Scottish Child Abuse Inquiry

Witness Statement of

Derek CHISWICK

Support person present: No

1. My name is Derek Chiswick. My date of birth is [redacted] 1945. My contact details are known to the Inquiry.

Professional background and experience

2. I am a retired consultant forensic psychiatrist. I have provided a copy of my full curriculum vitae to the Inquiry. I graduated in medicine in 1969 at the University of Liverpool. I trained in psychiatry and became a member of the Royal College of Psychiatrists in 1976. I have been based in Edinburgh since 1974. I specialised in forensic psychiatry and have held academic and clinical posts. I was admitted as a fellow of the Royal College of Psychiatrists in 1989. I served on the Parole Board for England and Wales from 2006 until 2018 and the Parole Board for Scotland from 1983 until 1988.

3. In 2000, I was the clinical lead in establishing the Orchard Clinic at the Royal Edinburgh Hospital, the first medium secure unit for mentally disordered offenders in Scotland. There are now three such units in Scotland. In 1995 I co-edited with Rosemarie Cope a book, *College Seminars in Practical Forensic Psychiatry*. I am also the author of many papers, reviews and book chapters on forensic psychiatry. In 1997 I was a member of the panel which produced a report on the treatment and care of Darren Carr, a psychiatric patient who had committed homicides after discharge from hospital. In 2000 I was a member of Lord McLean's Committee on Serious Violent and Sexual Offenders. It was

established to examine and report on the sentencing of serious violent and sexual offenders.

4. In the mid-1980s, I was a senior lecturer in forensic psychiatry at the University of Edinburgh and an honorary consultant forensic psychiatrist at the State Hospital, Carstairs and the Royal Edinburgh Hospital. I had responsibility for inpatients at the State Hospital. I also had some responsibility for patients in the Intensive Psychiatric Care Unit at the Royal Edinburgh Hospital.

5. I carried out assessments on people charged with offences in prisons throughout Scotland, usually at the request of the Procurator Fiscal. I assessed the suitability of prisoners for a psychiatric disposal from court or, if they were serving sentences, for transfer to hospital due to mental disorder. I was therefore regularly involved in the assessment of offenders who may be mentally disordered and in their treatment.

6. I retired from clinical practice in 2006, but I have been a medical member of the Mental Health Tribunal Service for Scotland since 2005.

Background to Working Group on Suicide Precautions at Glenochil

7. Between 1981 and 1984, there were five self-inflicted deaths at Glenochil detention centre and young offenders institution. These deaths understandably caused significant concern. Four of these deaths had occurred in the young offenders institution and one in the detention centre. Edward Heron (1981) had served six months of a fifteen month sentence at the time of his death. His death was attributed to solvent use. Richard MacPhie (1982) had served three days of a three month sentence. Allan Malley (1982) had served ten days of a three month sentence. Robert King (1983) had served ten months of a three year sentence. William MacDonald (1984) had served eight weeks of a three month sentence.

8. Following the death of William MacDonald in 1984, Sheriff Principal Taylor conducted a Fatal Accident Inquiry. He heard evidence from Doctor Norman Kreitman, who suggested that a working group be established. At the conclusion

of the Fatal Accident Inquiry, Sheriff Taylor recommended that a working group be established to review suicide precaution measures at Glenochil. The Secretary of State implemented this recommendation. In November 1984, I was appointed as chairperson of the Working Group on Suicide Precautions at Glenochil.

9. During our review there were two further deaths in Glenochil: in February 1985 Angus Boyd who had served two months of a three month sentence died in the detention centre; and in April 1985 Derek Harris who had also served two months of a three month sentence died in the young offenders institution.

10. In 1984 there was then no devolved government in Scotland. Mrs Margaret Thatcher was the Prime Minister and Mr George Younger was the Secretary of State for Scotland. Mr Michael Ancram was the Minister of State and Mr Donald Dewar was the shadow Secretary of State. Mr Martin O'Neill was the MP for the Clackmannan constituency in which Glenochil was located.

11. At that time, the governance of, and responsibility for, young offenders institutions in Scotland rested with the Scottish Home and Health Department of the Scottish Office, itself a department of the UK Government. The Scottish Prison Service had its headquarters at St. Margaret's House, London Road in Edinburgh. It was a civil service department responsible for administering all aspects of the Scottish Prison Service.

