

**SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW**

**[2026] FAI 17**

GLW-B1670-24

**DETERMINATION**

**BY**

**SHERIFF JONATHAN GUY**

**UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC  
(SCOTLAND) ACT 2016**

into the death of

**MICHAEL CHARLTON**

Glasgow, 15 April 2026

**DETERMINATION**

The sheriff, having considered the information presented at the inquiry, Determines that in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (the Act) the following:

**STATUTORY FINDINGS**

1. In terms of section 26(2)(a) of the Act, Mr Michael Charlton, born 18 May 1985, died at HMP Barlinnie, 81 Lee Avenue, Glasgow, at 1800 hours on 28 October 2019.
2. In terms of section 26(2)(b) of the Act, the death was not due to an accident.
3. In terms of section 26(2)(c) of the Act, the cause of death was hanging.
4. In terms of section 26(2)(d) of the Act, the death was not due to an accident.

5. In terms of section 26(2)(e) of the Act, the following reasonable precautions might realistically have resulted in the death being avoided:

- **Finding 1** - It was a reasonable precaution for officers at HMP Barlinnie to have observed Mr Charlton every 15 minutes, between 1600 and 1745 hours, on 28 October 2019, in accordance with healthcare staff's instructions and the Scottish Prison Service's (SPS) Management of Offender at Risk due to any Substance policy (MORS).
- **Finding 2** - It was a reasonable precaution for Mr Charlton's personal data, that he could not attend a visit with his partner, Ms Tait, because he was "under the influence", not to be shared with Ms Tait when she visited HMP Barlinnie, in accordance with the SPS's policy in respect of the Data Protection Act 2018 and General Data Protection Regulation (GDPR).
- **Finding 3** - It was a reasonable precaution for officers at HMP Barlinnie to have initiated the SPS's suicide prevention system, Talk to Me (TTM), in respect of Mr Charlton, at around 1530 hours on 28 October 2019, or when he said to an officer that he intended to kill himself, whichever occurred sooner.

6. In terms of section 26(2)(f) of the Act, the following defects in any system of working contributed to the death:

- **Finding 1** – It was a defect in the system at HMP Barlinnie in respect of MORS, to not require a specific officer to observe prisoners who had been placed on MORS and complete the observation documentation.
- **Finding 2** – It was a defect in the system at HMP Barlinnie in respect of MORS, to not require officers coming on duty to be informed by the outgoing officers of the prisoners that had been placed on MORS, as well as the frequency and type of observation that required to be undertaken in relation to them.
- **Finding 3** – It was a defect in the SPS's implementation of MORS, to have failed to provide officers with suitable and sufficient training in relation to this policy and the system that it sought to create.
- **Finding 4** – It was a defect in the system at HMP Barlinnie in respect of MORS, to have failed to adequately check and monitor that it was being complied with.
- **Finding 5** – It was a defect in the MORS and TTM systems that they do not interact in a manner that prevented officers at HMP Barlinnie from attributing the warnings signs of suicide that Mr Charlton was exhibiting to his intoxication.

7. In terms of section 26(2)(g) of the Act, the following facts are relevant to the circumstances of the death:

- **Finding 1** – The SPS’s planning and implementation of MORS at HMP Barlinnie was defective due to the failure to ensure that Greater Glasgow Health Board (GGHB) would implement aspects of this policy.
- **Finding 2** – Officers at HMP Barlinnie removed prisoners from association without authority as they incorrectly believed that this is authorised by MORS.
- **Finding 3** – It was a defect in the SPS’s suicide prevention system to have not carried out an assessment of the ligature risks in standard cells at HMP Barlinnie prior to Mr Charlton’s death.
- **Finding 4** – The care plans for prisoners that have been placed on MORS at HMP Barlinnie, have not been completed in accordance with this policy, as healthcare staff have not specified the type of observation that is to be completed in addition to the frequency of observations.
- **Finding 5** - The Death in Prison Learning, Audit and Review (DIPLAR) in relation to Mr Charlton was inadequate, as it failed to identify the defects in the system at HMP Barlinnie in respect of MORS, the failures by officers in respect of this death, and the steps that required to be taken to prevent other prisoners dying in similar circumstances.
- **Finding 6** – The SPS’s system for ensuring that HMP Barlinnie addressed its failure to comply with MORS was ineffective, as it relied on assurances

provided by this prison that it had resolved the identified issues without critically reviewing and verifying the information provided by this prison.

