SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

Under the Fatal Accidents and Sudden Deaths (Scotland) Act 1976

DETERMINATION

of

SHERIFF LINDA M RUXTON

FOLLOWING AN INQUIRY INTO THE DEATH OF ANDREW JAMES DUTHIE

GLASGOW, 4 April 2008. The Sheriff, having considered all the evidence adduced and submissions thereon at the Inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 **DETERMINES**:-

In terms of **section 6(1)(a)** *(when and where the death and any accident resulting in the death occurred)* That Andrew James Duthie, born 28 February 1969, died at approximately 0900 hours on 25 November 2006 within "B" Hall. Her Majesty's Prison, Barlinnie, 81 Lee Avenue, Glasgow while a prisoner there.

In terms of **section 6(1)(b)** (*the cause of death and any accident resulting in the death)* That Andrew James Duthie died from a head injury due to a fall from a height having jumped from the third landing of "B" Hall.

Evidence was led and concluded over two days on 20 and 21 February 2008. The proceedings were adjourned until 7 March 2008 to hear legal submissions. Miss K O'Sullivan, procurator fiscal depute, presented the Inquiry in the public interest. Mr C M Simpson, solicitor, appeared on behalf of the deceased's mother, Mrs Williamina Duthie and Miss G Martin-Brown, solicitor, appeared on behalf of the Scottish Prison Service.

The following facts are relevant to the circumstances of the death:-

Background

[1] Andrew James Duthie appeared at Hamilton Sheriff Court on 15 November 2006 and was sentenced to 8 months imprisonment in respect of a conviction under section 4(3)(b) of the Misuse of Drugs Act 1971. His estimated date of release was 15 March 2007.

[2] He was admitted to H M Prison, Barlinnie, Glasgow on 15 November 2006 and was allocated to cell 19 on the third floor or flat, "B" Hall. (In Barlinnie the ground floor is described as the first landing. Accordingly, although Mr Duthie's cell was on the third landing, it was only two storeys high.) He was sharing a cell with another prisoner. Mr Duthie had not previously served a prison sentence although he had spent some time on remand in another establishment. He had not been in Barlinnie before. Mr Duthie was a 37 year old man who was the sole parent of his 11 year old daughter.

[3] Barlinnie is a large prison consisting of five separate halls, each having the capacity of a moderate-sized prison. "B" Hall accommodates over 300 prisoners at any one time. On a daily basis, it is manned by a staff of 40 officers with 3 first-line managers. On each shift, there are 3 officers on each landing with a desk officer situated on the ground floor. Each landing houses about 80 prisoners, mostly in shared cells.

[4] "B" Hall is of traditional Victorian gallery-style design. It is 4 storeys high with cells on ladings around an atrium. The cells open out onto a balcony with retainer metal railings some 1.5 metres high. At various intervals along the balcony at a

slightly lower level than the railings are fire boxes connected by a pipe to the water supply. There are no nets in place in "B" Hall and the distance from the third landing to the first (ground) floor is a drop of some 40 feet.

Admission, induction and risk assessment procedures

[5] All prisoners undergo an admissions procedure when they are received into prison. This takes the form of several interviews. The procedure is more detailed when, like Mr Duthie, the prisoner is a "first -timer", serving his first custodial sentence. An integral part of the admissions procedure is an assessment designed to identify whether the prisoner is at risk of self harm or suicide.

[6] As part of the general admissions procedure, Mr Duthie was assessed in terms of risk of self harm and suicide in accordance with the *Act 2 Care* suicide risk management procedure in force (known as "ACT"). Reception risk assessment was carried out when Mr Duthie arrived at Barlinnie from Hamilton Sheriff Court on 15 November 2006. In accordance with the standard admissions procedure, Mr Duthie was seen first by the reception officer before undergoing 2 health care assessments, one a nursing assessment, the other a consultation with one of the prison medical officers. At each stage, he was independently assessed in terms of risk of self harm or suicide. All staff who conducted these interviews were fully trained in the ACT procedures and experienced in their application.

[7] The first interview was carried out by reception officer Mulholland. He noted that Mr Duthie was not currently subject to the ACT procedures, nor had any information been received from any source to suggest that there were any concerns in that connection. An assessment of Mr Duthie's behaviour, attitude and risk was carried out by asking a number of pre-set questions the answers to which were recorded. None of his answers highlighted any risk factors. It was noted that Mr Duthie was slightly depressed and low in mood due to his prison term and having had to leave his daughter. However, he stated that he had no intention of harming himself. He was, therefore, assessed as being of no apparent risk of self harm or suicide.