Review of suicide precautions at H.M. Detention Centre and H.M. Young Offenders Institution, Glenochil

Remit

12. The Working Group was established in November 1984 and its remit was set by the Secretary of State for Scotland. The terms of reference were: *"To review the precautionary procedures adopted at Glenochil Young Offenders Institution and Glenochil Detention Centre to identify and supervise inmates who might be regarded as suicide risks; and to make recommendations."*

13. My letter of appointment dated 26 September 1984 was from Mr Richard Allan, deputy director of the Scottish Prison Service. I have provided a copy of the letter to the Inquiry. It states: *"These broad terms of reference should, we feel, give the group scope to consider all the relevant factors identified in the Sheriff Principal's determination, and also any other factors that it may consider relevant."*

14. The reference to "any other factors that it may consider relevant" is, in my opinion important; it was repeated on 2 May 1985 by Mr Ancram in the House of Commons. He said, "The Working Group is free to examine and comment upon the wider issues arising from its remit." It was also contained in the Scottish Office Briefing Note dated 23 July 1985 which accompanied the release of our report.

15. I also had correspondence on this matter with the Scottish Office. I wrote initially to the Secretary of State on 1 May 1985, stating that we proposed to make recommendations, where appropriate, concerning aspects of the criminal justice system as it applies to those aged under 21 years. The reply is dated 20 May 1985 and I have provided a copy of the letter to the Inquiry. It stated that it was open to the Working Group to suggest that there are matters which the Working Group itself could not investigate or pursue which would justify further investigation or inquiry at a later stage.

Group members

16. The Working Group had eight members including myself as Chairperson. Initially, the members of the proposed Group were all men. I felt the review would benefit from a more balanced membership and the membership was modified at my request. The members of the group were:

- Alec Spencer, who was the governor of the Detention Centre at the time;

- Doctor Pamela Baldwin, clinical psychologist at the Douglas Inch Centre, Glasgow dealing with offender patients;

- Davina Drummond, assistant director of nursing services, who had a clinical background and full experience of psychiatric nursing care;

- Alan Henderson, who was the principal nurse officer at Glenochil, based at the health centre in the young offenders institution. Alan Henderson had first-hand knowledge and experience of the way that young offenders and trainees in the detention centre were managed if they were thought to be a suicidal risk;

- Doctor (later Professor) Norman Kreitman, Director of the MRC Unit for epidemiological studies in psychiatry at Edinburgh University. Professor Kreitman was an international expert on suicide and he gave evidence at the Fatal Accident Inquiry of William MacDonald. It was he that suggested it would be valuable to set up a working group;

- Robert Stark, a social worker with Central Region, had been seconded to Glenochil so had detailed knowledge of the social work that was carried out at the institution;

- Paul Youngjohns, who was a senior nurse at the adolescent unit at the Crichton Royal Hospital in Dumfries. He had long experience in the management of adolescents in the psychiatric inpatient unit at Crichton Royal Hospital, Dumfries.

Work of the Group

17. The deaths at Glenochil had become a matter of considerable public and political concern. For example on 16 April 1985 Mr O'Neill MP raised his concerns about the death of Derek Harris in a private notice question to the Secretary of State in the House of Commons. The Secretary of State emphasised that "none of the inquiries [into the deaths] has suggested that the nature of the regime had anything to do with any of these tragic deaths." The death of Derek Harris was also discussed on 16 April 1985 in the House of Lords after a statement made by the Lord Advocate.

18. On 2 May 1985 the House of Commons debated a motion by Mr O'Neill MP seeking the appointment of a standing commission on the sentencing of young offenders chaired by a High Court of Justiciary Judge. Mr Ancram, Minister of State, replied to the debate and in addition to his comment about the remit of the working group (see above) he also stated the detention centre regime was "physically demanding but worthwhile in terms of targets for performance". He referred to the arrangements for individuals "who might be medically or physically unfit" for the detention centre regime.

19. On 15 May 1985 Mr Steel MP asked a parliamentary question concerning the working group's review and mentioned the need for "a more widespread inquiry into sentencing policy in Scotland". The Secretary of State responded that if "further matters need to be inquired into, I should be glad to arrange that in due course" but that he first needed to get a response to the initial inquiries.