## **RECOMMENDATIONS**

The sheriff, having considered the information presented at the Inquiry, makes the following recommendations in terms of section 26(1)(b) and (4) of the Act:

**Recommendation 1** - As soon as reasonably practicable, the SPS should put in place a written system of work at HMP Barlinnie in relation to MORS that:

- Requires a specific officer to observe prisoners that have been placed on MORS and complete the observation documentation.
- Requires managers to actively monitor compliance with MORS to ensure that the required observations are carried out during every shift.
- Specifies the procedure that is to be followed in relation to the aspects of MORS that GGHB have refused to undertake.
- Specifies that MORS does not provide authority for removing prisoners from association, and if this is deemed necessary, the appropriate procedure (such as that prescribed under Rules 41 or 95 of The Prison and Young Offenders Institutions (Scotland) Rules 2011) should be followed.
- Requires healthcare staff to specify the type of observation that is to be undertaken for prisoners that have been placed on MORS when completing a prisoner's care plan. This should include the type of observation that

requires to be undertaken for prisoners that are sleeping and when it is appropriate to wake them for the purpose of carrying out observations.

- Specifies the procedure that is to be followed to ensure that officers coming on duty are made aware of the prisoners that have placed on MORS, as well as the frequency and type of observation that requires to be undertaken in respect of them.

**Recommendation 2** - As soon as reasonably practicable, the SPS should ensure that it provides officers at HMP Barlinnie with suitable and sufficient training on this prison's system for implementing MORS.

**Recommendation 3** – As part of the audits that FLMs undertake at HMP Barlinnie in relation to MORS, they should investigate whether the failure by officers to complete the observation documentation is because they have not undertaken the required observations and ensure that any failure to comply with these aspects of the system is appropriately addressed.

**Recommendation 4** - As soon as reasonably practicable, the SPS should amend MORS so that it:

- Requires a specific officer to observe prisoners that have been placed on MORS and complete the observation documentation.
- Ensures that compliance with this policy is actively monitored by managerial staff during every shift.

- Interacts with the TTM system in a manner that prevents officers from attributing the warning signs of suicide that Mr Charlton was exhibiting to intoxication.
- Specifies that when a prisoner is placed on MORS their person and cell are searched to remove their access to illegal substances.
- Specifies the type of observation that requires to be undertaken for prisoners that are sleeping, including when it is appropriate to wake them for the purpose of carrying out observations.
- Does not include a requirement for another organisation (such as GGHB) to undertake tasks that they have not consented to undertaking.

**Recommendation 5** - As soon as reasonably practicable the SPS should ensure that all its staff that are responsible for implementing MORS are provided with suitable and sufficient training in respect of this policy and the system for implementing it within the prison in which they work.

**Recommendation 6** - As soon as reasonably practicable the SPS should revise its TTM system so that it prevents officers from incorrectly attributing the warning signs of suicide that Mr Charlton was exhibiting to intoxication.

**Recommendation 7** - As soon as reasonably practicable the SPS should carry out a suitable and sufficient assessment of the ligature risks within standard cells at HMP Barlinnie and eliminate any risks that are identified so far as is reasonably practicable.

**Recommendation 8** – The SPS should consider the failings in the DIPLAR in respect of Mr Charlton’s death to ensure that the DIPLAR system provides a suitable and sufficient

method of establishing the cause of death of prisoners, any failings in relation to these deaths and the actions that require to be taken to ensure that other prisoners do not die in similar circumstances.

**Recommendation 9** – The SPS should consider its failures in respect of MORS and revise its system for implementing its policies, checking and monitoring that they are complied with and addressing issues of non-compliance identified within its prisons.

**NOTE:**

**THE PURPOSE OF THE INQUIRY**

[1] This inquiry is governed by the provisions of the Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (the Rules). It is a mandatory inquiry under sections 2(1) and 2(4)(a) of the Act, as the death occurred whilst the deceased was in legal custody. In terms of section 1(3) of the Act, the purpose of the inquiry is to (a) establish the circumstances of the death and (b) to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. The procurator fiscal represents the public interest and is required under section 1(1)(a) of the Act to investigate the circumstances of the death.

[2] Section 26(1) of the Act requires the sheriff to issue a determination setting out (a) in relation to the death to which the inquiry relates, their findings as to the circumstances mentioned in section 26(2), and (b) such recommendations (if any) as to any matters mentioned in section 26(4) as they consider appropriate.

[3] The circumstances mentioned in section 26(2) are:

- (a) When and where the death occurred.
- (b) When and where any accident resulting in the death occurred.
- (c) The cause or causes of the death.
- (d) The cause or causes of any accident resulting in the death.
- (e) Any precautions which— (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided.
- (f) Any defects in any system of working which contributed to the death or any accident resulting in the death.
- (g) Any other facts which are relevant to the circumstances of the death.

[4] Under section 26(4), the sheriff is to make such recommendations (if any) as they consider appropriate as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

**Sections 26(2)(a) to (d) – facts in relation to the death**

[5] Sections 26(2)(a) to (d) of the Act require the sheriff to undertake a fact-finding function based on the evidence led at the inquiry.

**Section 26(2)(e) – reasonable precautions**

[6] In relation to section 26(2)(e) of the Act, the explanatory notes state:

“In subsection (2)(e)(i), ‘reasonably’ relates to the reasonableness of taking the precautions rather than the foreseeability of the death or accident. A precaution

might realistically have prevented a death if there is a real or likely possibility, rather than a remote chance, that it might have so done.”

