Scottish Child Abuse Inquiry

Witness Statement of

Linda ALLAN

Support person present: No.

1. My name is Linda Margaret Allan. My date of birth is [redacted]1967. My contact details are known to the Inquiry.

Background

2. I was employed by NHS Greater Glasgow & Clyde from 1985 until my retirement in 2022 as a registered nurse for adults with learning disabilities. I began my career in Lennox Castle Hospital, a large Victorian institution on the outskirts of Glasgow. I worked at Lennox Castle hospital from 1985 until 1991 as a student nurse, staff nurse and ward sister. When I commenced my training the hospital had not undergone any refurbishment. The majority of staff working there lived in the surrounding villages and all knew each other. The was a significant lack of registered nursing staff. Wards were nightingale with more than fifty patients of the same sex. Patients did not have personal belongings, including clothing. Everything was controlled by the staff. The hospital was an example of a Victorian institution, out of sight and out of mind. Patients were known to be 'feebleminded' or 'imbeciles' or 'moral defectives'. Patients were depersonalised and had no rights.

3. With the change to legislation through the Community Care Act and media exposure, slowly the hospital began to change. The changes were mainly environmental at first. I remember as a newly qualified nurse cowriting 'a charter of rights for people living in Lennox Castle hospital'. It took decades for the hospital to close and significant investment in staff training in areas such as person centred care. I think many of the

appalling institutional practices were known by senior ward staff and perhaps management during the 1980s but it was 'normalised' and considered to be 'just what happens here' and never viewed as abusive, despite it being so. I always said Lennox Castle taught me everything I needed to know about how **not** to be a good nurse. There were no children in Lennox Castle hospital when I worked there.

4. Following Lennox Castle hospital, I qualified as a community nurse and spend a number of years working in community roles. I had various promotions throughout my career eventually working as a Consultant nurse. In 2014 I was seconded to the Scottish Government to advise on policy for adults with learning disabilities. I worked at the Scottish Government from 2014 until our daughters death in 2018. The nurse Consultant role had conferred honorary status with Glasgow University where initially as an honorary lecturer, I became research active. Over the years, after growing my body of publications, I became an honorary professor at Glasgow University. My research interests at the time were health inequalities and amenable deaths for adults with learning disabilities.

5. Following the death of our daughter, Katie, in 2018 my research interests shifted. I'm now part of a multidisciplinary research team at Glasgow University with criminology as well as health colleagues. Our research team have focussed on deaths in prison custody settings as well as Fatal Accident Inquiries (FAIs). Prior to Katie's death I was planning to undertake a doctorate on amenable deaths for adults with learning disabilities in the last three years of my career, (adults with learning disabilities die younger from preventable causes.) Unfortunately due to the trauma we experienced losing Katie I was unable to do so, however my recent research activity has highlighted that the Scottish prison population, like the adult learning disability population, die far younger than the general population, often from avoidable causes.

6. Before Katie's death, we were just a normal family. I lived in East Renfrewshire with my husband, Katie and our son, Katie's younger brother. Both our children did well at school and went on to study at University. Katie attended the University of Glasgow studying human geography. Katie was a normal young woman, studying at university and working part time to help fund her studies and day to day living expenses in a local

cafe. Katie moved into student accommodation at the beginning of her University career, then moved to a privately rented flat to begin her second year. Although Katie had moved out of her parental home, she often visited to spend time with us and her younger brother with whom she was incredibly close.

Katie's arrest and appearance at court

7. Prior to Katie starting her third year at University, Katie was arrested and charged with dangerous driving and driving under the influence. Katie had injured a 15 year old young man. Katie had never committed any previous offences. Unfortunately despite a positive social work report; despite the victims parents writing to the Sheriff requesting a non custodial disposal (the victim made a full recovery) and despite being told consistently by her legal representative that it would be 'highly unlikely' that Katie would receive a custodial sentence, the Sheriff sentenced Katie to 16 months for dangerous driving and four months for the drink driving, to be served concurrently.

8. Katie wasn't psychologically prepared for a custodial sentence. Before we went to the sentencing hearing, I asked Katie to prepare a bag to take to court with some toiletries, a change of underwear, a book and some money just in case the worst happened. We tried to prepare Katie for prison practically, but she wasn't prepared mentally. I remember Katie going to the dock in court, shaking and terrified. When she was sentenced, Katie turned to me and mouthed, "Help me, mum." It was horrendous. Katie was sentenced on 5 March 2018, she was dead 12 weeks later

HMP & YOI Polmont

First impressions

9. Katie was initially taken to Cornton Vale prison, before being transferred to Polmont. We were not told where Katie was. It wasn't until Katie was allowed to call us that we found out where she was. I telephoned an ex-colleague who was a prison nurse in Cornton Vale. I told him that I was really worried about Katie (Katie has experienced

an episode of self harming previously and also suffered from stress induced eczema and alopecia areata). He told me not to worry and that he'd let the health centre in Polmont know. He told me that Katie would be safe there. I think Katie was sentenced on the Monday and it wasn't until the Saturday that we got to see her. We were able to take her some underwear and socks but nothing else.