20. The Group began its work in November 1984; we had originally been given a period of about nine months to prepare our report, i.e. from November 1984 until August or September 1985. However following the death of Derek Harris in the young offenders institution on 13 April 1985 we were asked to expedite our review and accordingly we completed it by the end of June 1985.

21. The way in which we carried out our review is set out in 1.8 of the report. Our principal concern was with the current procedures for identifying and managing inmates who were thought to be at risk of suicide. We recognised that self-inflicted death is a complex occurrence and can rarely be explained solely in terms of a person's mental condition. We felt that seven such deaths within a single establishment required a contextual consideration of the environment, including its structure and its ethos, the resident population and the daily programme.

22. As far as we knew, there had been no comparable spate of deaths in any penal institution for young offenders in the United Kingdom. We felt that simply devising new screening procedures for inmates and suggesting a few modifications in the physical structure of the cells would be a thoroughly unreliable way of addressing the problems that had led to the series of self-inflicted deaths. We recognised the

need to take a broad view of our remit. We were also aware of the public and political concern described above.

23. We therefore tried to gain an understanding of how Glenochil worked, the sort of people it received, the daily life of the complex and the problems facing inmates and staff. We spoke to a varied group of people from a range of professions and organisations which seemed to have an interest in our task. Those individuals are listed at Appendix A of the report. A number of prison governors shared their views with us. We heard from Professor Andrew Coyle, who was then a prominent figure in the prison service and is currently the president of the Howard League Scotland. Only the Scottish Prison Officers' Association declined our invitation to participate, but we did hear from many individual prison officers.

24. We published letters in Scottish newspapers, inviting members of the public to come forward if they had any comment to make. We had a good response from the public, but I cannot now remember the detail of those responses. I do not have any of the evidence that the Working Group heard or the letters that we received. I do not know whether those documents still exist anywhere.

25. We all took part in speaking with staff and inmates at Glenochil. We were able to see the facilities there and the way that prisoners were managed if they were thought to be at risk of suicide. Those members of the Working Group who were not staff at Glenochil spent a day speaking with inmates, individually and in private, who were being supervised under strict suicidal observation. We also interviewed ten former inmates of Glenochil who had been transferred to an adult prison upon reaching the age of 21. At the social work offices in the Central Region we were able to speak to some former inmates who were now in the community. We attended more than one weekend visiting session and made ourselves available to any visitor who wished to speak to us.

26. We visited other institutions as listed in Appendix A: these included hospital and prison institutions in Scotland and youth custody centres in England.

27. We reached our conclusions on the basis of what we heard and what we saw. We all contributed to the final draft of the report. It was very much a team effort. I felt that members of the group who worked at Glenochil were placed in a difficult situation. They spoke openly and with candour about the institutions they were working in at the time, particularly Alan Henderson and Alec Spencer, who was the governor of the detention centre and had a responsible position there. They were able to take a detached view of the situation in which they were working.

Our findings

28. We concluded that identifying those at risk of acts of self-harm or suicide in Glenochil required us to consider three important elements. Firstly there was a significant number of emotionally damaged and immature young offenders coming into the institution; many would have had what today we call adverse childhood experiences. Secondly for many young offenders their entry into Glenochil following conviction, was a time of intense emotional distress, with separation from friends, family and life outside; they entered a strange environment which many of them perceived as hostile. Thirdly, they were located in an environment where it was not easy for them to discuss difficulties or problems with members of staff. We felt that we had to look at all of those elements and that was why we went about the work in the way that we did. We therefore felt it was important to set out how inmates spent their days, what opportunities there were for them to discuss problems with staff, how much access they had to family and relatives outside and what the problems were for them in day to day living in both parts of the Glenochil complex.

The Glenochil complex

29. The detention centre and young offenders institution shared the same site and certain facilities. The detention centre received inmates serving sentences between 28 days and four months for offences such as theft, Road Traffic Act offences, assault, breach of the peace and vandalism. Early release by remission depended upon the detainee's satisfactory behaviour. The date of liberation was therefore a matter of uncertainty for the detainee. The young offenders institution

received inmates serving sentences from nine months to life; more than half were serving in excess of three years. In addition it received offenders serving shorter sentences who were assessed as high security risks. Staff working overtime shifts could be allocated to either part of the complex. We were told that, as a result, staff continuity within both parts of the complex was poor. We described both regimes fully in our report in order to provide a context for our review of suicide precautions.

