

Progress Report Presented to Ministerial Accountability Board based on information from Scottish Government, NHS Forth Valley, Scottish Prison Service

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1. Introduction

Increased transparency is a key part of the remit of the Ministerial Accountability Board.

This publication contains self-reported information collected for a meeting in December which indicates the progress made in carrying out the recommendations from the Fatal Accident Inquiries (FAIs) into the deaths of Katie Allan and William Lindsay (also known as William Brown). It also covers additional actions promised by the Cabinet Secretary for Justice and Home Affairs in response to this FAI. Information about the recommendations from the FAI into Jack McKenzie's death are also included because of the significant overlap.

The information within this publication is provided by those responsible for completing the work ('action owners') through a dedicated reporting process. These action owners provide updates on key work which has been delivered and planned actions, as well as possible challenges and risks. They provide a 'delivery confidence RAG rating' for each recommendation to show whether or not progress is on track. This information is then reported to the Ministerial Accountability Board and helps focus discussions and action to make sure the necessary reforms are going to be delivered as promised.

To be clear, this report is a summary of the information which is sent for the MAB from action owners. The MAB are not involved in determining or approving the RAG rating of each recommendation; these are self-assessments by action owners. The MAB use the information they receive to aid their understanding of action owners' evaluation of progress for the recommendations or actions they have responsibility for. The MAB may seek assurances about the information they receive by asking for additional information of action owners and bring their own knowledge and expertise to test the information to perform their scrutiny role. This includes recommendations that are self-reported as being 'completed'. The MAB members do not have inspection powers. Inspection remains the responsibility of HMIPS, who publish reports after prison inspections.

This is the second in a series of progress reports following the publication of the September report. Updated versions will follow each Ministerial Accountability Board meeting in December (linked to this report), February, and March.

2. Summary of Progress

This report shows that 8 recommendations are considered 'completed' by the Action Owner. These include the removal of bunk beds from areas in which young people are accommodated in HMP & YOI Polmont (Recommendation 1), the removal of identified door stops (Recommendation 2), implementation of a 24 hour concern line (Recommendation 9), sharing of mental health referrals (Recommendation 12), training on accurate record keeping (Recommendation 13), revision of DIPLAR process to ensure physical environment is considered (Recommendation 15/2) and the appointment of independent DIPLAR Chairs (Action 1).

In addition to the completed recommendations, there are 6 rated as Green, 22 rated as Amber-Green and 7 rated as Amber-Red. At the time of reporting, none of the recommendations are rated Red or unachievable. The majority are rated as Amber-Green and are providing information which demonstrates progress towards completion.

Since September, five recommendations have seen a change in the delivery confidence RAG.

Four recommendations have moved from Amber-Green to Amber-Red:

- Recommendations 8 and 14(ix) around improvements to digital systems due to current work being undertaken to update the SPS digital infrastructure meaning this work cannot commence until 2026.
- Recommendation 5 around the SPS "items in use" policy as SPS consider the wider implications of removing personal items from young persons.
- Recommendation 2 (Jack McKenzi FAI) relating to the removal and replacement of ablution doors, due to delays in suppliers being able to deliver the new doors.

Recommendation 14(i) on the review of Talk to Me guidance pertaining to the first 72 hours has moved from Green to Amber-Green RAG rating. This is due to the upcoming publication of the Talk to Me findings and overhaul approach, and potential implications this could have on the 72 hour process.