[7] This is consistent with section 6(1)(c) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (the equivalent section in the predecessor legislation to the Act). In *Sutherland v Lord Advocate* 2017 SLT 333, Lord Armstrong discusses the interpretation of this section and states at para [31] of his judgment that:

“Lively possibility. Such a description is entirely apt and is consistent with the language of s.6(1)(c). According the provision its ordinary meaning, certainty or probability are not relevant considerations in determining whether the death might have been avoided. Further, given the nature of the process as I have described it, in considering whether a precaution is reasonable, foreseeability has no part to play. That question falls to be determined with the benefit of hindsight, and a finding that the death might have been avoided by the application of a reasonable precaution carries no implication that the failure to take the precaution was negligent or unreasonable.”

[8] The First Division of the Inner House provided guidance on the interpretation to be applied to section 26(2)(e) of the Act in *Dr Karen Duncan v Lord Advocate* [2025] SLT 1199. The opinion of the court was delivered by Lord President (Pentland). After discussing the background to this section of the Act at paras [30] to [37], his Lordship states at para [53] that:

“These considerations explain why it is important that a wide power has been conferred on the sheriff to identify any precautions which could have been taken which might have avoided the death. The identification of such precautions, even though it may have been reasonable not to take them in the particular circumstances of the case, may serve to encourage reflection and re-evaluation of established practices and understandings by interested parties, such as government, local authorities, statutory bodies, regulators, professional bodies, training authorities and the like.”

[9] The Lord President further states at para [58] that Lord Braid's following analysis, at paragraph 46 in *Marion Bellfield* [2011] FAI 21, "encapsulates the correct approach under the Act":

"I have already pointed out that negligence is not in issue and that it is not the function of this inquiry to attribute blame. It is therefore nothing to the point to inquire as to whether what was done was reasonable, and it seems to me to involve a non sequitur to hold that a precaution which was not taken can be held to have been reasonable only if what was done was not reasonable. To take that approach respectfully seems to me to apply the principles and language of negligence, which are irrelevant for the purposes of this inquiry. I do not see why it is not open to me to hold that, even though what was done was reasonable, other reasonable precautions might also have been taken which might have prevented the death."

#### **Section 26(2)(f) - system defects**

[10] For a finding to be made under section 26(2)(f), there must be a causal connection between the defect identified and the death. I agree with Sheriff Collins' observation in the inquiry into the deaths of *Katie Allan and William Brown* [2025] 1 WLUK 631 that the "but for" test does not apply to this section.

[11] The first step in interpreting this section is to identify the meaning of the words used by Parliament in the context of the legislation in which they appear (*R(O) v Home Secretary* [2023] AC 255, at paragraph 29). The key word that is used in the section in relation to causation is "contributed". This is defined in the Cambridge Dictionary as "to be one of the reasons why something happens". It is therefore apparent from the words used in this section that the defect identified does not need to be the sole or principal cause of the death.

**Section 26(2)(g) - facts which are relevant to the circumstances of the death**

[12] Section 26(2)(g) of the Act permits the sheriff to make findings in relation to the death when the causal connection required in sections 26(2)(e) and (f) is not present.

**Section 26(4) - recommendations**

[13] Section 26(4) of the Act provides the sheriff with significant discretion in relation to the recommendations that they make and only qualifies this to the extent that they must realistically be capable of preventing other deaths in similar circumstances.

**Other provisions of relevance in the Act**

[14] As a result of section 26(6) of the Act, the determination shall not be admissible in evidence or be founded on in any judicial proceedings of any nature. The purpose of this provision is to encourage a full and open exploration of the circumstances of a death, and in terms of section 1(4) of the Act, it is not the purpose of the inquiry to establish civil or criminal liability.

**Evidential issues**

[15] Any evidential issues in the inquiry require to be determined based on the civil standard of proof, the balance of probabilities.

**THE PROCEDURE IN THIS INQUIRY**

[16] Following the lodging of notice of inquiry, and Form 3.1, a preliminary hearing took place on 19 December 2024. During the inquiry, Ms Ramage, procurator fiscal depute, represented the Crown, Ms Arnott, advocate, represented the Scottish Ministers

(acting on behalf of the SPS), Ms McGinley, advocate, represented the family of Mr Charlton, Mr Rodgers, solicitor, represented the Prison Officers Association (POA), Ms Paton, solicitor, represented GGHB and Mr Kavanagh, solicitor, represented Mr Iain Templeton.

[17] Prior to evidence being led, I made various orders to identify the issues in the inquiry and to reduce the necessity for witnesses to give oral evidence. This included ordering parties to prepare a joint statement of issues, to agree a joint minute of admissions in respect of any uncontroversial evidence and to lodge affidavits or witness statements for any witness that they intended to call.