[8] The nursing assessment was carried out by 2 practitioners, one of whom was Miss Sarah King. She asked Mr Duthie a series of questions and noted his answers while

her colleague observed him, watching for any warning signs from his presentation that would suggest that he was at risk of harming himself. It was noted that Mr Duthie had a history of drug abuse and that he was currently on a methadone programme. Details of his previous misuse of controlled substances were recorded. He denied thoughts of self harm or suicide and the earlier assessment that he was at no apparent risk of self harm was confirmed. He was referred to the addictions nurse for further assessment of his drug misuse with a view to determining whether he needed any further support while he was in prison.

[9] The third stage of Mr Duthie's admission assessment was a medical consultation with one of the prison medical officers, Dr Jai Kural. Mr Duthie's previous history of drug misuse was noted and that he was currently prescribed methadone and diazepam by his general practitioner. Dr Kural, too, assessed Mr Duthie in terms of suicide risk and also concluded that he presented no apparent risk.

Supervision level

[10] On admission, every new prisoner is assessed to determine the appropriate level of supervision he requires. This assessment is a separate procedure from the ACT policy and its purpose is to maintain secure custody, good order and to ensure that prisoners receive the lowest appropriate level of supervision within establishments according to their behaviour and response in custody. In accordance with prison rules, Mr Duthie was categorized as requiring a high level of supervision on admission pending review by the residential staff within 72 hours. Mr Duthie's supervision level was duly reviewed and reduced from high to medium. Again this was in accordance with prison protocol that prisoners with a known risk factor of current substance abuse are classed as requiring a medium level of supervision. In Mr Duthie's case, this level was further downgraded to low risk by the second line manager. Mr Alan Combe, Residential Unit Manager confirmed that decision. Neither noted reasons for the departure from the supervision protocol as they were required to do. In evidence, Mr Combe explained that senior management at Barlinnie do not consider that a prisoner who is stable on a methadone programme requires medium level supervision. They are not regarded as having a current substance abuse problem. Futhermore, there is a policy, driven from Headquarters, to reduce prison numbers. There is pressure on

staff to classify prisoners as requiring only low level supervision as only prisoners at that level are eligible for early release on home detention curfew.

Induction process

[11] Mr Duthie spent his first night – as do all prisoners - in "E" Hall, a calmer and quieter environment which allows prisoners to orient themselves before being located in the larger residential halls within the mainstream prison. The following day, Mr Duthie commenced a 2-day induction course for first-time prisoners designed to explain prison routine and to identify further support which might be of benefit to him, either during his time in Barlinnie or after his release.

[12] The induction process also provides another opportunity to observe a prisoner on a one-to-one basis over an extended period. The first part of the interview deals with the issue of self harm. Indeed one of the first questions asked at induction is whether the prisoner has any thoughts of suicide or self harm. Prisoners are informed about the ACT strategy and how it operates.

[13] Prisoners are encouraged to discuss any problems they may have and during the induction process are given information and advice about who to contact in that situation. Specifically, they are told about the system of prisoner listeners (prisoners who have been trained by the Samaritans to provide a support service to fellow prisoners) and how to get in touch with them. Other support services such as the prison chaplaincy service are also explained.

[14] Mr Duthie's induction was carried out by Prison Officer Barry Hay. Again, during the 2-day course, nothing about Mr Duthie's presentation gave any cause for concern and he denied having any thoughts of harming himself.

Drug treatment regime

[15] As part of the heath care assessment, it was noted that Mr Duthie had been prescribed methadone and diazepam (valium) by his general practitioner. Prisoners who are already on a methadone programme as an opiate-substitute are maintained on that programme while in jail but, on grounds of medical safety, no methadone is dispensed until the dosage has been confirmed with the prescribing physician. For

some time, Mr Duthie had been on a daily maintenance dose of 50 millilitres of methadone from his own doctor. Accordingly, his methadone was stopped and he was prescribed dihydrocodeine for opiate withdrawal pending confirmation from his general practitioner of the methadone prescription. Confirmation was received the following day by fax and methadone was re-commenced on 17 November.