3. How to read this report

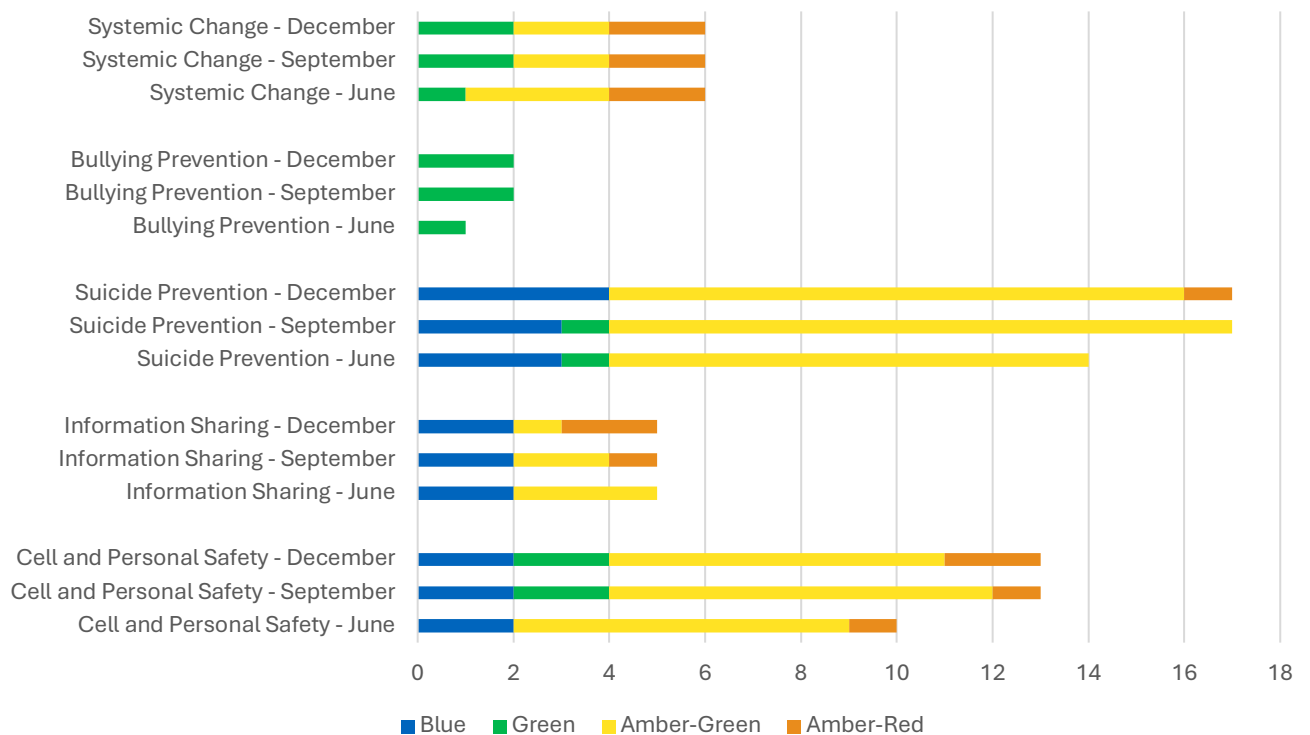
FAI determinations, and responses, in the cases of Katie Allan, William Lindsay and Jack McKenzie can be accessed via the SCTS website here - [Fatal accident inquiries and determinations | Scottish Courts and Tribunals Service](#)

In this report, recommendations and actions have all been grouped into 'themes'. These are wider areas of reform which multiple recommendations fall under. The themes are: bullying prevention; cell and personal safety; information sharing; systematic change and suicide prevention.

The chart shows how action owners' RAG ratings have changed over time and how this looks when grouped by theme area. Information about the 'delivery confidence RAG rating' is included in annex 2.

This report groups recommendations by thematic area and includes a shortened description of each recommendation or action. Full descriptions of each recommendation and commitment can be found in annex 1. Where a recommendation has a number of sub-recommendations (such as 3a, 3b) these have been grouped together under the recommendation number. In addition, where there is significant overlap between recommendations from different FAIs we have grouped these together and provided a single progress update against both.

4. Description: Graph showing the changes in RAG over time when recommendations/actions are grouped by Thematic Area



5. Theme: Cell and Personal Safety

Recommendation 1 (Katie & William FAI): Remove double bunk beds from all cells where young prisoners are accommodated.

RAG Ratings:

June	Blue	September	Blue	December	Blue
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Progress:

- Complete:
 - All bunk beds removed from all cells in HMP & YOI Polmont where a young person might be accommodated.
 - There are no bunk beds in place in HMP & YOI Stirling.

Recommendation 2 (Katie & William FAI): Remove and replace door stops with anti-ligature designs.

RAG Ratings:

June	Blue	September	Blue	December	Blue
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Progress:

- Complete:
 - All door stops of the type identified, and those of a similar design, have been removed from cells in Polmont where a young person is housed.
 - Door stops which remain are either sloping or positioned in a way which cannot be used as a ligature point.
 - Wider work ongoing to assess the physical environment of all prisons across the SPS estate.

Recommendation 3 (Katie & William FAI) & Recommendation 1 (Jack McKenzie FAI): Develop a standardised anti-ligature toolkit for auditing cells for the presence of anchor points; complete audits across all standard cells; and take necessary actions to address identified issues.

RAG Ratings:

June	Amber-Green	September	Amber-Green	December	Amber-Green
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Progress:

- Complete:
 - SPS has developed a proof of concept risk assessment toolkit to audit cells for the presence of ligature anchor points.
 - Pilot of toolkit conducted in HMP & YOI Polmont in September 2025.
- Ongoing:

- The Pilot findings and commissioned external research will help inform next steps.
- Engagement with key stakeholders to inform the work, including NHS and ligature experts.
- HMPs Stirling, Glasgow and Highland, as well as the Community Custody Units, were designed at the time, with the best available advice on mitigations for ligature points.