[18] All the participants, and those representing them, cooperated fully in respect of these orders, including agreeing various joint minutes of agreement. The evidence was heard over 14 days, with parties making submissions in writing and orally at the conclusion of the evidence on 22 January 2026.

[19] Various documents were lodged during the inquiry, some of which were lodged late. Except for emails that GGHB sought to lodge after the evidence had concluded, I allowed these documents to be lodged. The lodging of these emails was opposed by the Scottish Ministers on the basis that the evidence had concluded, and if this was allowed, it would necessitate further investigation and evidence.

[20] I refused GGHB's motion to lodge these emails as I considered that it had not explained why it did not provide them to Ms Paton prior to the conclusion of the evidence. I also did not regard the information contained in the emails as essential to

my determination, and I was concerned that their introduction would delay the conclusion of the inquiry, including identifying dates for further evidence to be led.

[21] The family of Mr Charlton were concerned by the late disclosure of information shortly before the conclusion of the evidence by the SPS, POA and Officer Templeton. This concerned the disclosure, following a question by me, about whether some prison officers involved in Mr Charlton's death had been disciplined. It also concerned a document that had been obtained by the Crown in relation to the causes of suicides in Scottish prisons, which was held by the SPS.

[22] The information regarding the disciplinary proceedings concerning the officers was addressed by the participants agreeing the relevant information in the 4<sup>th</sup> joint minute of agreement. In relation to the document that had been obtained by the Crown from the SPS, I allowed this to be lodged late.

[23] Although it was unfortunate that this information came to light shortly before the conclusion of the evidence, I do not consider that it was the result of any intentional failure to cooperate by any of the participants.

[24] All the participants took a sensible approach to the evidence, which meant that it was largely uncontroversial and the cross-examination of witnesses was limited. I do not therefore consider that it will assist the participants, or anyone that reads this determination, for me to set out the terms of the various joint minutes, which are in excess of 50 pages, and provide what would need to be a very lengthy summary of the evidence before the inquiry. The joint minutes are with the court process should they need to be consulted.

[25] I have set out the findings in fact that I consider are necessary to explain my findings and recommendations under the Act. The participants helpfully lodged detailed written submissions, which I refer to as appropriate in providing the reasons for my findings and recommendations. These are also with the court process should they need to be consulted.

### **FINDINGS IN FACT**

[26] The following facts were either agreed or established by the evidence before the inquiry.

#### **The SPS's polices and systems that are relevant to Mr Charlton's death**

- (1) On 30 December 2014, the SPS issued a Governor's and Managers Action (GMA) to HMP Barlinnie, requiring it to implement MORS, which it created following the death of a prisoner that had died from taking an illegal substance.
- (2) MORS provides that if an officer suspects that a prisoner is at risk due to a substance (whether due to being under the influence or having ingested or secreted a substance) an Observation Referral form within Appendix A should be completed. Healthcare staff should undertake an assessment and, if appropriate, complete a clinical test to establish the substance taken. Healthcare staff should complete the care plan within Appendix C, specifying the frequency and type of observation (visual and/or verbal) that is to be completed, and when the prisoner should be reviewed by them.

- (3) MORS requires officers to carry out general observations of a prisoner's presentation to establish if medical intervention is required. These are operational, not clinical observations. Officers are not clinically qualified and are not expected to assess the health of prisoners. Observations are to be carried out in accordance with the care plan and should be recorded within the observation documentation by the officer who undertook them. Visual observations are intended to observe the prisoner's presentation. Verbal observations require a clear and coherent response from the prisoner. If their speech is slurred or incoherent, the officer should seek assistance from healthcare staff or the on-call doctor.
- (4) A multi-disciplinary case conference (MDCC) should be arranged with healthcare staff to discuss the future management of the prisoner. The MDCC should take place as soon as practicable and no longer than 24 hours after the prisoner is placed on MORS. It is the function of the MDCC to co-ordinate any agreed referrals, such as prison-based addictions services. An intelligence-based Incident Report should be submitted to the Intelligence Management Unit, and a Reasonable Suspicion drug test form should be submitted to the Drug Testing Co-ordinator. The MDCC is to be documented on the Case Conference Record within Appendix E.
- (5) MORS does not provide authority to remove prisoners from association, including confining them to their cell. It provides that a First Line Manager (FLM) should consider the potential application of Rule 95 of The Prison

and Young Offenders Institutions (Scotland) Rules 2011 (hereinafter referred to as the Prison Rules) if this is necessary.