Benzodiazepine detoxification

[16] Mr Duthie had also been prescribed 30 milligrammes of diazepam per day by his general practitioner. That, too, had been confirmed by his doctor. In accordance with national pharmaceutical guidelines, he was started on a benzodiazepine detoxification regime. The regime was tailored to reflect the fact that Mr Duthie had been taking 30 mgs of diazepam daily. Gradually reducing levels of diazepam were dispensed twice a day under nursing supervision. No significant side effects or concerns were noted by nurses or hall staff as Mr Duthie's detoxification proceeded. Nor did Mr Duthie complain that he was experiencing any difficulty in this connection.

Behaviour

[17] At no time did Mr Duthie's behaviour or his demeanour give rise to any concern. He was seen regularly by the nurses who dispensed his medication and interacted with the hall staff. He made no complaints or gave any indication that he was particularly distressed, anxious or low in mood. Officer Kerr remembered Mr Duthie and described him as very quiet He did not come out of his cell much and had not asked to use the gym facilities but that was not out of the ordinary. Although he shared his cell with another prisoner, that prisoner had been released the day before Mr Duthie died. Accordingly, at the time of his death, Mr Duthie had the sole occupancy of cell 3/19.

[18] Mr Duthie's family were in Edinburgh. He kept in contact by telephone and had indicated during his induction that he did not need help in maintaining family contact. He appeared to have been looking to the future in that a visit was booked for 26 November and he had made an application for early release on home detention curfew. He had not formally applied for a transfer to H M Prison, Edinburgh. Had he done so, his request would have been considered sympathetically, although given overcrowding difficulties at Edinburgh, transfer would by no means have been

guaranteed. A letter from Mr Duthie's mother in which she urged that such a transfer be considered was received at the prison but, sadly, it arrived after his death.

Circumstances of death

[19] At about 0830 hours on Saturday 25 November, cells in Mr Duthie's section were opened up to allow prisoners to go to the far end of the flat to collect their breakfast before returning to their cells. Prison officer William Kerr was on duty at the desk to deal with any requests from prisoners. Mr Duthie approached him at about 0840 and asked permission to use the telephone. His request was noted and granted. He asked the officer whether he could use the phone right away and officer Kerr allowed him to do so.

[20] This was a regular request made by Mr Duthie. He routinely asked to use the telephone first thing in the morning. It was thought that on these occasions he telephoned his daughter to speak to her before she left for school. There was, therefore, nothing unusual about this request. Nor was there anything unusual about Mr Duthie's presentation or behaviour at that time which might have raised any concerns or given any warning of what he was about to do. He was described as quiet, as usual.

[21] Mr Duthie walked in the direction of the telephone but did not make any call. Moments later, Officer Kerr noticed that Mr Duthie had climbed onto the balcony railings just above the fire box opposite cell 8. Officer Kerr called to him and asked him what he was doing up there. Mr Duthie did not respond but merely looked at officer Kerr. Officer Kerr thought that Mr Duthie appeared to be very composed. At that point he was holding on to the pipe that leads into the fire box. Officer Kerr, aware that something was very wrong, started to walk towards Mr Duthie and endeavoured to maintain eye contact with him. He kept talking to him quietly, repeatedly asking him to come down. Mr Duthie did not respond but turned away and looked down towards the floor. He then stepped down onto the fire box, let go of the pipe and deliberately allowed himself to fall head-first to the ground floor, some 40 feet below.

[22] This was witnessed by two others in the immediate vicinity. Martyn Park, a fellow prisoner, saw Mr Duthie "jumping" on to the red fire box. He was crouched over and holding on to a pole. He pulled himself up. Mr Park saw Officer Kerr walking towards Mr Duthie, telling him to get down. At that point, Mr Duthie was standing on the railings a couple of feet above the fire box. As Officer Kerr approached, Mr Duthie stepped down onto the box. He did not respond to the officer. Mr Park noticed that Mr Duthie's left hand was shaking violently. Mr Duthie then glanced around then put both arms behind his back and leaned forward with his head down and went head-first to the ground below.

[23] Officer Douglas Haggarty was on the ground floor supervising at the nursing station when he looked up and saw Mr Duthie in a semi-crouched position on the fire box. He watched him as he stood up with his hand on the pipe. He then just leaned over and fell head-first off the fire box. He described Mr Duthie as falling forward but with "a slight leap" off the fire box.