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

Interactions with other prisoners

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

12. All through her sentence, Katie referred to cliques in the hall. Katie was quite mature for her age, so she found this quite difficult. There seemed to be factions between the cliques in the hall. Katie became friendly with a few of the young women. One of those girls, like Katie was a first time offender, who had been sentenced when she was 18. The other girls had been in and out of prison and appeared to be quite 'prison-wise'.

13. We were really concerned because we knew that during Katie's sentence she would turn 21 and therefore be moved to an adult prison. We initially thought that she would be moved upstairs in Polmont and we were concerned about that, however Katie's 'personal officer' told Katie that she wouldn't get moved because she wasn't 'prison-wise' and they could keep an 'eye on her' in the young offenders hall. Unfortunately on the night Katie died, she was told that she **would** potentially move upstairs in the prison.

Reporting of bullying/relationship with prison officers

14. All young prisoners should have an assigned personal officer. Katie had an assigned personal officer, however it seemed that when the personal officer was on days off or on leave, the prisoner was left not knowing what was happening. This was important for Katie as initially she was going through an appeal against her sentence and towards the time of her death she was being assessed for suitability for home detention curfew (HDC). Prison officers gave us conflicting information about the appeal and the HDC process, advising that the HDC process could not start whilst an appeal was ongoing. We had to instruct a solicitor to write to the Governor to clarify that this was not the case.

15. Katie was petrified of most of the prison officers. When Katie was being bullied by the older prisoner, I asked Katie to speak to the prison officers. She refused, she appeared very frightened. She told me not to tell the prison officers anything. Katie spoke highly of her personal officer as well as another couple of officers that she named, however even at the last visit I had with Katie she didn't want me to talk to the prison officers. I did do so (I had to, given how distressed Katie had been), but Katie didn't want me to talk to the prison officers about anything.

16. Polmont reminded me of Lennox Castle hospital. Despite it's façade, it's what goes on behind locked doors that is the most concerning. I can remember thinking when I visited Katie, how do you change this? Unlike Lennox Castle, Polmont isn't a long stay hospital, it's a prison. The punishment for individuals is loss of liberty, you can't open the doors and expose what going on to the public, as happened at Lennox Castle

hospital. Media coverage forced the doors of the hospital open and exposed what was happening. How can that happen on a prison site? How do you "open the doors"?

Access to education and work

17. Katie was in third year of her undergraduate course when she entered Polmont. She was allowed academic books, if purchased new and sent from Amazon to her in prison, which we arranged to allow Katie to continue with her studies whilst serving her sentence (Her university had indicated that she could return to her course on release). Unfortunately Katie was told by one of the prison officers that she had 'too many books' and she would have to get rid of some of them (Katie had reading books as well as academic books). Katie attended as many of the education, lifestyle and work party opportunities available to her, despite the unsuitability of these. For example Katie told us she was given a map of the world to colour in (having said she was studying geography) and being taught how to bake cakes, despite running her own flat. having school qualifications in food hygiene and cake craft and having worked in hospitality. I am sure the prison 'tried it's best' but all of these things served to erode Katie's self esteem. Some opportunities were not available to Katie, being female as some work opportunities appeared to be solely for male prisoners.

18. During Katie's sentence there were several bank holidays which meant long periods of time locked up in her cell (reportedly up to 23 hours a day). Access to healthcare was very difficult. Katie's predisposed conditions became acute almost immediately into her sentence when her eczema flared up. It took some time for Katie to receive ointment. Similarly her hair loss started early into her sentence, leaving her with visible patches of baldness (at her death she had lost most of her hair). Katie was bullied by other young women for her hair loss. Again we had to instruct a solicitor to ask for medical treatment for Katie's hair loss.

Visits

19. Katie didn't go more than two or three days without a visit. We had rota between family, friends and university friends. Katie reported the degradation of being strip-searched

after visiting time.. We found out after Katie's death that strip-searching is either intelligence based or carried out at random. There was no intelligence about Katie, so it would appear that Katie was just randomly selected. On one visit, Katie was upset. Katie told us that there had been a training exercise with new prison officers and she was taken into the strip-search area and told to strip naked while several trainees and a prison officer had a conversation for about ten or fifteen minutes. Katie felt incredibly vulnerable and violated.

Communication

20. If Katie had money on her phonecard, she could phone numbers that had been approved by the prison. Katie would phone us as much as she could, dependent on what money she had available and the availability of working telephones. Before Katie went into prison, we would speak to each other every day. When Katie was in Polmont I would use the 'email a prisoner' system as if I was talking to her on the telephone. When I came home from work, I would email her. If you sent an email, it got printed out in the prison and given to Katie. She would handwrite a reply, which was then scanned and emailed back. Often there were delays in Katie receiving emails and us receiving replies. It relied on prison officers having the time to facilitate the process. It was quite a draconian system.