Recommendation 4 (Katie & William FAI): Pilot and review 'signs of life' technology.

RAG Ratings:

June	Amber-Green	September	Amber-Green	December	Amber-Green
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Progress:

- Complete:
 - Engagement with possible suppliers of 'signs of life' technology and market research carried out.
- Ongoing:
 - Pilots of technology from three suppliers across HMP & YOIs Polmont and Stirling from August 2025. The initial phase of the Pilot involves testing device accuracy and responsiveness, as well as staff training. This will be followed by a six-month live operational trial on a voluntary basis.
 - Learning from the Pilot will inform next steps.

Recommendation 5 (Katie & William FAI): Review and revise 'items in use' policy.

RAG Ratings:

June	Amber-Red	September	Amber-Green	December	Amber-Red
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Progress:

- Complete:
 - SPS has set up a working group to review the 'items in use' policy.
 - Engagement with stakeholders across other custodial and state-care environments to review 'items in use' lists.
- Ongoing:
 - SPS considering commissioning research to better understand potential wider impacts of removing personal items from young people.
 - Learnings from this research, as well as wider reforms including the overhaul of 'Talk to Me', will inform a trauma-informed approach to implementation which balances safety with wellbeing.
 - Ongoing work to explore suitable alternatives to specific items; belts and dressing gowns have been removed.

Recommendation 6 (Katie & William FAI): Research alternative bedding materials and review use in standard cells.

RAG Ratings:

June	Amber-Green	September	Green	December	Green
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Progress:

- Complete:
 - SPS has commissioned and completed a research project into bedding options.
 - Engagement with stakeholders from other jurisdictions and state hospitals.
 - Paper provided to Cabinet Secretary outlining findings.
- Ongoing:
 - SPS intend to publish the research findings by the end of the year.
 - Ongoing consideration of alternative options which balance safety with trauma-informed care.

Recommendation 2 (Jack Mckenzie FAI): Remove and replace/modify toilet cubicle doors with anti-ligature designs.

RAG Ratings:

June	Not applicable	September	Amber-Green	December	Amber-Red
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Progress:

- Complete:
 - Ablution doors removed from all 12 transition cells which are used by young people in HMP & YOI Polmont (those used in the first 72 hours from admission).
 - Procurement exercise competed to source anti-ligature replacement abluion doors for these cells.
- Ongoing:
 - These replacement doors will be installed by the end of the year.

Recommendation 6 (Jack McKenzie FAI): Conduct visual hatch checks near end of night shifts.

RAG Ratings:

June	Not applicable	September	Green	December	Green
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Progress:

- Complete:
 - SPS has established a working group to explore this area.
- Ongoing:

- Work underway to consider operational feasibility, legal implications and best practice from other jurisdictions.
- Development of Equality and Human Rights Impact Assessment.
- This work will inform next steps, and the findings will be reported to Ministers by the end of the year.

6. Theme: Information Sharing

Recommendation 7 (Katie & William FAI): Put in place a system to ensure that all written information and documentation available to a court at time of remanding a young person is passed to SPS with that young person on admission.

RAG Ratings:

June	Amber-Green	September	Amber-Red	December	Amber-Red
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Progress:

- Complete:
 - Working group established including representatives from criminal justice, health, social work and third-sector agencies.
- Ongoing:
 - Ongoing consideration of the best way to ensure timely and secure transfer of information between courts and prisons, while complying with legal requirements.
 - Initial scoping exercise completed to identify areas for improvement. Draft report under review by stakeholders which will inform next steps.

Recommendation 8 (Katie & William FAI): Introduce a secure electronic portal for suicide risk information to be shared and accessible by prison staff.

RAG Ratings:

June	Amber-Green	September	Amber-Green	December	Amber-Red
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Progress:

- Complete:
 - Communication has been issued to social work, medical staff and third sector organisations so they know how to raise a concern directly to prison staff.
 - Systems are in place in HMP & YOI Polmont which alert the first line manager or nightshift manager to this information.
- Ongoing:
 - The 'Bail and Release from Custody (Scotland) Act 2023' and the 'Prisoners (Early Release) (Scotland) Act 2025' require significant updates and testing to SPS IT systems throughout 2025.
 - Scoping and engagement work is therefore expected to commence in 2026 which will inform next steps.

Recommendation 11 (Katie & William FAI): Review guidance and training for information sharing between SPS and FVHB relating to suicide risk.