[24] Each of the eye-witnesses was certain that Mr Duthie's actions were deliberate.

[25] Mr Duthie landed head-first on the ground floor. It was obvious that he had sustained a very serious head injury. Practitioner Nurse Jack Morrison had been dispensing medication nearby and attended immediately. Other officers and nursing staff attended promptly. Although Nurse Morrison initially detected a faint pulse, it was clear from the nature and extent of the head injury that any attempt to resuscitate would have been futile. In the event, Mr Duthie died a few minutes after he fell. Dr Vyas, one of the prison medical officers, attended and formally pronounced life extinct at 0955 hours.

[26] A post mortem examination was carried out by Dr John Clark, forensic pathologist, who concluded that Mr Duthie had died as the result of a very severe head injury which was consistent with a fall from a height. The cause of death was certified as head injury due to a fall from a height. The fatal injury was a complete fracture through the top and base of the skull showing that Mr Duthie must have landed on his head. This fracture was near to the part of the brain that controls breathing. The injury was unsurvivable and Mr Duthie would have died very quickly

from it. There were a number of other injuries noted, including rib fractures and extensive bruising to both lungs which were typical deceleration injuries. Toxicological examination revealed moderate levels of methadone and diazepam in his blood. These were consistent with the levels he was prescribed. No other substances were present.

NOTE

[27] In the course of the Inquiry, attention was focused on 3 areas of evidence in particular: the admission procedure with particular reference to suicide risk assessment; the mandatory benzodiazepine detoxification process with particular reference to Mr Duthie's diazepam prescription; and the layout of "B" Hall with particular reference to the gallery design and the absence of nets or other means to prevent falls from heights.

Submissions

[28] I was not invited to make any findings other than formal ones in terms of section 6 (1) (a) and (b) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. However, it was accepted that these 3 issues were worthy of further consideration and comment.

Admission procedure / suicide risk management and assessment

[29] The Scottish Prison Service have in place an active risk management strategy known as "ACT". This strategy was first introduced in 1999 as *Act and Care*. The current revised strategy - *Act 2 Care* – was introduced in 2005 and was in force at the time of Mr Duthie's death. ACT is not a suicide prevention strategy but is designed to manage the risk of suicide. It is accepted that those determined to take their own lives will find a way of doing so, even within the restrictions of a prison environment.

[30] The ACT strategy aims to foster a culture of care and support for individual prisoners as part of the management of suicide risk in prison. A supportive regime is envisaged in which staff are encouraged to build good relationships with prisoners, to listen to them and promote an environment in which prisoners themselves will feel able to approach officers if they are in difficulty and, particularly, if they feel at risk

of self harm. Thus communication is regarded as a key part of the strategy. All prison staff receive core training in ACT procedures which is supplemented by compulsory refresher courses every year. It was clear from the evidence that all of the staff who came into contact with Mr Duthie were well versed in the ACT principles and fully aware of the need for vigilance and to be sensitive to any behavioural changes that might indicate that an individual prisoner was at risk of self harm.

[31] The ACT risk assessment forms an important part of the admission process. The procedures are followed strictly and a detailed written record the assessment is kept. The procedure involves three separate interviews during which set questions are asked with reference to the ACT documentation. Each interview concludes with an assessment as to the individual prisoner's current risk of self harm or suicide. Although interviews follow a set pattern and the questions asked are those noted on the pre-printed forms, in reality this process is supplemented by discussion, interaction and direct observation of the prisoner's presentation, demeanor and responsiveness.

[32] ACT assessment can produce three conclusions as to risk of suicide or self harm: high risk, low risk or no apparent risk. ACT procedures are "raised" in the first two categories and there are immediate and direct consequences of ACT status being imposed. High risk prisoners are placed in specially adapted "safe cells" designed with certain anti-ligature features. Prisoners are dressed in special anti-ligature clothing and placed under fifteen minute observations. Those assessed at low risk of suicide are allowed to remain in their cells and to wear their own clothes but they are placed on hourly observation and may be subject to other restrictions. Thus the commencement of ACT procedures has real consequences for prisoners. Quite properly, such assessments require to be justified.

[33] There was no suggestion during the Inquiry that Mr Duthie should have been made the subject of ACT procedures at any time. Those who assessed him during the admission procedure did so thoroughly and professionally with proper regard to the ACT principles and procedures. Mr Duthie gave no warning signs that he was in difficulty, far less that he was contemplating suicide.