21. There was one occasion when I hadn't had any emails for about three or four days. I also hadn't had any calls for about two days. I was really concerned so I phoned the prison. The prison officer I spoke to was helpful. She allowed me to speak to Katie briefly on the hall telephone. I think there were three phones and two of them were broken so Katie hadn't been able to get access to a phone. It had been a holiday weekend so she hadn't had access to any emails.

22. Katie would get upset on the phone because there was no privacy when she was calling. I used to hear people screaming in the background. They might be waiting to use the phone and wanting Katie to get off the phone. Since Katie's death, we have campaigned for prisoners to have access to mobile phones. I really think that if Katie could have picked up a phone on the night she died, she might still be alive.

Healthcare/mental health provision

23. I don't think that the prison staff were aware of Katie's vulnerabilities. She was 'assessed' as not having a suicide risk under their suicide prevention strategy - 'Talk To Me'. Katie was assessed as no risk upon admission to Polmont and she wasn't assessed again. We assume that the prison had access to her medical records.

24. As mentioned, when Katie was acutely stressed, her eczema and alopecia entered an acute phase, it was a stress reaction. The first time we visited Katie, her eczema was present. I told Katie that she should to speak to the nurses about the treatment she'd need. Katie was used to the topical cream she required to treat these conditions. Katie didn't know how to access healthcare for a couple of weeks.

25. When Katie started to lose her hair, we were very concerned. Katie had previously been diagnosed with alopecia areata and received cortisone injections into her scalp to promote hair growth. This has been very successful. We were aware that timely access to treatment was crucial not only for hair growth but also to prevent the psychological impact that losing her hair would have on Katie. Following a solicitors letter to the Governor, Katie was seen by a GP with a 'special interest' in dermatology. At the visit after Katie was seen by the GP, Katie was very upset. She said she had felt like a 'piece of meat' because of the way that she'd been treated. The GP allegedly had a student with her, but she didn't ask for Katie's permission for the student to be present. They didn't speak to Katie. In a subsequent statement, the GP said that she was well aware of the mental health impact of alopecia on a young person but she took no action to ensure that Katie was protected.

26. As Katie's hair loss developed and became quite evident, she was bullied. Katie was seen by a mental health nurse. The mental health nurse is named in three FAIs into suicides in Polmont. At no time did the nurse assess Katie's mental health, she apparently 'befriended' Katie and gave her 'lived experience' advice of alopecia (this nurse was not a registrant in dermatology, thus working out with the scope of her practice). The nurse was apparently starting 'low-level therapy and relaxation

techniques' with Katie, which did not happen as Katie died. All the nurse did was facilitate getting a wig that I'd purchased into the prison.

27. Following Katie's post mortem, we discovered that Katie had mirtazapine (an anti depressant) in her system when she died, which hadn't been prescribed. I wrote to the chief pharmacist at the Scottish Government to ask how Katie had access to mirtazapine, as it hadn't been prescribed to her. He wrote back saying that they liked to treat prisons like a 'home environment' and make it as normal as possible. Apparently, prisoners are given a supply of certain medication to self-medicate with. What it actually means is that there are not enough staff to give out the medication. Despite certain medications have a currency in prison, prisoners are given a supply to self medicate with. One such drug is mirtazapine because it has a sedation effect.

28. The last time I saw Katie, she hadn't slept for three nights. She was exhausted. She'd obviously sourced the mirtazapine from someone else to try and get a sleep. mirtazapine carries a black box warning, which is a warning label that the FDA in the USA use to signal the risk of potentially very dangerous side effects. Some studies have linked taking mirtazapine with increase in suicidal thoughts thoughts or actions in children, teenagers, and young adults. The risk seems to reduce after the age of 24 years, and people are more prone to these effects when they first start taking the drug.

Suicide prevention strategies in Polmont

29. One focus of my research and reading since Katie's death has been the suicide prevention strategy used by SPS, which is called Talk To Me (TTM). TTM relies upon prison officers looking for what is described as 'cues and clues' of suicidal ideation. Suicide is either planned or impulsive. The strategy makes no reference to impulsive acts, which Katie's appeared to be. Many of the other young people who have taken their lives in custody have also done so impulsively.

30. As part of Talk to Me, prison officers ask prisoners if they feel suicidal. The 'prison-wise' population will say 'no'. They know that if they say yes they will be put into a safer cell, which is simply barbaric. For somebody who is suicidal, all of their personal

belongings are removed and 'anti-ligature' clothing and bedding is supplied. The person is observed at 15, 30 or 45 minute intervals, often by putting a light on. It's torture. If someone is suicidal, what they need is a therapeutic environment. Instead, they are literally put into a torture cell. That happens all over the prison estate. Prisoners talk about it so they all know that happens. The SPS have carried out their own research which is quoted in FAIs, highlighting that prisoners will not admit to suicide ideation for fear of being placed into a 'safe' cell.

