year of her undergraduate course
5 when she entered Polmont. She was allowed academic
6 books, if purchased new, and sent from Amazon to her in
7 prison, which we arranged to allow Katie to continue
8 with her studies whilst serving her sentence. Her
9 university had indicated that she could return to her
10 course on release. Unfortunately Katie was told by one
11 of the prison officers that she had 'too many books' and
12 she would have to get rid of some of them. Katie had
13 reading books as well as academic books. Katie attended
14 as many of the education, lifestyle and work party
15 opportunities available to her, despite the
16 unsuitability of these. For example, Katie told us she
17 was given a map of the world to colour in, having said
18 she was studying geography, and being taught how to bake
19 cakes, despite running her own flat, having school
20 qualifications in food hygiene and cake craft, and
21 having worked in hospitality. I am sure the prison
22 'tried its best', but all of these things served to
23 erode Katie's self esteem. Some opportunities were not
24 available to Katie, being female as some work
25 opportunities appeared to be solely for male prisoners.

1 During Katie's sentence there were several bank
2 holidays, which meant long periods of time locked up in
3 her cell. Reportedly up to 23 hours a day. Access to
4 healthcare was very difficult. Katie's predisposed
5 conditions became acute almost immediately into her
6 sentence, when her eczema flared up. It took some time
7 for Katie to receive ointment. Similarly her hair loss
8 started early into her sentence, leaving her with
9 visible patches of baldness, and at her death she had
10 lost most of her hair. Katie was bullied by the other
11 young women for her hair loss. Again, we had to
12 instruct a solicitor to ask for medical treatment for
13 Katie's hair loss.
14 Katie didn't go more than two or three days without
15 a visit. We had a rota between family, friends and
16 university friends. Katie reported the degradation of
17 being strip searched after visiting time. We found out
18 after Katie's death that strip searching is either
19 intelligence based or carried out at random. There was
20 no intelligence about Katie, so it would appear that
21 Katie was just randomly selected. On one visit, Katie
22 was upset. Katie told us that there had been a training
23 exercise with new prison officers and she was taken into
24 the strip search area and told to strip naked while
25 several trainees and a prison officer had a conversation

1 for about 10 or 15 minutes. Katie felt incredibly
2 vulnerable and violated.
3 If Katie had money on her phonecard she could phone
4 numbers that had been approved by the prison. Katie
5 would phone us as much as she could, dependent on what
6 money she had available, and the availability of working
7 telephones. Before Katie went into prison we would
8 speak to each other every day. When Katie was in
9 Polmont, I would use the 'email a prisoner' system, as
10 if I was talking to her on the telephone. When I came
11 home from work I would email her. If you sent an email
12 it got printed out in the prison and given to Katie.
13 She would hand write a reply which was then scanned and
14 emailed back. Often, there were delays in Katie
15 receiving emails and us receiving replies. It relied on
16 prison officers having the time to facilitate the
17 process. It was quite a draconian system.
18 There was one occasion when I hadn't had any emails
19 for about three or four days. I also hadn't had any
20 calls for about two days. I was really concerned, so
21 I phoned the prison. The prison officer I spoke to was
22 helpful. She allowed me to speak to Katie briefly on
23 the hall telephone. I think there were three phones,
24 and two of them were broken, so Katie hadn't been able
25 to get access to a phone. It had been a holiday

1 weekend, so she hadn't had access to any emails.
2 Katie would get upset on the phone, because there
3 was no privacy when she was calling. I used to hear
4 people screaming in the background. They might be
5 waiting to use the phone and wanting Katie to get off
6 the phone. Since Katie's death we have campaigned for
7 prisoners to have access to mobile phones. I really
8 think that if Katie could have picked up a phone on the
9 night she died, she might still be alive.
10 I don't think that the prison staff were aware of
11 Katie's vulnerabilities. She was 'assessed' as not
12 having a suicide risk under their suicide prevention
13 strategy Talk To Me. Katie was assessed as no risk upon
14 admission to Polmont, and she wasn't assessed again. We
15 assume that the prison had access to her medical
16 records.
17 As mentioned, when Katie was acutely stressed her
18 eczema and alopecia entered an acute phase. It was
19 a stress reaction. The first time we visited Katie her
20 eczema was present. I told her that she should speak to
21 the nurses about the treatment that she would need.
22 Katie was used to the topical cream she required to
23 treat these conditions. Katie didn't know how to access
24 healthcare for a couple of weeks.
25 When Katie started to lose her hair, we were very