The detention centre regime

30. The emphasis of the regime was on keeping a clean and tidy room, on personal hygiene and on the demonstration of effort and improvement in physical training, running, drilling and daily work. The regime was colloquially known as the "short, sharp shock".

31. We provided a full description of the detention centre regime in chapter 3 of the report. It was a rigidly structured and disciplined regime; the day being spent in enforced silence and with commands given in the style of a drill sergeant. For example, the tea-break, taken in silence, required the trainee to march up to the table, take a mug of tea and a sandwich, say "thank you, sir," and return to the ranks to consume the tea and sandwich, while standing in silence. There were five changes of clothing per day, and a great emphasis on inspections and keeping a clean room. For example, bedding and clothing had to be folded to the required standard. Each folded item had to have a sharp edge which the trainee usually achieved by pressing the item between his Bible and a library book. Remembering and complying with these routines presented difficulties for some trainees, particularly those with emotional problems or of limited educational ability. We were told that one third of the trainees were in need of remedial education.

32. Detainees were regularly graded and, if successful, would work their way through a colour-grading system, gaining privileges including a longer visiting allowance. If unsuccessful due to a perceived lack of effort, they could face charges of offending against discipline and a liability to lose remission.

33. Paragraph 3.2.5 of the report details that a trainee was entitled to a 30 minute visit on admission and two visits per month thereafter. Those visits increased to 45 minutes for those awarded with a yellow grade and 60 minutes for those with a red grade. How much the detainee saw of his family or friends therefore depended upon his perceived effort.

Fitness of offenders for detention centre

34. The issue of an offender's mental fitness for detention centre was clearly a significant matter for our consideration and it is discussed in Chapter 9. We felt that there were a number of problems in relation to the issue of "fitness" and its assessment. Before a court imposed a custodial sentence upon a person under the age of 21, it had to be of the opinion that no other method of dealing with the offender was appropriate and it had to obtain a social enquiry report prepared by a social worker. Guidance for social workers in respect of "medical fitness to undergo detention in a detention centre" was issued by the Social Work Services Group and is shown in Appendix G of our report. The guidance stated that consideration "of the general physical and mental health of an offender is an integral part" of the preparation of a social enquiry report. It goes on to discuss certain physical conditions (e.g. epilepsy and heart conditions) that would render an offender unfit for detention centre. However it makes no further reference to the types of mental condition that would render an offender unfit: indeed it makes no further reference to mental conditions.

35. We contrasted the guidance with a similar document issued by the Home Office in England concerning fitness for regimes in detention centres; it is contained in Appendix I of our report. It contains a specific section about mental factors and states: "Young men with mental illness, severe emotional disorder or mental subnormality are not suitable." It goes on to give further examples of offenders who should be excluded from detention centre including "those who are particularly prone to histrionics or self-injury". We felt that it provided a more comprehensive guide for social workers than its Scottish equivalent.

36. There was evidence that a large number of youngsters initially sentenced to detention centre were then transferred from it to a young offenders institution because of their unsuitability. We noted that 32 offenders were transferred in this way between January 1984 and June 1985: see Appendix F of the report. For nine offenders the reason was clearly a mental health issue, while "could not cope" was the reason given for a further 12 offenders being transferred out. We were therefore concerned that there were people being sentenced to training in the detention centre who were not suitable for such a sentence due to mental health factors.

37. Trainees had a medical examination on arrival or the day after arrival; the examination could be a key factor in determining whether they remained at the detention centre or not. We recommended that revised criteria of fitness for detention centre training should be circulated to all doctors who were required to carry out examinations. We also recommended a second medical examination after the first week and a mechanism for releasing detention centre trainees in exceptional circumstances.

38. We also considered that asking a doctor or a social worker to assess a youngster's "unsuitability", and by implication "suitability", for detention centre training presented particular difficulties. We could find no official document setting out exactly what the detention centre regime was supposed to achieve. Thus it was difficult for any sentencer or professional to assess who was suitable for such a disposal. Inevitably, that drew us into identifying some wider issues about the criminal justice system that we felt required review by others.