31. Katie hanged herself. We wondered how she knew how to do that. I'm pretty sure that she didn't know how to do that before she went into Polmont. Prisoners at each side of Katie's cell had been screaming and shouting to Katie towards the end, "Just go and hang yourself," and so she did.

32. There are very vulnerable, abused youngsters going into Polmont but there are ligature points everywhere. Lots of youngsters who have taken their own lives in Polmont have [redacted]. The Health and Safety Executive (HSE) tell us that they can't investigate the fact that Katie took her own life as they are not 'mental health experts', despite investigating similar deaths in mental health hospitals.

Reporting of concerns

33. As part of the Talk to Me suicide prevention strategy, concern forms should be completed when *anyone* raises a concern about a prisoners mental health / suicide ideation. Concern forms were introduced when Talk to Me changed from the previous strategy, Act To Care. I have noted many dates when I raised concerns with various people in Polmont. There is not one completed concern form for Katie. Nobody did anything about the concerns that were raised. I spoke to every one of the family liaison officers about concerns that I had. I spoke to two prison guards who took me on a 'tour of the prison'. I spoke to the chaplain. I spoke to anybody that I could speak to.

Bullying and lead up to Katie's death

34. The days leading up to Katie's death were horrendous for Katie. At the last visit I had with her, she looked exhausted. Katie never usually displayed any emotion in the visit hall as it was very public. The day of our last visit, Katie's brother and I knew something was very wrong as soon as we went into the hall and saw Katie. I asked Katie what was wrong and she burst out crying, which was really unusual. The prison officer sitting near us gave her a cleaning cloth because she couldn't find a tissue. Katie explained that she had not slept for 3 nights and there had been a fight in the hall between some girls and there had been violence. Katie had been really frightened during this fight as she had never witnessed violence before. I asked Katie if she had been involved and she said no..

35. Katie described bullying in the hall. I asked Katie why she wasn't sleeping. She said that she couldn't sleep because of all the nasty things that people were shouting. She said that during the night they were banging and shouting that she was a 'fat cow and a baldy bastard'. They were saying that she might as well go and 'top herself'. This had apparently been going on all night for the past three nights. It all poured out of Katie during that visit. There was a prison officer sitting near us. I told Katie that she needed to speak to a prison officer or I needed to speak to a prison officer. She was petrified. I asked her whether she could move cells. The hall was only about a third full. Katie said that she had asked to move further down the hall to a quieter cell, but this had been refused.

36. Eventually Katie calmed down at the visit. When I was leaving the hall, a prison officer stopped me. I got upset and explained everything that Katie had said. Following Katie's death we found out that the officer went down to Katie's hall to find out everything that was going on and report what Katie had said during the visit. Katie's personal officer spoke to her and said that they could move her upstairs the next day. She was locked in her cell and she was found dead the next morning.

Katie's death

37. On 4 June 2018, 2 police officers came to our home and informed me that Katie had been found dead in her cell. I went into shock. I phoned my husband at his work. He

made me tell him on the phone and then he drove home from work. The police left us with the number for Falkirk CID, who were dealing with Katie's death. Informing Katie's grandparents, her brother and other family members and friends was very difficult.

38. The trauma of being told your daughter died, alone in a cell was the beginning of what has been a five year journey of bureaucracies and further trauma. It would seen that the more we uncover, the worse it gets.

Aftermath of Katie's death

39. The immediate aftermath of Katies death is indescribable. We were simply left with a telephone number for Falkirk CID and nothing else. We had to find out everything through our own personal research and questioning.

40. We were told that if we wanted to see Katie's body, we would have to go to the mortuary the following day because the post mortem might be delayed and then we wouldn't be able to see her. We had to drive to CID at Falkirk Police Station to view her suicide note and I was asked to provide a statement. I should never have given a statement then, nor should I have been asked, it had been 24 hours since being told of Katie's death and I was in shock. I explained what had happened with the girls on her hall to the CID. We then went straight to the city mortuary in the cowgate, Edinburgh. That was really hard. We weren't allowed to touch Katie as she hadn't had a post mortem.

41. We simply didn't know what to do. We just wanted Katie home. I wanted her back in Glasgow. We had no contact from the Crown sudden deaths unit that we discovered were dealing with Katie's death. Following some confusion as to who was actually dealing with Katie's case we eventually traced the name of the crown agent dealing with the case, we were told that 'everything was going to take a very long time'. She wasn't wrong about that. Five years on and we're still waiting for the FAI. It was horrendous. We were never contacted by a family liaison officer. The Crown Office has never invited us to meet with them or indeed contacted us to provide information

on their investigation into Katie's death. They have never taken a statement from any family member. The only statemen they have is the one I gave to the police 24 hours of being told of Katie's death.

42. We contacted the prison and arranged a visit with the Governor 4 days after Katie's death. Katie was found dead on the Monday and on the Friday we met with the governor of Polmont, now I don't know how we did that. I had a list of things that had happened during Katie's sentence. I told the governor what had been going on in the hall and asked her why the prison officers didn't stop it. We told her about the things other prisoners had been shouting at Katie in the days before her death. We were told that sound doesn't travel out of the cell into the hall. It only travels out of the building or between cells so the prison officers wouldn't have heard the bullying. We asked the governor a variety of questions for which she had no answers.