1 concerned. Katie had previously been diagnosed with
2 alopecia areata and received cortisone injections into
3 her scalp to promote hair growth. This has been very
4 successful. We were aware that timely access to
5 treatment was crucial, not only for hair growth, but
6 also to prevent the psychological impact that losing her
7 hair would have on Katie. Following a solicitor's
8 letter to the Governor, Katie was seen by a GP with
9 a special interest in dermatology. At the visit after
10 Katie was seen by the GP Katie was very upset. She said
11 she had felt like a piece of meet because of the way
12 that she had been treated. The GP allegedly had
13 a student with her but she didn't ask for Katie's
14 permission for the student to be present. They didn't
15 speak to Katie. In a subsequent statement, the GP said
16 that she was well aware of the mental health impact of
17 alopecia on a young person, but she took no action to
18 ensure that Katie was protected.
19 As Katie's hair loss developed and became quite
20 evident, she was bullied. Katie was seen by a mental
21 health nurse. The mental health nurse is named in three
22 fatal accident inquiries into suicides in Polmont. At
23 no time did the nurse assess Katie's mental health, she
24 apparently 'befriended' Katie and gave her 'lived
25 experience' advice of alopecia (this nurse was not

1 a registrant in dermatology, thus working outwith the
2 scope of her practice). The nurse was apparently
3 starting 'low-level therapy and relaxation techniques'
4 with Katie, which did not happen, as Katie died. All
5 the nurse did was facilitate getting a wig that I had
6 purchased into the prison.
7 Following Katie's post mortem we discovered that
8 Katie had mirtazapine (an anti depressant) in her system
9 when she died, which hadn't been prescribed. I wrote to
10 the Chief Pharmacist at the Scottish Government to ask
11 how Katie had access to mirtazapine, as it hadn't been
12 prescribed to her. He wrote back saying that they liked
13 to treat prisons like a 'home environment' and make it
14 as normal as possible. Apparently prisoners are given
15 a supply of certain medication to self medicate with.
16 What it actually means is that there are not enough
17 staff to give out the medication. Despite certain
18 medications having a currency in prison, prisoners are
19 given a supply to self medicate with. One such drug is
20 mirtazapine because it has a sedation effect.
21 The last time I saw Katie she hadn't slept for three
22 nights. She was exhausted. She had obviously sourced
23 the mirtazapine from someone else to try to get a sleep,
24 mirtazapine carries a black-box warning, which is
25 a warning label that the FDA in the USA use to signal

1 the risk of potentially very dangerous side effects.
2 Some studies have linked taking mirtazapine with
3 increase in suicidal thoughts or actions in children,
4 teenagers and young adults. The risk seems to reduce
5 after the age of 24 years and people are more prone to
6 these effects when they first start taking the drug.
7 One focus of my research and reading since Katie's
8 death has been the suicide prevention strategy used by
9 the Scottish Prison Service, which is called Talk To Me
10 (TTM). TTM relies on prison officers looking for what
11 is described as 'cues and clues' of suicidal ideation.
12 Suicide is either planned or impulsive. The strategy
13 makes no reference to impulsive acts, which Katie's
14 appeared to be. Many of the other young people who have
15 taken their lives in custody have also done so
16 impulsively.
17 As part of Talk To Me prison officers ask prisoners
18 if they feel suicidal. The 'prison-wise' population
19 will say no. They know that if they say yes, they will
20 be put into a safer cell, which is simply barbaric. For
21 someone who is suicidal, all of their personal
22 belongings are removed and anti-ligature clothing and
23 bedding is supplied. The person is observed at 15-, 30-
24 or 45-minute intervals, often by putting a light on. It
25 is torture. If someone is suicidal what they need is