RAG Ratings:

June	Amber-Green	September	Amber-Green	December	Amber-Green
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Progress:

- Complete:
 - Information Sharing Agreement and Memorandum of Understanding between SPS and NHS has been revised to ensure a continued commitment to sharing information nationally.
 - Information sharing and professional boundaries training included in all staff inductions.
- Ongoing:
 - Final sign-off of Information Sharing Agreement and Memorandum of Understanding. Approval expected by the end of November 2025.
 - Work ongoing to strengthen training in this area and align with broader commitments including SPS' overhaul of 'Talk to Me' and the Scottish Government's 'whole system approach' framework.

Recommendation 12 (Katie & William FAI): FVHB should implement a system for sharing and acting on mental health referral information.

RAG Ratings:

June	Blue	September	Blue	December	Blue
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Progress:

- Complete:
 - System review completed and all referral forms are now sent directly to admitting prisons for young people (HMP & YOIs Polmont and Stirling) and triaged daily by a band 6 Registered Mental Health Nurse.
 - Standard Operating Procedure well established and shared with all staff.
 - Where indicated, prisoners will be seen within 24 hours and full assessment undertaken which will include a documented risk assessment/care plan.

Recommendation 13 (Katie & William FAI): FVHB should provide further training to prison staff on accurate record keeping and the 'VISION' system.

RAG Ratings:

June	Blue	September	Blue	December	Blue
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Progress:

- Complete:

- The VISION system and information sharing is covered in staff inductions and delivered via one-to-one sessions with new staff.
- Mandatory information governance training is completed annually by all staff.
- Documentation has been strengthened in line with 'Nursing and Midwifery Council' record keeping standards.
- Regular audits are undertaken.
- Redesign of staffing resources undertaken to create additional senior posts.
- Care assurance visits occur quarterly which includes evidencing the quality and standard of documentation.

7. Theme: Suicide Prevention

Recommendation 9 (Katie & William FAI): SPS should provide a 24 hour helpline for family members to report suicide concerns to prison staff.

RAG Ratings:

June	Blue	September	Blue	December	Blue
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Progress:

- Complete:
 - In February 2024, SPS strengthened the ability to raise a concern by introducing a dedicated 24-hour concern line for all prisons in Scotland.
 - This concern line can be utilised by anyone to raise a concern about someone in SPS custody. The telephone numbers are readily available on the SPS website in the Family and Friends section.
 - The webpage also details how to raise a concern about an individual's mental health and wellbeing and what action SPS will take following receipt of such information.

Recommendation 14 (Katie & William FAI): Review and overhaul of 'Talk to Me'; and

Recommendation 4 (Jack McKenzie FAI): Suicide risk assessment to be completed for chronic/habitual drug-users when removed from MORS; and

Recommendation 5 (Jack McKenzie FAI): Review and overhaul of 'Talk to Me' to reflect enhanced risk for chronic/habitual drug use.

RAG Ratings:

June	Amber-Green	September	Amber-Green	December	Amber-Green
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Progress:

- Complete:
 - New process introduced across HMP & YOIs Polmont and Stirling where every young person is placed on Talk to Me for their first 72 hours in prison custody and then until such time as a Case Conference assesses they have all suitable information required to support a

decision to remove them from Talk to Me. Standard Operating Procedures have been developed to ensure the process is robust and staff understand their responsibilities.

- Independent review of Talk to Me commissioned and completed. The findings will inform SPS' approach to overhaul Talk to Me.
- Ongoing:
 - SPS intend to publish findings from the independent review of Talk to Me by the end of the year.
 - SPS intend to publish their intended approach to overhauling Talk to Me by the end of the year.

Recommendation 15 (Katie & William FAI) & Recommendation 3 (Jack McKenzie FAI): Where a prisoner has died by suicide, the DIPLAR process must consider, and if so advised make recommendations, in relation to the safety of their physical environment with Polmont and the means by which they were able to complete suicide.

RAG Ratings:

June	Blue	September	Blue	December	Blue
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Progress:

- Complete:
 - SPS has reviewed and implemented revised DIPLAR paperwork and guidance in October 2024 across the SPS estate. This requires staff to include details of the environment in cases where the death was suicide by ligature, including recording the fixture point and ligature used.
 - It is required as part of the DIPLAR process, to consider and where appropriate, make recommendations, in relation to the safety and condition of the physical environment, the means by which a person dies by suicide and if by ligature the nature and availability of the item used.
 - SPS has appointed four independent individuals to chair all DIPLARs.

Action 1 (Cabinet Secretary Commitment): All Death in Prison Learning and Audit Reviews (DIPLAR) reviews should have an independent chair.