43. After Katie had died, the solicitor representing us at the time contacted us. He said that he had received letters from the prison and he wanted to give us them. We had seen him the day before, but our son had been with us and he did not want to give us the letters when our son was present. There were about five or six letters from another prisoner, the letters were horrendous. They were explicit and sexual. They talked about 'spice' and sexual acts that he wanted to perform on Katie. The letters referred to drugs and supplying spice in the prison. They named other girls in the hall who the prisoner had given spice to.

Our experience of the legal process after Katie's death

44. Prior to Katie's arrest we as a family had no experience of the criminal justice system. It was not something that had ever touched our lives. I wasn't aware before Katie went into prison that she was going into an environment that she was highly unlikely to come out of. I trusted the duty of care that the prison service had for Katie. I have subsequently learned that I should not have done so.

45. Katie's experiences in Polmont (and our research since her death) suggested to us that a crime had been committed, at the least a breach of health & safety legislation if

not corporate culpable homicide. We have campaigned for 5 years to not only expose what is happening across the Scottish prison estate but also to seek justice for Katie's death.

46. There is nowhere in Scotland that supports families in our situation. INQUEST, an organisation based in England supports families across England and Wales who have experienced the death of a loved one in the care of the state. We contacted INQUEST following Katie's death and they have been an (albeit informal) lifeline for us, offering support and advice. We first met our legal team towards the end of 2018 and have pursued criminal action since.

47. We asked the Crown to investigate for breaches of health and safety legislation and corporate homicide. We met with them around 2019 and they said that there was insufficient evidence for a H&S prosecution. A Victims' Right to Review followed. It took the Crown from 2019 until November 2022 to tell us that **there was** credible and reliable evidence for a successful prosecution and that the SPS had materially contributed to Katie's death. However, we were also told that prosecution could not proceed as the SPS (Scottish ministers) are protected by Crown immunity.

48. We were told that the matter would be passed to the Health and Safety Executive (HSE) for a censure. The Crown Office told us that a crime had been committed and there was enough evidence for a successful prosecution *but* they couldn't prosecute due to crown immunity. They also have never investigated NHS Forth Valley, despite our requests. Healthcare is not the responsibility of SPS. Health care is delegated to the NHS, who do not benefit from crown immunity.

49. If Katie had died in one of the private prisons in Scotland, like Kilmarnock, then the Crown could prosecute. This is another example of the journey we have been on for 5 years. Another barrier, another challenge.

50. Recently, we received a letter from HSE sating that they won't investigate the SPS for censure. They say that they can't investigate Katie's death because they're not 'experts in mental health'. We received that letter on the same day that a Sheriff fined Greater Glasgow and Clyde following an HSE investigation into Dykebar Hospital for a man who took his own life. This appears contradictory. We've appealed the decision.

51. At present, it would seem that there is no recourse or accountability for the prison service. They appear to have carte blanch to do what they like; literally a law unto themselves. When I worked as a Consultant nurse, I can remember two FAIs for people with learning disabilities in NHS Tayside. In the board area where I worked, I would risk assess the likelihood of any similar events happening. I would be responsible for assuring the NHS Board that we were taking any necessary actions to minimise the risk of a similar event happening. We would learn lessons, there would be an action plan overseen by a governance structure. Health Improvement Scotland would monitor any progress.

52. There does not appear to be a similar governance structure after FAIs in the prison service. For example, inspection report after inspection report refer to bullying being a problem in Polmont, in 2004 it was a problem, in 2019 it was still a problem. There does not appear to be any accountability for factors that contribute to amenable deaths. The themes in the inspection reports are similar to those in the FAIs, such as lack of transfer of information, bullying, time in cells, lack of opportunity, medication issues, access to ligature points, the same points that have come up for decades and the same points that contributed to our daughters death.

53. In the spring of 2023, I was invited to give evidence to the Justice Committee at the Scottish Parliament. The discussion was focussed on changes to sentencing and whether 16 and 17 year olds should be sent to secure care rather than young offenders institutions. Despite the sentencing guidelines that were published previously (citing robust scientific information) the proposed changes to legislation were only focussing on 16 and 17 year olds.

54. The Justice Committee was considering young offenders institutions versus secure care, i.e. seeking to find a solution based on existing models of supervision. This focus could potentially result in a limited outcome. When Katie was in prison, she described three types of women: She said that there were people like her, who had made a mistake; there were people who felt safer in Polmont than they did at home; and there were 'unwell' people, by which she meant people who were severely mentally disturbed and had personality disorders. There is a solution for individuals with severe mental illness such as state hospital. The issues for the people who feel safer in custody are wider societal issues including poverty, domestic abuse, employment, housing and drug/alcohol abuse. The people who make a mistake should be dealt with by community disposals, most offences of this nature a low level offences.