1 a therapeutic environment. Instead they are literally
2 put into a torture cell. That happens all over the
3 prison estate. Prisoners talk about it so they all know
4 what happens. The Scottish Prison Service have carried
5 out their own research, which is quoted in fatal
6 accident inquiries, highlighting that prisoners will not
7 admit to suicide ideation for fear of being placed into
8 a safe cell.
9 Katie hanged herself. We wondered how she knew how
10 to do that. I am pretty sure that she didn't know how
11 to do that before she went into Polmont. Prisoners at
12 each side of Katie's cell had been screaming and
13 shouting to Katie towards the end 'just go and hang
14 yourself', and so she did."
15 I just pause there, my Lady, to say that
16 Professor Allan's research discovered that young people
17 have used a variety of means to take their own life by
18 ligature in custody.
19 LADY SMITH: Thank you.
20 MS FORBES: Returning to the statement:
21 "As part of the Talk To Me suicide prevention
22 strategy, concern forms should be completed when anyone
23 raises a concern about a prisoner's mental
24 health/suicide ideation. Concern forms were introduced
25 when Talk To Me changed from the previous strategy ACT 2

1 Care. I have noted many dates when I raised concerns
2 with various people in Polmont. There is not one
3 completed concern form for Katie. Nobody did anything
4 about the concerns that were raised. I spoke to every
5 one of the family liaison officers about the concerns
6 that I had. I spoke to two prison guards who took me on
7 'a tour of the prison'. I spoke to the chaplain.
8 I spoke to anybody I could speak to.
9 The days leading up to Katie's death were horrendous
10 for Katie. At the last visit I had with her, she looked
11 exhausted. Katie never usually displayed any emotion in
12 the visit hall as it was very public. The day of our
13 last visit, Katie's brother and I knew something was
14 very wrong as soon as we went into the hall and saw
15 Katie. I asked Katie what was wrong and she burst out
16 crying, which was really unusual. The prison officer
17 sitting near us gave her a cleaning cloth, because she
18 couldn't find a tissue. Katie explained that she had
19 not slept for three nights and there had been a fight in
20 the hall between some girls and there had been violence.
21 Katie had been really frightened during this fight, as
22 she had never witnessed violence before. I asked Katie
23 if she had been involved, and she said no.
24 Katie described bullying in the hall. I asked Katie
25 why she wasn't sleeping. She said that she couldn't

1 sleep because of all of the nasty things that people
2 were shouting. She said that during the night they were
3 banging and shouting that she was 'a fat cow and a baldy
4 bastard'. They were saying she might as well go and
5 'top herself'. This had apparently been going on all
6 night for the past three nights. It all poured out of
7 Katie during that visit. There was a prison officer
8 sitting near us. I told Katie that she needed to speak
9 to a prison officer or I needed to speak to a prison
10 officer. She was petrified. I asked her whether she
11 could move cells. The hall was only about a third full.
12 Katie said that she had asked to move further down the
13 hall to a quieter cell, but this had been refused.
14 Eventually Katie calmed down at the visit. When
15 I was leaving the hall a prison officer stopped me.
16 I got upset and explained everything that Katie had
17 said. Following Katie's death, we found out that the
18 officer went down to Katie's hall to find out everything
19 that was going on and report what Katie had said during
20 the visit. Katie's personal officer spoke to her and
21 said that they could move her upstairs the next day.
22 She was locked in her cell and she was found dead the
23 next morning.
24 On 4 June 2018, two police officers came to our home
25 and informed me that Katie had been found dead in her