RAG Ratings:

June	Green	September	Blue	December	Blue
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Progress:

- Complete:
 - Procurement exercise completed to appoint independent chairs for all DIPLARS.
 - Four individuals selected and will chair DIPLARS going forward to ensure suitable independence.

8. Theme: Bullying Prevention and Response

Recommendation 10 (Katie & William FAI): SPS should introduce a system so as to ensure that where intelligence information is received suggesting that a young prisoner has been or is being bullied it is promptly and proactively shared with the relevant SPS staff.

RAG Ratings:

June	Green	September	Green	December	Green
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Progress:

- Complete:
 - Working group established by SPS made up of individuals with operational expertise and third-sector insight. The group's purpose is to develop a new anti-bullying strategy.
 - Thematic analysis completed, drawing on user voice led qualitative research, a literature review, and a staff survey. This work identified systemic, cultural, and operational barriers that impacted the effectiveness of the previous 'Think Twice' approach.
- Ongoing:
 - Ongoing work to develop a three-phase anti-bullying strategy. The first phase will focus on an approach specifically tailored to young people; the second phase will be for adult females; and the third phase for adult males.
 - Ongoing work to develop an implementation pathway for phase 1 (young people). This is expected to be finalised by the end of the year and launched early in 2026. Phases 2 and 3 for adult cohorts will be delivered throughout 2026.

Recommendation 7 (Jack McKenzie FAI): Review active patrolling guidance to address anti-social behaviour at night.

RAG Ratings:

June	Green	September	Green	December	Green
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Progress:

- Complete:
 - Review completed by SPS of relevant Standard Operating Procedures and training provided across all prisons in their estate, with a focus on instructions given to patrol and night shift staff.
 - Engagement with stakeholders, including young prisoners and SPS staff, to gather user-voice input.
 - Analysis of available information completed. Findings and options to strengthen the current approach submitted to the Cabinet Secretary in November 2025.
- Ongoing:
 - Advice from Ministers will inform next steps.

9. Theme: Systemic Change

Action 2 (Cabinet Secretary Commitment): Legal aid should be made free and non-means tested for families involved in FAIs related to deaths in custody.

RAG Ratings:

June	Green	September	Green	December	Green
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Progress:

- Complete:
 - Ministerial powers in place to remove means-testing for legal aid from 7th April 2025. This enables access to free non-means-tested legal aid for families involved in an FAI relating to death in custody.
- Ongoing:
 - Primary legislation required for any new parliament to ensure that all families involved in FAIs related to deaths in custody have access to legal aid.

Action 3 (Cabinet Secretary Commitment): Independent review of FAI system.

RAG Ratings:

June	Amber-Green	September	Amber-Green	December	Amber-Green
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Progress:

- Complete:
 - Sheriff Principal Abercrombie appointed in May 2025 to conduct an independent review of the FAI process.
 - Terms of Reference for the review agreed and will include a broadened scope to include deaths in Police custody as well as those in Prison custody.
 - Call for evidence completed in September 2025.
- Ongoing:
 - Report of findings in progress and due to be completed by the end of the year. This will incorporate evidence obtained during the review, consideration of published research and previous reviews.

Action 4 (Cabinet Secretary Commitment): Pursue the lifting of Crown Immunity.

RAG Ratings:

June	Amber-Red	September	Amber-Red	December	Amber-Red
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Progress:

- Complete:
 - Relevant UK Government minister identified and contact initiated from Scottish Government.
- Ongoing:

- Ongoing engagement between Scottish Government and UK Government officials to progress this work.

Action 5 (Cabinet Secretary Commitment): Establishment of National Oversight Mechanism.

RAG Ratings:

June	Amber-Red	September	Amber-Red	December	Amber-Red
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Progress:

- Complete:
 - Initial proposals developed.
 - Position reached that feasibility and timescales mean establishing a NOM will not be possible within this parliamentary term.
- Ongoing:
 - Phased approach developed by SG officials. Firstly, to commission an independent bespoke thematic report on the culture of implementing recommendations which will lay the groundwork for the NOM. Secondly, to continue to progress longer-term delivery options for establishment of NOM.

Action 6 (Cabinet Secretary Commitment): His Majesty’s Inspector of Prisons for Scotland review.

RAG Ratings:

June	Amber-Green	September	Green	December	Green
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Progress:

- Complete:
 - HMIPS and HIS agreed methodology for prison inspections against the FAI recommendations.
 - HMIPS inspection completed at HMP & YOI Polmont in August 2025.
- Ongoing:
 - Report from inspection being finalised and is intended to be published.
 - Ongoing stakeholder engagement from HMIPS to discuss key findings, including with families and with Forth Valley Health Board to discuss health-related matters.