Research with Glasgow University

55. Our research interests began almost from Katie's death, so great was our need to find answers to what we believed and still believe was an avoidable death. My husband and I initially trawled publicly available records and established a database of deaths in custody from 2005 to date. From 2019 with colleagues from Glasgow university we have expanded our database to include information from published fatal accident inquiries as well as pre 2005 deaths. We have published a number of reports.

56. The FAI determinations have been one of our biggest sources of information. Prior to 2016, not all were published. We've read over two hundred FAI determinations between us. We have completed some qualitative and quantitative analysis. We found that there seems to be an inference of blaming of the deceased and the deceased's family throughout the determinations. Despite FAIs being about the death, not the offence, many of the determinations mention offending histories.

57. A number of themes have emerged, for example if you're in the early days of your sentence, if you're young, if you're a first offender and if it's the weekend then you're more likely to take your own life. People spend more time in their cells at the weekend.

They're locked up more often. These themes could quite easily be remedied. Other themes that often come up are bullying, medication and transfer of information. There are difficulties with prisoners not having access to medication that should be prescribed or accessing medication that is not prescribed.

58. The themes we identified in FAIs are recorded in our paper, '*Nothing to See Here? 15 years of FAI determinations for deaths in Custody',* which was published in October 2021. This is a statistical paper and a brief of fifteen years of FAI determinations. We record basic epidemiological information, like the establishment, gender, number of days in custody, the person's age, the date of death to date of FAI publication, which was when we discovered the horrendous length of time that people have to wait for the FAI to happen. We have noted the number of families who are actually represented, which is small. There was a clear correlation between the families being represented and a greater likelihood of a positive outcome from the FAI. In 2021, we also published a qualitative paper called, *'A Defective System: Case Analysis of 15 years of FAI's After Deaths in Prison'*.

59. In November 2022, we published an update to the statistics, '*Still Nothing to See Here?'* We were interested to see whether the COVID-19 pandemic had an impact. There were a lot of rumblings about the huge increase in deaths being caused by COVID. They weren't. They were caused by drugs or suicide. It's difficult, from the limited publicly available information to be certain if all drug deaths weren't suicides, that is intentional overdoses. It does appear to be more likely that some drug deaths are likely to be intentional overdoses.

60. There are also issues with the 'natural' deaths across the SPS in that they're not natural at all. For example a man who had been in prison since he was a young adolescent, died of coronary heart disease. He'd lived in prison for all his adult life so where did his coronary heart disease come from? There are many examples of amenable deaths from conditions such as diabetes and epilepsy. A young offender died of a diabetic coma in 2005, which was potentially avoidable. Another young man died from an epileptic seizure, which was also potentially avoidable. Even when you

strip out expected deaths from cancer or expected deaths in older prisoners, the number of deaths is significant. The biggest cause of death is suicide.

61. Because of my professional background, I've also been undertaking research into the efficacy of the Talk to Me strategy. It was introduced in Scottish prisons in 2016. The National Institute for Health and Care Excellence (NICE) have really good, evidence based guidelines around mental health screening in custody, which appear to be ignored in Scotland. The SPS claim that Talk to Me was developed with a team of experts, however it is difficult to see what evidence it is grounded in. Our research has shown that suicides in prison have increased by over 40% since Talk to Me was introduced.

62. The suicide prevention strategy used by SPS prior to the introduction of Talk to Me (TTM) was called ACT2Care. The main difference between Talk to Me and Act2Care is that Talk to Me claims to be a 'holistic' strategy and it introduced 'concern forms', whereby *anyone* who has a concern about an individuals mental health / suicide ideation can raise this with a member of SPS staff, who in turn will complete a concern form, to be actioned under the strategy. However, TTM is not a holistic strategy and the concern forms don't get used (a theme in FAI determinations). From 2020 to 2022, there were 121 deaths across the prison estate in Scotland. Only 15 of those were COVID related. We discovered that since the introduction of Talk to Me in 2016, there have been 64 suicides. In the six year period before that, there were 45. There has therefore been a 42% increase in suicides since Talk to Me was introduced.

63. The number of suicides has also increased since the NHS took over the responsibility for healthcare prisons, which is quite astounding. The healthcare provision across the whole prison estate requires investigation, both in terms of the tools (validity and efficacy) that staff use and the environment that they work in to deliver their service. I don't think there were any standardised mental health assessments when Katie died or, if there were, on the efficacy and utility is questionable. Another theme that comes up in FAIs is, "It wasn't me." It wasn't the prison officer, it was the NHS. It wasn't the NHS, it was the prison officer. The NHS will say they didn't know about it because the prison officers didn't tell them. The prison officers will say that they told the NHS and

they didn't do anything about it. There's no joint working and people fall through the cracks with often fatal consequences.