[34] Evidence was led about the assessments carried out on admission under the Prisoner Supervision System. Some failures to complete important sections of the relevant documentation were noted. However, while any pressure on staff to classify prisoners at low supervision in order to release more prisoners on home detention curfew might raise concerns in some quarters, the supervision level afforded to Mr Duthie had no relevance to the circumstances of his death. There was nothing to suggest that low level supervision was inappropriate for him. Even if he had been on a medium level of supervision, that would not have interfered with his freedom to have been on the balcony unaccompanied or to have been granted permission to use the telephone on the day of his death.

Diazepam detoxification

[35] On admission to Barlinnie, Mr Duthie was immediately commenced on a benzodiazepine detoxification. This was in accordance with national pharmaceutical guidelines and protocol. Diazepam, taken for long periods, is a highly addictive drug. It is recognised good medical practice that it should only used on a short-term basis. Accordingly, prisoners who are prescribed diazepam or who abuse it are put on a controlled detoxification programme. This is carried out under medical supervision. The length of the programme is tailored to each prisoner having regard to the level of drugs involved.

[36] On 16 November, Mr Duthie commenced a short (11 day) detoxification based on a prescribed amount of 30mgs, as disclosed by him to Nurse King and Dr Kural and thereafter confirmed by his general practitioner. He continued to consume 30mg (15mg twice daily) for the first 3 days. That was reduced to 20mgs (10mgs twice daily) for the following 3 days and for 3 days after that, the dose was further reduced to 10mgs (5mgs twice daily). The medication was dispensed under the supervision of the nursing staff. At no time did Mr Duthie give any cause for concern as to how he was tolerating the detoxification procedure. He gave no indication that he was experiencing any serious side effects and made no complaints that he was suffering withdrawal symptoms or any adverse reaction. His detoxification appeared to be progressing without difficulty.

[37] There was evidence, however, that Mr Duthie had later disclosed that he might have been taking illicit methadone and illicit diazepam in considerably larger amounts than he had initially indicated. It seemed from the information recorded in the course of is addiction assessment on 16 November, that he had been topping up his prescribed medication with illicit drugs. If this information were correct, it suggested that Mr Duthie had been taking 100mls of illicit methadone on top of the prescribed 50mls and up to 50mgs of diazepam on top of his prescribed doze of 30mgs. This information was not made known to Dr Kural. Two questions arose from this: first, whether there ought to have been a procedure whereby the information supplied at the later stage was checked against earlier information to ensure that it corresponded; and, secondly, whether it would have made any difference to length and pace of Mr Duthie's detoxification programme and any side-effects that he might have experienced.

[38] It is important to note that the information given by Mr Duthie during his addiction assessment was entirely unconfirmed. In respect of methadone, itself a dangerous drug, it would be irresponsible for any medical practitioner to prescribe on the basis of wholly unsubstantiated information, particularly from someone with a long-standing addiction to drugs. The same considerations apply to diazepam, although with somewhat less force in terms of the potential danger to the patient.

[39] When the discrepancies in the amounts were put to him, Dr Kural's position was that it would not have affected his decision either in respect of the methadone prescription or the diazepam detoxification. The former could only be continued on the basis of the prescribed maintenance dose as confirmed by the Mr Duthie's doctor. As far as the diazepam was concerned, Mr Duthie had earlier denied taking illicit drugs. Changes of position were not uncommon and the higher amounts later reported were unclear and unsubstantiated. Although Dr Kural might have commenced the detoxification at a higher dose had he been aware of the information at the outset, if it *had* been brought to his attention later he would not have altered the regime once the detoxification had commenced and was proceeding without incident. The procedure was carried out in a controlled manner under medical and nursing supervision and Mr Duthie was closely monitored throughout by trained and experienced nursing staff. He showed no signs of distress. Had he complained of withdrawal symptoms, or had the

nursing staff or the residential staff been concerned in any way, these concerns would have been reported to Dr Kural and the regime reviewed. Accordingly, there is no basis on which to conclude that the diazepam detoxification had any direct bearing on Mr Duthie's death. The position is that same in respect of the methadone. Mr Duthie was simply continued on his maintenance programme without any apparent difficulty.