Regime in the young offenders institution

39. The young offenders institution opened in 1976 and contained 496 cells for single occupancy. Its design enabled staff to observe, from a distance, multiple levels and corridors of cells. It had centrally controlled locking on the cell doors so that if an inmate needed to come out at night to use a toilet, he pressed a button and the door was opened centrally. The design militated against meaningful contact between inmates and staff.

40. We described the regime in the young offenders institution in chapter 3.3 of the report. There was a grading and progression system for inmates. Offenders began their sentences in an assessment unit called D-block. They could, subject to satisfactory assessments, progress to A, then B and finally C-block, the most relaxed of the blocks. There was a highly structured day in which young offenders were occupied with meaningful activities. These included work parties, vocational training courses and significant educational opportunities.

41. We gathered much information from governors, discipline staff, inmates and ex-inmates on the difficulties posed by the aggressive behaviour of a minority of inmates. It was put to us that in addition to individual cases of bullying, a number of alliances existed within the institution that may have exerted considerable pressure on vulnerable inmates. For example, alliances formed among inmates from the same area or among those who had previous experience in penal institutions.

42. The transfer of detainees from the detention centre to the young offenders institution, as referred to above, created another set of problems. It resulted in a mix of inexperienced minor offenders serving brief sentences alongside some very criminally experienced near-adult men. It contributed to an environment perceived by some offenders as hazardous.

43. We characterised the more vulnerable young offenders as including those who had no allies, those who had committed sexual offences, those who had committed crimes against the elderly or the young, those who had an unusual physical appearance; those who had any kind of handicap, mental or physical, and those who had not managed to assert themselves from the start of their sentence. We heard that those individuals were victimised in several ways, such as tobacco and money being extorted, and physical or verbal harassment. They may be taunted by other inmates through the night, including encouragement and incitement for an inmate to hang himself. For those vulnerable inmates, there were limited remedies. Reporting these matters to staff carried the stigma of being

identified as a 'grass'. Although we were told that staff did their best to deal with these situations, they were apparent to us at the time of our review.

44. It was our view that young offenders who were vulnerable in any of the ways described above would perceive their environment as hostile and that this factor contributed to a high proportion of inmates being on strict suicide observations.

Staffing of Glenochil

45. We identified significant issues in the area of staffing. Although continuity of staffing was an aim at Glenochil, it was not satisfactorily achieved because many shifts were covered by staff working overtime who could be allocated to any duty within either part of the complex or outwith the establishment on escort duties. We were told that a number of staff may change between the two parts of the complex on a day-to-day basis. The lack of continuity negated attempts to achieve a meaningful welfare and caring role between staff and inmates. That was one of the institutional factors that we felt was contributing to the problem. There were also no female prison officers at the institution. We made a number of recommendations about staffing.

Contact with relatives

46. There were no telephones for use of inmates at that time. They were permitted one postage-paid letter every week in the detention centre and the young offenders institution. After that one letter had been sent, inmates had to pay for letters and postage. Letters coming in and out were read by prison officers. Visiting arrangements were one of the issues that we examined in the report. It was also a very difficult place to visit for a variety of reasons. In particular it could not be accessed by public transport.

Strict suicide observation within Glenochil

47. Our strongest criticism was of the regime known as "strict suicide observation", which we describe in detail in 5.4 of the report. In 1984 164 inmates were placed

on strict suicide observation for periods ranging from 2-365 days. Modified cells were used from which all protruding fitments had been removed. Ventilation was through a non-closable grille making the cell extremely cold in winter. The electric light was inoperable by the inmate and remained on at all times though dimmed at night. Daytime furniture consisted of a desk and chair made from toughened cardboard, a coarse canvas blanket, a plastic chamber-pot, one paperback book and a copy of the Bible. The inmate wore a canvas gown. At night the inmate was provided with a mattress and a second canvas blanket. Apart from some cleaning tasks and the collection of meals, the regime consisted essentially of the inmate sitting in his room and being regularly observed at 15 minute intervals through the cell door spy-hole. Daily exercise consisted of walking up and down a corridor. Two periods of exercise per week took place in the gymnasium. Inmates were visited once per week by the medical officer. There was very limited interaction between inmates and staff.