Action 7 (Cabinet Secretary Commitment): Family Advocacy

RAG Ratings:

June	Amber-Green	September	Amber-Green	December	Amber-Red
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Progress:

- Ongoing:

- Work ongoing to procure a third-sector organisation to deliver the Family Advocacy role.
- Ongoing engagement with stakeholders to inform this work.

10. Annex 1: Full Descriptions for Recommendations and Actions

FAI into the deaths of Katie Allan and William Lindsay (Brown)

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

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

Recommendation 3a: SPS should take steps to make standard cells at Polmont safer by identifying and removing, as far as reasonably practicable, ligature anchor points present in such cells. In that regard it should: Develop a standardised toolkit for auditing cells for the presence of ligature anchor points. This toolkit should, in particular, (i) identify both obvious and potential ligature anchor points; (ii) specify whether such points are inherent to the design of fixtures or fittings within the cell, or due to modification of, or damage to, such fixtures and fittings; (iii) provide a system of grading the level of risk in relation to each identified ligature anchor point (for example, by reference to the ease/level of ingenuity required to use it for self-ligature), and so provide a system of grading the level of ligature anchor point risk in relation to the cell as a whole.

Recommendation 3b: Use the foregoing toolkit to conduct an audit of potential anchor ligature points within all standard cells. This should result in the production of a report detailing all obvious and potential ligature anchor points within each cell, identifying whether they are inherent to the fixtures and fittings within the cell or are due to modification or disrepair, and provide a grading of the risk for each identified ligature anchor point and for the cell as a whole.

Recommendation 3c(i): In the light of the foregoing audit: As regards any ligature anchor points arising from damage to or modification of fixtures or fittings, (a) repair or replace same so as to remove or at least reduce the risk of ligature arising therefrom as soon as practicable; and thereafter (b) institute a policy of regular ongoing cell audit using the said toolkit so as to promptly identify and repair 12 or replace any further damage or modifications which have created further ligature anchor points.

Recommendation 3c(ii): As regards any ligature anchor points arising from the inherent nature of fixtures or fittings, (a) develop and publish a plan for their phased removal, replacement or modification, again so as to remove or at least reduce the risk of ligature arising therefrom; (b) specify a timeframe over which this plan is to be implemented having due regard to available resources; (c) commence implementation, for example, beginning with removal, replacement or modification of those fixtures and fittings graded as presenting the highest level of risk pursuant to

the said toolkit; and (d) publish annual reports of progress in implementation of the said plan.

Recommendation 3d: Ensure that proposed fittings and fixtures in any new build or refurbished cells are audited using the said toolkit at the planning stage, and that any fittings or fixtures graded as presenting an inherent and significant risk of being used as ligature anchor points are not included within such cells when built or refurbished.

Recommendation 4: SPS should actively pilot and review use of in cell “signs of life” suicide prevention/ monitoring technology in Polmont. SPS should not confine this pilot and review to Safer Cells but should also consider its use in standard cells. SPS should report the findings of this pilot and review, and any recommendations arising therefrom, to Scottish Ministers, within 12 months of the date of publication of this determination.

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

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

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

Recommendation 8: SPS should introduce a secure electronic portal whereby social work, medical staff and third sector organisations can provide information relevant to

a prisoner's suicide risk directly to Polmont, and a system whereby any such information received will be immediately drawn to the attention of the first line manager ("FLM") or nightshift manager of the hall where the prisoner is located, and recorded in a form which is readily accessible by SPS staff having contact with the prisoner.

Recommendation 9: SPS should provide a dedicated 24 hour telephone number by which family members can call into Polmont in order to notify a concern relevant to suicide risk which they may have in relation to a prisoner. This phone number should be readily accessible on the SPS website, along with guidance as to its purpose and use. Where such a concern is received, an electronic concern form should be completed immediately, sent to the FLM or nightshift manager of the hall where the prisoner is located, and recorded in a form which is readily accessible by SPS staff having contact with the prisoner.

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

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

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

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

Recommendation 14(i): TTM should be revised as follows: TTM guidance should be amended to emphasise the increased risk of suicide (a) within a prisoner's first 72 hours in custody and (b) during the more restrictive regime in operation at weekends. TTM should provide as a default, and in the absence of exceptional circumstances to the contrary, that all young prisoners should be made subject to TTM for a minimum of 72 hours after admission to Polmont, and not removed from TTM thereafter until and unless a case conference has so decided.