1 cell. I went into shock. I phoned my husband at his
2 work. He made me tell him on the phone and then he
3 drove home from work. The police left us with the
4 number for Falkirk CID, who were dealing with Katie's
5 death. Informing Katie's grandparents, her brother and
6 other family members and friends was very difficult.
7 The trauma of being told your daughter died alone in
8 a cell was the beginning of what has been a five-year
9 journey of bureaucracies and further trauma. It would
10 seem that the more we uncover the worse it gets.
11 We contacted the prison and arranged a visit with
12 the Governor four days after Katie's death. Katie was
13 found dead on the Monday and on the Friday we met with
14 the Governor of Polmont. Now, I don't know how we did
15 that. I had a list of things that had happened during
16 Katie's sentence. I told the Governor what had been
17 going on in the hall, and asked her why the prison
18 officers didn't stop it. We told her about the things
19 other prisoners had been shouting at Katie in the days
20 before her death. We were told that sound doesn't
21 travel out of the cell into the hall, it only travels
22 out of the building, or between cells, so the prison
23 officers wouldn't have heard the bullying. We asked the
24 Governor a variety of questions for which she had no
25 answers.

1 After Katie had died, the solicitor representing us
2 at the time contacted us. He said that he had received
3 letters from the prison and he wanted to give us them.
4 We had seen him the day before, but our son had been
5 with us and he did not want to give us the letters when
6 our son was present. There were about five or six
7 letters from another prisoner, the letters were
8 horrendous. They were explicit and sexual. They talked
9 about 'spice', and sexual acts that he wanted to perform
10 on Katie. The letters referred to drugs and supplying
11 spice in the prison. They named other girls in the hall
12 who the prisoner had given spice to.
13 There is nowhere in Scotland that supports families
14 in our situation. INQUEST, an organisation based in
15 England, supports families across England and Wales who
16 have experienced the death of a loved one in the care of
17 the State. We contacted INQUEST following Katie's
18 death, and they have been an, albeit informal, lifeline
19 for us, offering support and advice."
20 Professor Allan then moves on to talk about
21 inspection reports in her statement and I continue.
22 LADY SMITH: Thank you.
23 MS FORBES: "Inspection report after inspection report refer
24 to bullying being a problem in Polmont. In 2004 it was
25 a problem. In 2019 it was still a problem. There does

1 not appear to be any accountability for factors that
2 contribute to amenable deaths. The themes in the
3 inspection reports are similar to those in the fatal
4 accident inquiries, such as lack of transfer of
5 information, bullying, time in cells, lack of
6 opportunity, medication issues, access to ligature
7 points, the same points that have come up for decades
8 and the same points that contributed to our daughter's
9 death.
10 In the spring of 2023 I was invited to give evidence
11 to the Justice Committee at the Scottish Parliament.
12 The discussion was focused on changes to sentencing and
13 whether 16- and 17-year olds should be sent to secure
14 care rather than young offenders institutions. Despite
15 the sentencing guidelines that were published previously
16 (citing robust scientific information), the proposed
17 changes to legislation were only focusing on 16- and
18 17-year olds.
19 The Justice Committee was considering young
20 offenders institutions versus secure care, ie seeking to
21 find a solution based on existing models of supervision.
22 This focus could potentially result in a limited
23 outcome. When Katie was in prison, she described three
24 types of women: she said that there were people like
25 her, who had made a mistake; there were people who felt

1 safer in Polmont than they did at home; and there were
2 'unwell' people, by which she meant people who were
3 severely mentally disturbed and had personality
4 disorders.
5 There is a solution for individuals with severe
6 mental illness, such as State Hospital. The issues for
7 the people who feel safer in custody are wider societal
8 issues, including poverty, domestic abuse, employment,
9 housing and drug and alcohol abuse. The people who make
10 a mistake should be dealt with by community disposals.
11 Most offences of this nature are low-level offences."
12 I just pause here, my Lady, to say that
13 Professor Allan's research interest changed after
14 Katie's death, and she made use of publicly available
15 records to establish a database of deaths in custody
16 from 2005 to date.
17 I will just now continue her statement:
18 "From 2019, with colleagues from Glasgow University,
19 we have expanded our database to include information
20 from published fatal accident inquiries as well as
21 pre-2005 deaths. We have published a number of reports.
22 The fatal accident inquiry determinations have been
23 one of our biggest sources of information. Prior to
24 2016, not all were published. We have read over 200
25 fatal accident inquiry determinations between us. We