48. We described the regime as punitive, inhumane and unacceptable. Strict suicide observation at Glenochil was really the antithesis of the way patients at risk of self-harm in a hospital would be managed. In hospitals, talking and interacting with staff so that patients can discuss their feelings and problems would be crucial elements of managing patients at risk of self-harm. The prolonged use of strict suicide observations was unique to Glenochil. In other prisons, it was used for periods of less than 24 hours. In some other prisons, mentally unwell patients were treated in the prison hospital.

49. In our opinion there were two significant factors that had led to the regime for suicide observation developing a punitive aspect. Firstly, it was managing inmates with a diverse range of difficulties. We interviewed in private 24 inmates who were under strict suicide observation at the time of our review and the details are in Appendix E of or report. Of the 24 inmates, 13 told us that they were seeking protection from other inmates. Another four inmates told us they did not want to do the detention centre regime and, by what they said or how they behaved, almost elected to be removed from the detention centre regime and placed on strict suicide observation. We concluded that two of the inmates we interviewed described suicidal thoughts and were suffering from a mental disorder. We were

told that of the other five inmates, three had been in receipt of distressing news and two had made previous attempts at self-harm. Undoubtedly one of the hazards of the environment was the bullying culture that I have previously described; this resulted in some mentally stable inmates seeking the protection of the strict suicide observation regime in order to be safe. In our visits to other institutions, we did not see that occurring.

50. We considered that the regime of strict suicide observation had become contaminated by its use for those who sought a refuge (for whatever reason) and those who found the conditions preferable to the mainstream (for whatever reason).

51. Secondly, each successive death at Glenochil had an institutional effect on the way that Glenochil was run. Understandably, because of those events, staff wanted to take every precaution that they possibly could to avoid further deaths; the regime had thereby become progressively and increasingly restrictive.

Abuse at Glenochil

52. I note that "abuse" for the purpose of this Inquiry is taken to mean primarily physical abuse and sexual abuse, with associated psychological and emotional abuse. We did not hear evidence of that, though the regimes in both parts of the complex were highly disciplined. Some members of staff were more inclined to physical sanctions and being more firm than others but we also heard that the majority of staff were "fair and considerate" in dealing with inmates (3.6). We did not hear evidence of systemic or individual acts of abuse by staff. We did report upon the bullying, threats and taunting amongst the inmates. I have read witness statements to the Inquiry relating to other institutions and I have considered whether there may have been abuse at Glenochil of which we were unaware. While this is clearly possible, I can only say it was not reflected in what we heard from inmates, former inmates and staff.

Recommendations in the report

53. Chapter 11 provided a summary of our 63 recommendations and suggestions. Underlying our specific recommendations were two fundamental statements. First that the aim in suicide precautions should be to have a proper balance between procedures that reduce risk to a minimum but are compatible with an acceptable way of life within a penal establishment. Second that there needed to be a balance between the prison officer's concern for discipline and his interest in the welfare of inmates.

54. We emphasised that the problem of suicide precautions required more than simply new procedures and practices. We said that significant general changes in approach were needed in both the detention centre and the young offenders institution. For example: structural modification of the young offenders institution to provide smaller living units; separate staff for the detention centre and young offenders institution; continuity of staff within the living units; development of a personal officer scheme; employment of female prison officers in both parts of the complex; regular meetings between prison officers and inmates; special training for officers to work with young offenders; improved visiting arrangements; and introduction of pay phones for the use of inmates

55. We recommended that the practice of "strict suicide observation" as described above should be abandoned. In its place we recommended systems of care called 'extra care', 'close care' and 'special care'. Extra care could be applied with the inmate remaining within his own unit and having enhanced opportunities for talking with staff who should have reliable systems for sharing relevant information. We considered that communication between inmate and staff to be essential.

56. We recommended that close care and special care should take place within the hospital facility so that the inmate would be the responsibility of medical and nursing staff as opposed to prison officer staff. We felt that was more appropriate, given that the individual had been assessed as at a higher risk of self-harm.

57. These methods of caring for people at risk of self-harm and suicide were nothing exceptional. They were simply in line with the systems of care that would operate within a psychiatric setting for patients with similar problems.