Recommendation 14(ii): All TTM risk assessment forms should be amended so as to contain a guided process for the assessor. This should include specific prompts, checklists, and questions to be answered and recorded, so as to better enable (i) the identification, assessment and recording of the prisoner's suicide risk and protective

factors at the time of assessment; and (ii) ongoing assessment in the light of any changes in any of those factors thereafter.

Recommendation 14(iii): Where a prisoner is assessed to be at risk of suicide, TTM initiation forms should be amended as to contain a guided process for the assessor in relation to care planning for a prisoner being made subject to TTM. This should include specific prompts, checklists, and questions to be answered and recorded, so as to better enable the initiating member of staff to grade the level of risk presented and so put in place protective measures for the prisoner which are sufficient and proportionate to it.

Recommendation 14(iv): TTM should contain specific guidance to prison staff in relation to obtaining background information relative to a prisoner's suicide risk on admission, with express reference to the particular types of information which should be sought, when it is appropriate to obtain them, the process to be followed, and the person or persons who are responsible for doing so. In particular TTM should require staff to try to obtain background information relevant to suicide risk from the prisoner's family, and from relevant health and social care agencies, (i) where the prisoner is young, (ii) it is their first time in prison, and/or (iii) there is evidence which may suggest a history of self-harm or suicide attempts. In such circumstances, and pending receipt of such information, the default position should be that the prisoner is made - or should continue to be - subject to TTM.

Recommendation 14(v): TTM guidance as regards risk assessment should be amended so as to better emphasise the importance of reduction of the risk of self-ligature in the context of suicide prevention. All risk assessment forms should be amended to require the assessor to consider the cell environment in which the prisoner is (or is to be) accommodated, and to assess the ligature anchor point risk within that particular cell as part of the overall risk assessment.

Recommendation 14(vi): TTM guidance as regards ongoing risk assessment should be amended so as to better emphasise (i) the importance of obtaining background information in relation to a prisoner, (ii) identifying dynamic risk and protective factors in relation to the particular prisoner, and (iii) that a prisoner's self-report and non-verbal presentation in relation to a risk of suicide should not be taken as determinative, but must be considered in the light of such information. Where a prisoner is observed to be in distress such as should trigger the completion of a concern form, guidance should place a requirement on the officer concerned to review all TTM documentation in relation to the prisoner.

Recommendation 14(vii): In addition to the present system of suicide risk assessment based on RRAs and reactive day to day assessment by prison officers, TTM should include periodic proactive reviews and evaluations of a prisoner's suicide risk and protective factors in the light of all available information. This should include review of prisoners who are not currently subject to TTM, and be at such frequency as may be determined on a case by case basis.

Recommendation 14(viii): SPS should develop a new system of recording issues of concern which relate to a prisoner's suicide risk under TTM, so as to ensure that all relevant information in relation to such a risk is recorded in writing, collated in a

single place, and is available to be periodically reviewed and assessed. Pending development of a new system of recording issues of concern, SPS should issue further guidance and provide specific training so as to clarify when a concern form should be completed by prison staff and its importance and purpose for TTM. This should emphasise: (i) that concern forms should be used where prison staff have witnessed a prisoner in distress, and are not only for use by external agencies or staff without regular access to prisoners; (ii) that a concern form should be completed even where it is not thought that the prisoner is at risk of suicide; and (iii) the importance of accurate and timeous record keeping in relation to concerns relevant to ongoing assessment of suicide risk.

Recommendation 14(ix): SPS should develop a system of electronic recording for all TTM documentation, that is, relating to a prisoner's suicide risk assessment, recorded concerns and reviews, so as to ensure that all such documentation is not lost or mislaid, and is in any event readily accessible to frontline SPS staff.

Recommendation 14(x): A transitional care plan should continue to be mandatory for all young people removed from TTM, so as to ensure appropriate supports and follow-up checks are in place, and that their cell environment is appropriate in relation to potential ligature anchor points. Specific guidance and training should be provided on the options available to staff when compiling a transitional care plan for a young prisoner, including referrals to the FVHB mental health team, other agency referrals, counselling/other supports, or chaplaincy visits. This guidance and training should emphasise the prevalence of suicide by persons who have previously been subject to TTM.

Recommendation 14(xi): TTM refresher training should be provided to all staff at a significantly greater frequency and/or duration than 2 hours every 3 years, the precise amount to be determined by the current TTM review. Training should place particular focus on ligature anchor point and ligature item risks, the importance of accurate record keeping, the importance of obtaining information from external agencies, how to properly conduct a case conference, the use of concern forms, and any changes implemented as a result of the ongoing TTM review and this inquiry.

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

Cabinet Secretary for Justice and Home Affairs additional commitments

Action 1: Death in Prison Learning and Audit Reviews (DIPLAR): All DIPLAR reviews should have an independent chair.