- (6) Rule 95 of the Prison Rules provides the Governor with the power to order a prisoner to be removed from association, either generally or in respect of prescribed activities. A Rule 95 order may only be made when the Governor is satisfied that removal from association is necessary for maintaining good order or discipline, protecting the interests of any prisoner and / or ensuring the safety of other persons.
- (7) An application for a Rule 95 order is initiated on the SPS's prisoner record system (PR2), which marks the official start time of the order. It should be authorised by the Governor, or a senior Operational Manager, within an hour where practically possible, and no later than 24 hours, or the application will lapse. Whilst the application is being processed, temporary removal from association may commence. The maximum initial period for a Rule 95 order is 72 hours from the time of the application. An extension beyond this period must be authorised by the Scottish Ministers. The Governor may revoke or amend the order when they consider it appropriate to do so. This procedure recognises the significance of removing a prisoner from association and provides an important safeguard against this step being taken unless it can be justified.
- (8) Rule 41 of the Prison Rules provides an alternative basis upon which a prisoner's right to association can be restricted. It provides that a Governor

must order that a prisoner be accommodated in specified conditions when a healthcare professional (a) advises the Governor that it is appropriate to do so in order to protect the health or welfare of the prisoner, or other prisoners, and (b) informs the Governor of the care and treatment planned for the prisoner while the prisoner is accommodated in specified conditions, which include a specified part of the prison, accommodation separate from other prisoners and confining the prisoner to their cell.

- (9) The SPS's implementation of MORS was defective insofar as it applied to HMP Barlinnie, as it failed to obtain GGHB's consent to undertaking aspects of the policy (such as participating in MDCCs and completing the care plan in Appendix C) prior to sending it to this prison with an instruction to implement it fully.
- (10) When GGHB were provided with MORS, after it had been sent to HMP Barlinnie, it communicated to the SPS that it would not participate in MDCCs and complete the care plan in Appendix C of this policy.
- (11) The SPS's implementation of MORS was defective as it did not plan to formally train officers to ensure that they understood their role and responsibilities in relation to the policy and the system that it sought to create.
- (12) Between 30 December 2014 and 26 October 2019, the SPS's implementation of MORS at HMP Barlinnie was defective as: (a) it failed to put in place suitable and sufficient arrangements to ensure that key aspects of this

policy, such as the completion of observations and documentation were complied with; (b) it did not provide suitable and sufficient training to officers; (c) it did not adequately check and monitor whether the system was being complied with; (d) it failed to adequately address GGHB's refusal to undertake aspects of the MORS system; and (e) it failed to adequately address the poor practices of officers that were responsible for implementing MORS.

- (13) Between 30 December 2014 and 28 October 2019, these defects in the SPS's implementation of MORS at HMP Barlinnie contributed to officers developing practices that resulted in: (a) officers completing the documentation for observations that they had not themselves undertaken; (b) officers not completing the relevant observation documentation at the time the observation was carried out; (c) officers completing entries for multiple observations at the same time without recording the response provided by the prisoner; (d) managers not effectively supervising officers; (e) officers going on their break without informing patrol staff of the prisoners that had been placed on MORS, as well as the frequency and type of observation that required to be undertaken in relation to them; and (f) officers removing prisoners that had been placed on MORS from association without this being appropriately authorised.
- (14) The SPS introduced TTM in 2016, which replaced Act 2 Care as its suicide prevention system in its prisons.

- (15) To comply with its duties under Data Protection Act 2018 and GDPR the SPS introduced policies to ensure that its officers did not unlawfully disclose the personal data of prisoners. Officers were trained in respect of these policies. As part of this training, officers were advised that it is unlawful to disclose any personal data regarding a prisoner to a visitor, even if they are a member of the prisoner's family.

**Mr Charlton and his circumstances at HMP Barlinnie prior to his death**

- (16) On 9 August 2019, Mr Charlton appeared on petition at Glasgow Sheriff Court and was remanded at HMP Barlinnie. On 16 August 2019, his remand was continued and he was given cell 3/20 within Delta Hall North Upper, which is contained within Delta Hall at HMP Barlinnie.
- (17) Delta Hall at HMP Barlinnie is split into four units. There is a main desk for the hall and a desk within each unit. Ordinarily, three officers will be assigned to each unit. The main desk is additionally staffed by a desk officer who is usually an experienced officer. The desk officer holds information about the numbers within the hall as well as any prisoners that are to be observed. A FLM will also be present. With a full staff compliment, there should be 13 officers and an FLM on duty during a shift on Delta Hall. During break times, patrol officers carry out some of the functions of these officers, including observing prisoners that have been placed on MORS and TTM.

- (18) On 16 August 2019, Mr Charlton admitted abusing heroin, diazepam and cocaine prior to being remanded.
- (19) On 27 August 2019, Mr Charlton told healthcare staff that he was feeling depressed and suffering from anxiety.
- (20) On 2 September 2019, Mr Charlton was seen by a doctor who prescribed him Mirtazapine as he said that he was depressed.
- (21) Mr Charlton had been in a relationship with Ms Lyndsay Tait for around three years at the time of his remand. Their relationship was affected by his addiction issues. Ms Tait did not initially visit him at prison. In September 2019, she heard that he had stopped taking illegal drugs and visited him around once a week after this. They spoke each day on the telephone, making plans for when he was released from prison, including getting married.
- (22) Mr Charlton was liked within HMP Barlinnie by staff and his fellow prisoners. He did not act aggressively towards staff.
- (23) Around 24 October 2019, one of Mr Charlton's fellow prisoners died by suicide. Mr Charlton was aware of this.
- (24) On 25 October 2019, at 2034 hours, Mr Charlton made a telephone call from HMP Barlinnie to Ms Tait. Ms Tait asked him if he was ok and said that he did not sound his "usual self". Mr Charlton responded by saying that everyone keeps asking him about the prisoner that had died by suicide. He

said that he would not take drugs again. Ms Tait said she would leave him if he failed a drugs test.