1 have completed some qualitative and quantitative
2 analysis. We found that there seems to be an inference
3 of blaming of the deceased and the deceased's family
4 throughout the determinations. Despite fatal accident
5 inquiries being about the death not the offence, many of
6 the determinations mention offending histories.
7 A number of themes have emerged, for example if you
8 are in the early days of your sentence, if you are
9 young, if you are a first offender and if it is the
10 weekend, then you are more likely to take your own life.
11 People spend more time in their cells at the weekend.
12 They are locked up more often. These themes could quite
13 easily be remedied. Other themes that often come up are
14 bullying, medication, and transfer of information.
15 There are difficulties with prisoners not having access
16 to medication that should be prescribed, or accessing
17 medication that is not prescribed."
18 I will just pause there, my Lady, to list some of
19 the publications which have been provided to the Inquiry
20 by Professor Allan. These are available publicly, but
21 we also have them.
22 LADY SMITH: Thank you.
23 MS FORBES: One is titled, "Nothing to see here? 15 years
24 of FAI determinations for deaths in custody". That was
25 published in October 2021 and it identified the themes

1 in fatal accident inquiries. It is a statistical paper,
2 and a brief of 15 years of fatal accident inquiry
3 determination, and records basic -- I can't say that
4 word, my Lady.
5 LADY SMITH: Epidemiological.
6 MS FORBES: Epidemiological information like the
7 establishment, gender, number of days in custody, the
8 person's age, the date of death to the date of the fatal
9 accident inquiry publication, and this is something that
10 highlights the length of time that people have to wait
11 for the fatal accident inquiry to happen.
12 They also note the number of families who are
13 actually represented at fatal accident inquiries, which
14 is small, and noted there appeared to be a clear
15 correlation between the families being represented and
16 a greater likelihood of a positive outcome from the
17 fatal accident inquiry. The reference for that is
18 WIT-3-000005501.
19 LADY SMITH: Thank you.
20 MS FORBES: There is also a qualitative paper that was
21 published in 2021 called, "A defective system: case
22 analysis of 15 years of FAIs after deaths in prison".
23 The reference for that is WIT-3-000005500.
24 In November 2022 they published an update to the
25 statistics called "Still nothing to see here?" That was

1 concerning whether the Covid-19 pandemic had had
2 an impact on the increase in deaths in prison. That
3 research discovered, according to their research, that
4 that was not as a result of Covid-19. The increase
5 appeared to be caused by drugs or suicide, and there was
6 a comment in that publication that it was difficult from
7 the limited publicly available information to be certain
8 about how many of these deaths were suicide or
9 intentional overdoses and there was a view given that it
10 is likely that some drug deaths were actually
11 intentional overdoses. The reference for that is
12 WIT-3-000005499.
13 If I can go back now to Professor Allan's statement.
14 She continues:
15 "There are also issues with the 'natural' deaths
16 across the Scottish Prison Service, in that they are not
17 natural at all. For example, a man who had been in
18 prison since he was a young adolescent died of coronary
19 heart disease. He had lived in prison for all of his
20 adult life, so where did his coronary heart disease come
21 from? There are many examples of amenable deaths from
22 conditions such as diabetes and epilepsy. A young
23 offender died of a diabetic coma in 2005, which was
24 potentially avoidable. Another young man died from
25 an epileptic seizure, which was also potentially