64. After every death in custody, there must be something called a Death in Prison Learning, Audit and Review (DIPLAR). Since Katie's death, the SPS say that they've reviewed DIPLAR and improved it. DIPLARs are there to assess what happened and see whether any learning can occur. They're like mini FAIs. In my opinion, they should be independent. They shouldn't involve the staff that were there other than to gather information from. They should be held jointly with the NHS. In the course of our research, we couldn't find any evidence of there being systemic change across the prison estate after DIPLARs. Where there are formal recommendations in FAIs, we also can't find any evidence of any systemic change across the prison estate, despite claims made by the SPS to the contrary.

65. When I've read FAI reports in the course of my research, families are often unrepresented. Even when they are, there is frequently no written or oral evidence led, all is progressed by a joint minute of agreement. Recently, I've obtained some older FAI reports following a Freedom of Information (FOI) request to the Scottish Courts and Tribunal Service. I wanted to dig a bit deeper into the Polmont suicides to inform us of our arguments for Katie's FAI. Some of the reports are redacted. I've now got all the published FAIs for Polmont since 1989. Prior to 2016, it was at the Sheriff's discretion as to whether they were published or not. Some of them were unpublished and no wonder. They were basically one page long and say what the cause of death was.

66. One of the reports I obtained following my FOI request concerns a young offender. It details the Sheriff; who appeared at the inquiry and then states: "Mr X, date of birth x, of x Road, died between x pm x [redacted] 1989 and x am on x [redacted] 1989 within x, HM Young Offenders Institution, Polmont whilst detained in said institution, as a result of self-inflected hanging." It's been signed by the Sheriff and there's a backing page. That's it.

67. Another report I obtained through my FOI relates to another young offenders death in 1998. It states, "The following further witnesses were added at the insistence of the Procurator Fiscal Depute and examined on oath." The names are redacted. It continues, "The Procurator Fiscal hereby declared that no further evidence would be adduced on behalf of the Crown. No evidence was adduced by any other Procurators. The Procurator Fiscal Depute addresses the court on the evidence. Mr x counsel for the family, addressed the court on the evidence. Miss x addressed the court on the evidence." It's then signed by the clerk of court and continues with the Sheriff's determination: "The Sheriff determines that x, late of x Street, Glasgow, born x, died on x [redacted] 1998 at about x hours at Her Majesty's Young Offenders Institution, Polmont, Blair Lodge Avenue, Brightons of epileptical seizure whilst in lawful custody there." It's then signed by the Sheriff.

68. These reports I've referred to are pre-2016 reports. However, I've also seen post-2016 FAI reports that are one or two pages long. It's not only because they weren't published at the time that they were only one page long. Post 2016 when the act changed and all determinations were published, many often just state formal findings - cause of death, time and place of death, no lessons learned. The other area of interest from our research into FAIs is the joint minute of agreement and the number of FAIs that the joint minute of agreement is the only evidence: no oral or written evidence being led. We wonder if this has a correlation to the number of families that have no legal representation. Unfortunately there appears to be no examination of systemic patterns of failures, despite FAIs benefitting from hindsight. The FAI system requires a national oversight mechanism.

69. Our database, highlights 48 young people aged 21 and under to have died in Polmont since 1995. 27 of that 48 were 19 or younger and 11 were 18 or younger. 40 were male and 8 were female. Of the aged 18 and younger, 9 were male and 2 were female. Perhaps the most shocking statistic it is that 90% of these young people died by suicide, all but one were hangings. Most of the deaths occur within the first few weeks of the young person entering custody. Of the under 21s in Polmont, 56% of the suicides occurred within two weeks or less of the young person entering custody. The

risk factors we've found are, - youth, first time offenders, weekends, history of previous suicide attempts / mental ill health and being on remand.

70. One young 19 year old died in 2014. His FAI reflects most of the systemic failings we've encountered. The young man was failed from birth. He failed to meet his developmental milestones and was taken into care before his first birthday. At six, he was described as having 'behavioural difficulties and being somewhat obsessional'. He experienced several failed foster placements as a child and a safe guarder raised a concern that he'd been placed inappropriately with ill-suited foster carers. His behavioural issues escalated. Psychiatric and psychological services identified attachment difficulties. However, changes of placements and schools continued until the age of fifteen when he was sent back to live with his mum, who he'd been removed from at birth.

71. Behavioural difficulties and offending led to frequent appearances before Children's Hearings and adult courts and then he was admitted to Polmont. He was assessed for suicide where he was noted to have anxiety and depression, but identified as not having a suicide risk. He requested help for his anxiety. He had been prescribed 15mg of mirtazapine by his GP prior to admission. Following his admission, he was seen by a mental health nurse about his anxiety. He was given a workbook to complete for his next appointment. He was seen twice by the nurse for "low-level therapy" for relaxation. The nurse then cancelled all further appointments due to leave and training. The young man was told about this but his case wasn't reallocated to another nurse. The FAI states that it was deemed "better to wait until the nurse's return rather than reallocate the case".