**26 October 2019, when Mr Charlton was first observed by officers to be intoxicated**

- (25) At 0830 hours, Officer Mduze Dube observed that Mr Charlton had a cut on his left eye, that his speech was slurred and he appeared unsteady on his feet.
- (26) At 0900 hours, Officer Dube decided that Mr Charlton was intoxicated and completed an Observation Referral form for an Offender at Risk Due to a Substance. She had never received any formal training on MORS but was aware that the policy existed, as it had been shown to her. This led to Mr Charlton being examined by Nurse Laura Crossan. During this examination, Mr Charlton denied taking an illegal substance.
- (27) Officer Dube conducted a search of Mr Charlton and his cell. She failed to follow the procedure of recording that she had undertaken these searches on PR2.
- (28) Nurse Crossan did not complete the care plan in Appendix C of MORS in respect of Mr Charlton. She completed an NHS document specifying that Mr Charlton was to be observed every 15 minutes. This document does not require the type of observation to be specified, and this information was not included in the document.

- (29) Officer Dube completed the care plan in Appendix C of MORS, which is supposed to be completed by healthcare staff, recording that Mr Charlton was to be observed every 15 minutes. She did not specify whether verbal and visual observations were to be completed.
- (30) In accordance with the procedure at HMP Barlinnie in respect of prisoners that had been placed on MORS, Officer Dube prevented Mr Charlton from associating with other prisoners by confining him to his cell without this being authorised.
- (31) Although Mr Charlton was observed by Officer Dube to be intoxicated, she considered that he appeared well.

#### **27 October 2019, Mr Charlton's behaviour changes**

- (32) Mr Charlton was reviewed by Nurse Amy Smith on 27 October 2019. She recorded that he was still under the influence of a substance and there was vomit on the floor of his cell.
- (33) Ms Tait attended at HMP Barlinnie at around 1400 hours in respect of a pre-arranged visit with Mr Charlton. She went to the area for visitors, was given a number and waited on Mr Charlton attending. Officer Dube then received a call from Officer Francis Hunstone, who was working within the visitor's area, advising her that Mr Charlton had received a visitor. Officer Dube advised Officer Hunstone that Mr Charlton could not attend his visit because he was being observed in accordance with MORS. Officer Hunstone called out Ms Tait's number, took her to a side door and

informed her that Mr Charlton was not allowed to attend the visit as he was “under the influence”. Ms Tait asked Officer Hunstone what he meant by “under the influence”. Officer Hunstone said he could not say and that Mr Charlton would need to tell her. He also said that a lot of prisoners take legal highs and that it could be that.

- (34) Officer Hunstone should not have shared this information with Ms Tait as this was contrary to the SPS’s policy in relation to the sharing of personal data under the Data Protection Act 2018 and GDPR. It was also contrary to the training provided to staff in relation to this policy.
- (35) Ms Tait was angry and upset when she was provided with this information, as she considered that Mr Charlton had broken his promise to her that he would not continue to take illegal drugs.
- (36) Following the cancellation of this visit, Mr Chalton was allowed to make a telephone call to Ms Tait. Prior to doing so, Officer Dube told him that his partner had attended for a visit but had been turned away as he was unfit to attend. Mr Charlton was unhappy with this and said to Officer Dube that this was her fault.

- (37) At 1546 hours, Mr Charlton telephoned Ms Tait and the following conversation took place:

**Ms Tait** - Under the influence, aye?

**Mr Charlton** - What?

**Ms Tait** - Aye, they telt me that you're on drugs.

**Mr Charlton** - I'm on drugs?

**Ms Tait** - Aye that's why you couldn't come to your visit cos they told me that you're under the influence of drugs.

**Mr Charlton** - Oh my God Lyndsay.

**Ms Tait** - Listen to the state of you, you can hear it in you, they said they're monitoring you cos you're on drugs

**Mr Charlton** - (talking to someone else) Oh my god, she trying to say I'm on drugs. Fuck it I fell and banged my head fucksake.

**Ms Tait** - Naw, they told me. They just told me when I was up at the visit

**Mr Charlton** - (Stutters, unable to decipher)

**Ms Tait** - They couldn't tell me what you were taking but they told me you can't make your visit cos you're under the influence of drugs.

**Mr Charlton** - I wisnae influence.

**Ms Tait** - You are. You fucking are ya lying xxxx. Don't phone me ever again. I'm blocking this number. Goodbye Michael".