1 avoidable. Even when you strip out expected deaths from
2 cancer or expected deaths in older prisoners, the number
3 of deaths is significant. The biggest cause of death is
4 suicide.
5 Because of my professional background I have also
6 been undertaking research into the efficacy of the Talk
7 To Me strategy. It was introduced in Scottish prisons
8 in 2016. The National Institute for Health and Care
9 Excellence (NICE) have really good evidence-based
10 guidelines around mental health screening in custody,
11 which appear to be ignored in Scotland. The SPS claim
12 that TTM was developed with a team of experts, however
13 it is difficult to see what evidence it is grounded in.
14 Our research has shown that suicides in prison have
15 increased by over 40 per cent since Talk To Me was
16 introduced.
17 The suicide prevention strategy used by Scottish
18 Prison Service prior to the introduction of Talk To Me
19 was called ACT 2 Care. The main difference between Talk
20 To Me and ACT 2 Care is that Talk To Me claims to be
21 a holistic strategy and it introduced concern forms,
22 whereby anyone who has a concern about an individual's
23 mental health/suicidal ideation can raise this with
24 a member of SPS staff, who in turn will complete
25 a concern form to be actioned under the strategy.

1 However, TTM is not a holistic strategy and the concern
2 forms don't get used, a theme in FAI determinations.
3 From 2020 to 2022 there were 121 deaths across the
4 prison estate in Scotland. Only 15 of those were Covid
5 related. We discovered that since the introduction of
6 Talk To Me in 2016 there had been 64 suicides. In the
7 six-year period before that there were 45. There has
8 therefore been a 42 per cent increase in suicide since
9 Talk To Me was introduced.
10 The number of suicides has also increased since the
11 NHS took over the responsibility for healthcare in
12 prisons, which is quite astounding. The healthcare
13 provision across the whole prison estate requires
14 investigation, both in terms of the tools (validity and
15 efficacy) that staff use, and the environment that they
16 work in to deliver their service. I don't think there
17 were any standardised mental health assessments when
18 Katie died or, if there were, their efficacy and utility
19 is questionable. Another theme that comes up in FAIs is
20 'it wasn't me', it wasn't the prison officer, it was the
21 NHS. It wasn't the NHS, it was the prison officer. The
22 NHS will say they didn't know about it because the
23 prison officers didn't tell them. The prison officers
24 will say that they told the NHS and they didn't do
25 anything about it. There is no joint working and people

1 fall through the cracks with often fatal consequences.
2 After every death in custody there must be something
3 called a Death in Prison Learning, Audit & Review
4 (DIPLAR). Since Katie's death the SPS say they have
5 reviewed DIPLAR and improved it. DIPLARs are there to
6 assess what happened and see whether any learning can
7 occur. They are like mini FAIs. In my opinion they
8 should be independent. They shouldn't involve the staff
9 that there were other than to gather information from.
10 They should be held jointly with the NHS. In the course
11 of our research we couldn't find any evidence of there
12 being systematic change across the prison estate after
13 DIPLARs. Where there are formal recommendation in FAIs,
14 we also can't find any evidence of any systemic change
15 across the prison estate, despite claims made by the
16 Scottish Prison Service to the contrary.
17 Our database highlights 48 young people aged 21 and
18 under have died in Polmont since 1995. 27 of that 48
19 were 19 or younger, and 11 were 18 or younger. 40 were
20 male and 8 were female. Of the aged 18 and younger,
21 nine were male and two were female. Perhaps the most
22 shocking statistic is that 90 per cent of these young
23 people died by suicide. All but one were hangings.
24 Most of the deaths occur within the first few weeks of
25 the young person entering custody. Of the under 21s in