58. I have previously referred to the recommendations we made in respect of the assessment of fitness for detention centre training. In accordance with our terms of reference we identified (Chapter 10) three broader issues that we recognised were beyond our remit but that others may wish to consider. First was the quality and nature of support provided by the Scottish Prison Service to Glenochil at times of crisis. Second was the overall philosophy of Glenochil, a matter that we thought would benefit from the work of a policy and development unit. Third was a reflection of our concern at the number of vulnerable and immature inmates received by Glenochil and whether there needed to be a much broader review of sentencing policy for under 21-year olds.

Publication of the report

59. I submitted our report to the Scottish Home and Health Department on 28 June 1985. Prior to the report being published, I was asked to a meeting with William Reid (later Sir William Reid), Secretary of the Scottish Home and Health Department, and Alistair Thomson, Director of the Scottish Prison Service. It was clear to me that there were parts of the report Alistair Thomson found difficult to accept, for example our discussion about the quality of support provided by the Prisons Department to institutions at times of crises. However we did not adjust our report in any way and the report was published exactly as submitted.

60. The Secretary of State acknowledged receipt of the report on 17 July 1985. A background briefing note was issued to the press and Parliament by the Secretary of State on 23 July 1985. I have provided a copy of this note to the Inquiry. The briefing note included the terms of reference of the Working Group and stated that these "broad" terms would give the Group "scope to consider all relevant factors in Sheriff Principal's Determination, and also any other factors that it may consider relevant". The Secretary of State published the report on 24 July 1985 and made a statement in the House of Commons on that day.

61. It was stated in the Secretary of State's response that 29 recommendations were accepted outright, 5 were said to be already in operation, 16 were under consideration, and 13 were rejected. There was some ambiguity in the response. For example the three levels of care accepted by the Secretary of State were not the three levels we proposed.

62. Other rejected recommendations were: the implementation of a programme of psychiatric training for nurse officers (17); selection of prison officers at Glenochil according to their motivation and aptitude (30); modification of the young offenders institution to smaller living units (35, 36); extra resources for initial assessment units (37); group meetings of inmates with personal officers (44); a review of loss of remission as a sanction in the detention centre (47); exclusion from detention centre of certain offenders with vulnerable characteristics (49); consideration of mechanisms for release from detention centre under exceptional circumstances (53); increased visits at the start of detention centre (57); co-ordination and review of travel arrangements for visitors (54); tours of the establishment for visitors (59); and consideration of the best way to provide support to an institution at times of crisis (61).

63. Recommendations for improved facilities for visitors in the waiting room (56) and the introduction of pay phones in both parts of the complex (58) were said to be under consideration. Some of the recommendations were said, in the response, to be already happening but we were unsure what exactly that meant.

Publication of and response to the report

64. In his statement to the House of Commons the Secretary of State said that he was "ready to accept [the majority of the recommendations] although some will require more detailed examination". He emphasised more than once that the inquiries had shown that "there was no evidence that the regimes operated at Glenochil or the actions of staff were responsible for any of the seven deaths". He continued that evidence for the regimes being responsible for any of the tragic deaths "has been examined particularly carefully by Dr Chiswick and his group"

and "one conclusion without doubt" was that "the regime has not been responsible for them". He later added that the "atmosphere of the regime has been applauded by Dr Chiswick and his committee as humane and reasonable".

65. These remarks surprised us because firstly we had not made them, and secondly we were not asked to say whether the regimes had been responsible for the deaths. The Secretary of State was also critical of parts of our report where he considered we had exceeded our terms of reference; this in spite of the fact that the remit had included consideration of any relevant factors. My personal view was that the Secretary of State's remarks, made in a political arena, were a defensive approach to any attribution of blame directed at Glenochil generally and the "short, sharp shock" in particular, the latter having become a contentious political issue.

Aftermath

66. Some months later, on 7 November 1985 in the Debate on the Address, the Secretary of State told the House of Commons: "The majority of the report's 63 recommendations were accepted and many of them are now in operation at the institution, thanks to the commendable efforts and positive approach of the governor and his staff". He continued: "I believe that further inquiries or investigations at Glenochil would now seem inappropriate given the findings of the Chiswick report and the determinations of recent fatal accident inquiries. They gave a clean bill of health to the Glenochil complex. That demonstrates that there is no evidence that there is anything in the regimes or in the actions of staff at either of the two institutions to which any of the deaths could have been attributed".