[40] It was noted in evidence that although the prescription for diazepam had been confirmed by Mr Duthie's general practitioner, the reason for the prescription had neither been sought nor given. It was explained that the prescribing information might not have come from the general practitioner in person but from administrative staff at the general practice who might not have been in a position to disclose the basis on which the drug had been prescribed. Nevertheless, the question arose whether Mr Duthie might have needed to continue to receive this medication on an acute, short-term basis rather than requiring detoxification for more long-term use. Again, Dr Kural's position was that detoxification would have commenced in any event given that the policy in prisons is not to continue to prescribe diazepam. Accordingly, it cannot be said that the absence of further information in connection with the prescribing of diazepam was of any significance in relation to Mr Duthie's death.

Design of "B" Hall

[41] Two senior officials from the Scottish Prison Service gave authoritative evidence on this subject: Mr Jack Kane, Head of Estates, and Dr Andrew Fraser, Director of Health and Care. It was explained that Barlinnie is part of an aging prison estate originally built about 120 years ago. It is made up of five large halls which accommodate over 1500 prisoners. "B" Hall houses some 300 prisoners on four levels. The hall is a traditional Victorian prison with an open atrium between two cell landings connected by bridges. The landings are bordered by strong mesh railings of steel which rise to a height of 1.5 metres. The distance between the railings and the flat above is open space. "C" Hall is of an identical layout but has a safety net in place at foot level on the first landing above the ground floor. This was installed some time in the late 1970s. By contrast, "D" Hall, while identical on the outside, has been completely converted internally as part of a major refurbishment in the 1990s when the atrium was filled in and the hall divided into four separate accommodation areas.

[42] There are no plans to refurbish "B" Hall or to install any nets there. In the long term, a new prison will be built and will replace Barlinnie. (Modern prisons are designed as single-storey buildings thus removing any dangers associated with falls from heights.) The issue of nets has been explored in earlier fatal accident inquiries and has been the subject of debate within prison services at local, national and international level. Policy - in Scotland generally and Barlinnie specifically - has been reviewed from time to time and recently. Not only are there no plans to install nets, the recommendation is to have the net is "C" Hall removed as soon as resources allow.

[43] The term "net" is something of a misnomer. These are no soft, flexible nets made from a springy material. Rather they are hard, flat, rigid structures made of reinforced steel which are bolted on. They are used as a means of protection rather than a safety feature. They are used to protect vulnerable prisoners and staff on lower floors from debris or missiles thrown from above. They are not used for the purpose of preventing suicide. Indeed, anyone falling from a height and landing on such a net is likely to sustain serious or fatal injury.

[44] There are significant operational difficulties associated with nets. Collected dirt, dust, food debris and other items give rise issues of health and hygiene, together with operational difficulties associated with cleaning and maintenance. A more fundamental objection is on environmental grounds. In the last decade, there has been a shift away from containment and physical barriers towards techniques prevention and risk assessment engaging human techniques (such as the ACT strategy) as a far more effective means of managing and reducing the risk of suicide in prisons. Nets are considered to create a claustrophobic and oppressive atmosphere both for the prisoners and for the staff who work there. This is particularly so where nets are installed on several levels. They are not, therefore, conducive to a supportive environment. Moreover, as nets tend to obscure and restrict vision, they can give rise to operational difficulties and security concerns for the safety of staff.

[45] There requires to be a balance between the protection afforded by nets and the associated environmental and operation problems. The negative features of nets seem heavily to outweigh the benefits. Furthermore, when it is considered that a very small

number of prisoners choose to commit suicide by jumping to their deaths, the erection of nets as a means of suicide prevention (if, indeed they *would* safely break a fall) would appear to be a disproportionate response in all the circumstances.

[46] It was suggested that another option might be increase the height of the railings with floor to ceiling wire mesh or by enclosing he space above the current railing with Perspex so that it was impossible for a prisoner to climb onto and over the balcony. Such a proposal attracted the same criticism as the nets, effectively placing staff and prisoners in a cage and creating an unjustifiably oppressive environment.

[47] The sad fact remains that a prisoner determined to take his own life will find the means to do so. In Scotland, the evidence is that the approach enshrined in the ACT strategy appears to be working. The number of suicides has fallen significantly. But there will always be prisoners who, like Mr Duthie, give no indication that they are in crisis, display no outward signs that they are suicidal and whose actions are entirely unforeseeable.