- (38) Following this telephone call, Mr Charlton smashed the telephone and charged towards Officer Dube whilst saying that she was a "fucking rat" and "dirty scumbag". He was ushered back to his cell and warned regarding his behaviour by other officers. He then clenched his fists, gritted his teeth and said to Officer Dube that he was going to kill her.
- (39) No verbal observations are recorded in the MORS documentation in respect of Mr Charlton between 2130 and 2400 hours. The only entry that is made for this period is "appears asleep".

**28 October 2019, the day that Mr Charlton died**

- (40) No verbal observations are recorded in the MORS documentation in respect of Mr Charlton between 2400 and 0645 hours.
- (41) At around 0700 hours, Officer Dube completed a suspected breach of discipline report in respect of Mr Charlton's conduct on 27 October 2019.

In this report, Officer Dube wrote:

"At 1500 hrs on Sunday 27/10/19...Michael Charlton was declined a family visit with his partner due to being placed on MORS. At 1540 hrs he (sic) and was allowed out of his cell to make a call to his partner. During the phone call, his partner stated that she was not happy with him as she had been declined a visit due to him taking substances, which resulted in her terminating his phone call. Prisoner Charlton proceeded to smash the phone of the receiver and began charging towards myself, (sic) I was situated at the feeding station at the end of the section he went past Officer Reid and Officer McRoberts. He was calling me a 'fucking rat' and 'dirty scumbag...He was ushered back to his cell. He was warned regarding his behaviour and inappropriate language towards me. He was clenching his fists and gritting his teeth while threatening me at his door".

- (42) Officers Alexander Gemmel and Steven Fyfe were on duty with Officer Dube in Delta Hall North Upper at HMP Barlinnie. They had not received any formal training in relation to MORS.
- (43) Mr Charlton damaged his television during the morning. Officer Dube, and another officer, removed his television and blankets that he had vomited on from his cell.
- (44) Mr Charlton continued to blame Officer Dube for his visit with Ms Tait having been cancelled. Due to this, and Mr Charlton's previous aggressive behaviour towards her, she agreed with officers Gemmel and Fyfe that she

should have limited contact with him. In terms of the practice that was used on occasions at HMP Barlinnie, they agreed that they would adopt a collective approach to observing Mr Charlton and documenting the observations, whereby officers Fyfe and Gemmel would observe Mr Charlton and Officer Dube would complete the observation documentation. There was no operational reason that would have prevented officers Gemmel or Fyfe from carrying out the observations and completing the observation documentation, without involving Officer Dube.

- (45) A prisoner that had been placed on MORS would not normally be allowed to make telephone calls at HMP Barlinnie. Due to the extent to which Mr Charlton was distressed, the officers in Delta Hall agreed that he would be allowed to do so.
- (46) As the day progressed, Mr Charlton repeatedly asked the officers in Delta Hall to be allowed to make a telephone call. When he did so, he was observed by Officer Fyfe to slur his words.
- (47) FLM Gillian Crossan was on duty within Delta Hall at HMP Barlinnie. She had not received any formal training on MORS. She was asked by the FLM on the morning shift to make an application for a Rule 95 order in respect of Mr Charlton. She made the application at 1326 hours, and the order was approved at 1431 hours, which provided authority for Mr Charlton to be confined to his cell.

- (48) At some point during the day, Officer Fyfe entered Mr Charlton's cell and observed that he had adopted an aggressive stance and that he had wrapped a sheet around a small television unit so that it formed a handle. As this could potentially be used as a weapon, Officer Fyfe arranged for these items to be removed from his cell.
- (49) At an unknown time, Mr Charlton threw a plate at an unknown officer after he had made a telephone call to Ms Tait.
- (50) The CCTV footage of Delta Hall North Upper shows that between 0655 and 1532 hours, Mr Charlton was not visually observed every 15 minutes in accordance with healthcare staff's instructions, and MORS, during the following periods: between 0709 and 0747 hours; between 0747 and 0838 hours; between 0841 and 0942 hours; between 1009 and 1138 hours; between 1201 and 1254 hours; between 1303 and 1320 hours; between 1322 and 1405 hours; between 1420 and 1446 hours and between 1447 and 1515 hours.
- (51) Verbal observations were recorded in the MORS documentation relating to Mr Charlton between 0700 and 1315 hours. No verbal observations were recorded after this time despite the officers believing that they required to be completed.
- (52) Mr Charlton spoke with officers through the intercom system from his cell at 0710, 0730, 0749, 0805, 0820, 0857, 0910, 0946, 0949, 0954, 1034, 1103, 1125, 1231, 1251, 1304, 1312, 1324, 1345, 1352, 1403, 1427, 1509 and 1513 hours.

During most of these conversations, he asked if he could use the telephone.

The officers that spoke to him did not follow the procedure that is specified in MORS when carrying out verbal observations.

(53) Mr Charlton was examined by Dr Grace Campbell at around 1151 hours.