67. Following the publication of the report, I returned to Glenochil in April 1986. I was asked to see a young offender there by the visiting psychiatrist. I was very concerned about the individual I examined, who disclosed that he was under pressure from other inmates and had sought the sanctuary of strict suicide observation. It seemed to me that almost a year after the publication of the report, the regime had not changed in respect of strict suicide observation.

68. I wrote a letter to Sir William Reid at the Scottish Home and Health Department on 18 April 1986. I stated that: *"I was concerned to find that the institution continues to be dominated by the problem of self-injurious behaviour and its management." ... "The inmate whom I examined and staff to whom I spoke confirmed my view that the major reason for acts of self-injury at Glenochil continues to be the bullying and the victimisation carried out by certain inmates upon others. I have no doubt that suicidal behaviour will continue to be prevalent as long as a substantial number of inmates perceive their environment as unsafe. It is disappointing that there seems to have been so little effective action to deal with this fundamental problem."*

69. Sir William Reid replied on 21 April 1986 and stated that he would have expected me to make my views known to Mr McVey, the governor, in the first instance. He did then reply to my letter on 2 June 1986 at greater length, stating: *"It seems to me that it would have been appropriate for you to raise the points you put in your letter with the governor direct, since I rely upon the governors in charge to run their establishments ... As I have emphasised before, implementation of the various points of action in the Secretary of State's announcement last year will be a lengthy process."* He also said that a problem with urgent repairs to the plumbing was holding things up. I have provided copies of the relevant letters to the Inquiry.

Helping the Inquiry

70. I note that detention centre as a sentencing disposal in Scotland was abolished in S.124 of the Criminal Justice Act 1988. Glenochil has been entirely rebuilt to a different design and is now an adult prison for men. I note it includes a well-resourced Family Centre Area.

71. Strict suicide observation did eventually disappear. I cannot be certain of the timescale but I think a suicide prevention strategy known as "ACT and Care" was introduced in 1998, followed by "ACT 2 Care" in 2005 and "Talk To Me" (TTM) in 2015. As I understand it, TTM is now used by the Scottish Prison Service (SPS)

which states: "Through the use of the strategy, SPS will promote and encourage: improved family involvement where the individual has given consent; improved care-planning and communication through the case conference process; less dependence on 'anti-ligature' clothing and accommodation and an improved culture of contact and support". What has eventually been adopted in Scottish prisons is very much in line with what our report was recommending in 1985.

72. Having said that, the suicide rate in prisons has increased and increases every year, particularly amongst youngsters; indeed the most common cause of death amongst young people in prisons is death by self-harm. The Independent Review of the Response to Deaths in Prison Custody was published in November 2021 (HM Inspectorate of Prisons for Scotland 2021). It reported that Scotland's prison mortality rate at 47.6 per 10,000 is well above the European average of 30.4 per 10,000 prisoners. The largest cause of death is natural causes reflecting an ageing prison population. The second highest cause of death is self-inflicted death. In particular, the leading cause of death of young people aged 21 or under in Scottish prisons is death by suicide. It is a major and continuing issue.

73. I do not underestimate the difficulty of managing while also caring for young people in a prison setting; the prison suicide problem is complex. The expert review by HM Inspectorate of Prisons for Scotland of mental health services at Polmont (May 2019) referred to there being no single cause for self-harm and suicides in prison. It quoted an international research study published in the *Lancet Psychiatry* (2017; 4: 946–52) which stated: *"That there are no simple ecological explanations for prison suicide. Rather, it is likely to be due to complex interactions between individual-level and ecological factors. Thus, suicide prevention initiatives need to draw on multi-disciplinary approaches that address all parts of the criminal justice system and address individual and system-level risk factors."* I assume "ecological", in this case, refers to all aspects of the prisoner's environmental situation. With that in mind it is perhaps significant that there is now a developing political debate in Scotland about prison sentences not being imposed on those under the age of 18.

74. I have no objection to my witness statement being published as part of the evidence to the Inquiry. I believe the facts stated in this witness statement are true.

Signed..... [redacted] .....

Dated..... 4th July 2022 .....