1 Polmont, 56 per cent of the suicides occurred within two
2 weeks or less of the young person entering custody. The
3 risk factors we found are youth, first-time offenders,
4 weekends, history of previous suicide attempts or mental
5 ill health and being on remand."
6 Pausing there, my Lady, to say that at some
7 subsequent paragraphs Professor Allan provides some
8 examples of fatal accident inquiry determinations after
9 deaths in custody in Polmont.
10 If I continue later in her statement:
11 "When recommendations are made following an FAI, the
12 organisation they apply to has to formally respond to
13 the Sheriff. There does not appear to be any link
14 between FAI recommendations and the inspectorate for
15 prisons. As mentioned, there is no oversight mechanism
16 in Scotland across the prison estate. The expert review
17 of mental health services provision in Polmont,
18 published in May 2019, found seven key recommendations,
19 plus two overarching recommendations with 81
20 sub-recommendations, yet in the media coverage it was
21 described as 'a leading edge institution', quite
22 a juxtaposition.
23 As part of our research work we have examined all of
24 the inspection reports for Polmont, going back to
25 February 2003. Many of the same themes are repeated in

1 report after report, for example in 2003 chronic
2 problems with bullying were highlighted. Then in 2004,
3 bullying is not mentioned. It then reappears in 2006.
4 Often inspection reports highlight numerous points for
5 improvement, which are not referred to at the next
6 inspection visit.
7 The evidential part of the fatal accident inquiry
8 into Katie's death is due to take place at Falkirk
9 Sheriff Court for six weeks at the start of 2024. There
10 are further preliminary hearings scheduled between now
11 and the start of evidence being heard. The Crown
12 requested a conjoined FAI with William Lindsay,
13 a 16-year old young man who died in Polmont four months
14 after Katie, both families have agreed.
15 During our research, a recurring theme is that of
16 blame. Either the deceased being blamed, drug or
17 alcohol abuse leading to an inevitable suicide, or the
18 family is blamed; family difficulties, socioeconomic
19 challenges. The research we do can be challenging,
20 however I think it has helped prepare us for the fatal
21 accident inquiry."
22 If I continue on:
23 "It is evident that prisons and young offenders
24 institutions are dangerous places. Having examined 196
25 published fatal accident inquiry determinations over

1 a 15-year period, 2005 to 2019, the death rate in
2 Scottish prisons has risen by 44 per cent. This cannot
3 be explained by an ageing prison population alone.
4 Suicides and drug-related deaths are also rising.
5 Scottish prisons have one of the highest suicide rates
6 per head of population in Europe.
7 When entering Polmont you are met with a large sign
8 which states 'Unlocking potential, transforming lives'.
9 The irony is not lost on me. Five years on and still no
10 accountability for Katie's death. Five years of
11 campaigning and research to discover what we always
12 suspected, that our daughter's death was entirely
13 preventable. We have lost so much."
14 Professor Allan ends her statement by stating:
15 "I have no objection to my witness statement being
16 published as part of the evidence to the Inquiry.
17 I believe the facts stated in this witness statement are
18 true."
19 She signed it, my Lady, on 14 September, 2023.
20 LADY SMITH: Thank you very much.
21 As Professor Allan explains, the fatal accident
22 inquiry will not begin until early next year. It is
23 expected to last at least six weeks. By the time they
24 get an answer from the FAI it will probably be nearer
25 six years since Katie's death.

1 MS FORBES: Yes, my Lady.

2 LADY SMITH: Thank you.

3 Perhaps, Mr Peoples, you can just outline for me the

4 plans for next week.

5 MR PEOPLES: Yes, my Lady.

6 That is obviously the whole evidence for this week.

7 We will resume on Tuesday, when there will be

8 evidence by individuals representing the Care

9 Inspectorate. That evidence should be over Tuesday and

10 Wednesday.

11 I think that following that, which will be dealt

12 with by Mr MacAulay, Mr Sheldon will deal with Education

13 Scotland on Thursday.

14 There will be a further witness on Friday who is

15 more relevant to the Scottish Prison Service.

16 That is the broad plan for next week.

17 LADY SMITH: Thank you very much. I am sure people will

18 find it helpful to have had that outlined.

19 I am going to rise now until Tuesday morning at

20 10 o'clock. I hope everybody has a good weekend.

21 Thank you.

22 (4.03 pm)

23 (The hearing adjourned until 10.00 am on

24 Tuesday, 26 September 2023)

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3 I N D E X
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