Action 2: Legal aid will be made free and non-means tested for families involved in Fatal Accident Inquiries related to deaths in custody. Primary legislation will bring this forward at the earliest opportunity.

Action 3: A focused, independent review of the FAI system will be conducted to improve its efficiency, effectiveness, and trauma-informed nature.

Action 4: Pursue the lifting of Crown Immunity with the UK Government.

Action 5: Independent national oversight mechanism to be introduced for deaths in custody.

Action 6: His Majesty's Inspector of Prisons for Scotland will monitor and review the actions taken to ensure they are meeting the required outcome, reporting directly to CSJHA.

Action 7: Family Advocacy

FAI into the death of Jack Mckenzie

Recommendation 1: SPS should take steps to make standard cells at Polmont safer by identifying and removing, as far as reasonably practicable, ligature anchor points present in such cells. In that regard it should: a. Develop a standardised toolkit for auditing cells for the presence of ligature anchor points. This toolkit should, in particular, (i) identify both obvious and potential ligature anchor points; (ii) specify whether such points are inherent to the design of fixtures or fittings within the cell, or due to modification of, or damage to, such fixtures and fittings; (iii) provide a system of grading the level of risk in relation to each identified ligature anchor point (for example, by reference to the ease/level of ingenuity required to use it for self-ligature), and so provide a system of grading the level of ligature anchor point risk in relation to the cell as a whole; b. Use the foregoing toolkit to conduct an audit of potential anchor ligature points within all standard cells. This should result in the production of a report detailing all obvious and potential ligature anchor points within each cell, identifying whether they are inherent to the fixtures and fittings within the cell or are due to modification or disrepair, and provide a grading of the risk for each identified ligature anchor point and for the cell as a whole; c. In the light of the foregoing audit: i. As regards any ligature anchor points arising from damage to or modification of fixtures or fittings, (a) repair or replace same so as to remove or at least reduce the risk of ligature arising therefrom as soon as practicable; and thereafter (b) institute a policy of regular ongoing cell audit using the said toolkit so as to promptly identify and repair or replace any further damage or modifications which have created further ligature anchor points; ii. As regards any ligature anchor points arising from the inherent nature of fixtures or fittings, (a) develop and publish a plan for their phased removal, replacement or modification, again so as to remove or at least reduce the risk of ligature arising therefrom; (b) specify a timeframe over which this plan is to be implemented having due regard to available resources; (c) commence implementation, for example, beginning with removal, replacement or modification of those fixtures and fittings graded as presenting the highest level of risk pursuant to the said toolkit; and (d) publish annual reports of progress in implementation of the said plan; (d). Ensure that proposed fittings and fixtures in any new build or refurbished cells are audited using the said toolkit at the planning stage, and that any fittings or fixtures graded as presenting an inherent and significant risk of being used as ligature anchor points are not included within such cells when built or refurbished.

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

Recommendation 3: Where a prisoner has died by suicide, the DIPLAR process must consider, and if so advised make recommendations, in relation to the safety of their physical environment within Polmont and the means by which they were able to complete suicide. Where suicide has been by self-ligature, the DIPLAR process must consider the ligature anchor point risk of the cell or other place in which the death by suicide took place, and the nature and availability of the item used as a ligature.

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

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

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

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

11. Annex 2: Delivery Confidence RAGs

The below table outlines the used RAG (Red, Amber, Green) ratings used by action owners to rate their confidence in the successful delivery of the work.

Blue	Green	Amber-Green	Amber-Red	Red
Delivery has been successfully completed with no outstanding actions.	Successful delivery to time and cost as agreed appears highly likely with no major challenges at this stage appearing to threaten delivery.	Successful delivery appears probable however close attention is required to ensure identified challenges do not materialise into threats to delivery.	Successful delivery faces significant challenges in a number of key areas and urgent action is underway to ensure these are addressed and agree resolution.	Successful delivery faces major challenges. Urgent work is underway to agree resolutions and/or viability of delivery.

Where recommendations do not report a previous RAG rating this is due to them not being included in scope for previous reporting.

12. Annex 3: Abbreviations List

- CJSWR – Criminal Justice Social Work Report
- CSJHA – Cabinet Secretary for Justice and Home Affairs
- DIPLAR – Death in Prison Learning and Audit Reviews
- FAI – Fatal Accident Inquiry
- FLM – First Line Manager
- FVHB – Forth Valley Health Board
- MAB – Ministerial Accountability Board
- RRA – Risk Readiness Assessment
- SPS – Scottish Prison Service
- TTM – Talk to Me



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