72. The determination then states that he was seen by a psychiatrist, who doubled his dose of mirtazapine despite noting that she had no particular concerns. She agreed to review him in four to six weeks. There appeared to be nobody monitoring him. Following a spot-check of his medication, he was found to have less than he should have. His remaining medication was removed on 3 July, reinstated on 9 July and he was found dead on 14 July. The FAI stated that improvements had been made in case management by the mental health team and spot-checks of medication.

Recommendations were made, yet the similarities between this young mans death and that of our daughters is undeniable.

73. Another young man who died in Polmont was acutely psychotic. Whether prison was the correct environment for him in itself is questionable. The young man had previously been treated with anti-psychotic medication, including lithium. He was started on a new anti-psychotic one morning in Polmont. He had a case conference in the afternoon and reference is made that his presentation had improved (suggesting an immediate improvement from a single dose on an anti psychotic)

74. When recommendations are made following an FAI, the organisation they apply to has to formally respond to the Sheriff .There does not appear to be any link between FAI recommendations and the inspectorate for prisons. As mentioned there is no oversight mechanism in Scotland across the prison estate. The expert review of mental health services provision in Polmont, published in May 2019, found 7 key recommendations (plus 2 overarching recommendations) with 81 sub recommendations, yet in the media coverage it was described as 'a leading edge institution', quite a juxtaposition. .

75. As part of our research work, we have examined all the inspection reports for Polmont going back to February 2003. Many of the same themes are repeated in report after report. For example, in 2003 chronic problems with bullying were highlighted. Then in 2004, bullying is not mentioned. It then reappears in 2006. Often inspection reports highlight numerous points for improvement, which are not referred to at the next inspection visit.

Fatal Accident Inquiry into Katie's death

76. The evidential part of the FAI into Katie's death is due to take place at Falkirk Sheriff Court for six weeks at the start of 2024. There are further preliminary hearings scheduled between now and the start of evidence being heard. The Crown requested

a conjoined FAI with William Lindsay, a 16 year old young man who died in Polmont 4 months after Katie, both families have agreed.

77. Since Katie's death, we've had three meetings with the Crown. At our first meeting the crown stated that there was insufficient evidence to pursue a criminal prosecution. A victims right of review was submitted. We had a second meeting with the Solicitor General, Ruth Charteris and a third meeting last year, where we were told that *there was* credible evidence to prosecute, but due to crown immunity no prosecution would be taken forward. In terms of the Crown's family charter and our personal grief journey, we've never met once with the Crown that hasn't resulted from our campaigning. We've never had a liaison officer meet with us to help us. We haven't met the Procurator Fiscal Depute dealing with the FAI in court.

78. During our research, a recurring theme is that of 'blame', either the deceased being 'blamed' – drug or alcohol abuse leading to an inevitable suicide or the family is blamed – family difficulties, socioeconomic challenges. The research we do can be challenging, however I think it has helped prepared us for the FAI.

Impact

79. Following the early days of shock and trauma that followed hearing of Katie's death, we have been on a 'parallel journey'. Our private grief continues (often compounded by the experiences we have had over the past 5 years) and there is also our public campaign, informed by our research. Having to wait 5 years (it will be closer to 6 by the time the FAI concludes) has been torturous. Not only having to accept the obvious breach of the human rights act but importantly having to move on with our lives in the full knowledge that one day we will have to sit in court and hear the minutia of Katie's death when it has taken us so long to remember Katie in life as the vibrant, loving young woman she was. However we try to be positive and look for any benefits of waiting so long.

Lessons to be learned

80. As mentioned there's no oversight mechanism for deaths in custody in Scotland. Our research has shown that many people die prematurely in similar circumstances, either by suicide, natural causes or drug related deaths. One of the ambitions of the FAI process is to prevent deaths in custody in similar circumstances, yet it is clear that the lack of any legal accountability (for implementing recommendations) or oversight mechanism prevents this from happening.

81. Sheriffs are required to make findings identifying precautions, defects and recommendations aimed at preventing future deaths where the evidence establishes this. Our research highlighted that 91% of published FAI determinations (N=196) from 2005-2019 there was no reasonable precaution identified; in 96% no defect was found and in 94% no recommendations were made.

82. Several of the FAI determinations we have analysed note that the SPS has implemented corrective actions in the time between the individuals death and the FAI hearing therefore the Sheriff may not make any corrective recommendations. Then a few months will pass and another person will die, often in similar circumstances.

83. It is evident that prisons and young offenders institutions are dangerous places. Having examined 196 published FAI determinations over a 15 year period (2005-2019) the death rate in Scottish prisons had risen by 44%. This cannot be explained by an aging prison population alone. Suicides and drug related deaths are also rising. Scottish prisons have one of the highest suicide rates per head of population in Europe.

84. When entering Polmont you are met with a large sign which states "Unlocking Potential, Transforming Lives". The irony is not lost on me. 5 years on and still no accountability for Katie's death. 5 years of campaigning and research to discover what we always suspected, that our daughters death was entirely preventable. We have lost so much.

85. 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…… 14 September 2023 ……