Dr Campbell observed that he had bruising around his left eye, and eyebrow, and that he appeared sedated and vague. She decided that he should remain under a management plan.

(54) When Mr Charlton spoke with a prison officer at 1403 hours through the intercom system, the officer that he spoke to would have heard him cry.

(55) Mr Charlton made a telephone call to Ms Tait at 1521 hours. During this telephone call he said that he intended to kill himself.

(56) After making this telephone call, Mr Charlton kicked a bin and cried. This was observed by officers Dube, Fyfe and Gemmel.

(57) Mr Charlton made a further telephone call to Ms Tait at 1527 hours.

During this telephone call he said that he had been suicidal. Ms Tait informed Mr Charlton that he had "blown it" and she did not want to see him again.

(58) Ms Tait considered contacting HMP Barlinnie to let them know that Mr Charlton had said that he intended to kill himself, but decided not to do so, as she believed that he was being observed and would be kept safe.

- (59) At some point following Mr Charlton being placed on MORS, he said that he intended to kill himself to an officer but then said that he had changed his mind.
- (60) As soon as Mr Charlton said that he intended to kill himself, the officer to whom he said this should have initiated TTM in respect of him. Even if the officer to whom he said that he intended to kill himself did not share this information with the other officers on duty on 28 October 2019, they should have initiated TTM in respect of him at around 1530 hours, after the repeated telephone calls that he made to Ms Tait when he was observed to be distressed.
- (61) The officers did not initiate TTM in respect of Mr Charlton as they attributed his behaviour, some of which is listed as warning signs of suicide in the "cues and clues" section of TTM, to him being intoxicated. This was partly due to a defect in the TTM and MORS systems that they do not interact in a manner that prevented these officers from attributing these warnings signs of suicide to his intoxication.
- (62) If Mr Charlton had been placed on TTM, this would have facilitated a consistent and robust care plan of observations relating to his mental health, and case conferences involving mental health staff, as well as consideration of additional risk management strategies such as him being placed in a safer cell at HMP Barlinnie and the use of anti-ligature clothing and bedding.

- (63) Safer cells at HMP Barlinnie have been designed to reduce the risk of suicide. Ligature points in these cells have been removed as far as possible, including preventing the windows from being opened.
- (64) Shortly before 1600 hours, Mr Charlton asked Officer Fyfe if he could make a telephone call. Officer Fyfe reassured him that he would be allowed to do so.
- (65) Officers Dube, Fyfe and Gemmel took their break at around 1600 hours. Officer Templeton was the patrol officer allocated to Delta Hall and was required to undertake these officers' responsibilities during their break, including carrying out the observations of prisoners that had been placed on MORS. It had been written on the whiteboard in Delta Hall North Upper that Mr Charlton was to be observed every 15 minutes in accordance with MORS. Mr Walker was the desk officer on duty at this time.
- (66) When Officer Templeton arrived in Delta Hall to provide cover for officers Dube, Gemmel and Fyfe, Officer Walker did not know that Mr Charlton had been placed on MORS. He did not therefore inform Officer Templeton that he required to be observed every 15 minutes in accordance with MORS.
- (67) In terms of the practice at Delta Hall, officers Dube, Fyfe and Gemmel did not inform Officer Templeton of the prisoners that required to be observed in accordance with MORS, as well as the frequency and type of observation that required to be undertaken in relation to them, prior to going on their

break. If this information had been provided to Officer Templeton, he would have known to observe Mr Charlton every 15 minutes. It was a defect in the MORS system at HMP Barlinnie for it not to require officers that were going on their break to provide this information to patrol officers, such as Officer Templeton.

- (68) FLM Crossan was present within Delta Hall during this break period and was aware that Mr Charlton had been placed on MORS. She spoke to Officer Templeton at the start of his patrol shift and said that he should base himself at Delta South Upper, outside the cell of a prisoner who she was concerned about. She did not inform Officer Templeton that Mr Charlton had been placed on MORS and that he required to be observed every 15 minutes.
- (69) Officer Templeton complied with FLM Crossan's instructions and based himself outside this other prisoner's cell between 1600 and 1700 hours. He did not go to Delta Hall North Upper and see that it was written on the whiteboard within this unit that Mr Charlton required to be observed every 15 minutes in accordance with MORS. Neither he, nor any other officer, observed Mr Charlton during this period.
- (70) At around 1700 hours, officers Dube, Fyfe and Gemmel returned from their break and assumed responsibility for the prisoners on Delta Hall North Upper. In terms of the practice on Delta Hall, Officer Templeton did not provide them with a handover in relation to the prisoners that required to

be observed in accordance with MORS, as well the frequency and type of observation that required to be undertaken in relation to them.

- (71) On returning from their break, officers Dube, Fyfe and Gemmel began serving food to the prisoners on the hall. They did not carry out any observations of Mr Charlton between 1700 and 1745 hours, as they assumed that another officer would do so. No observations were carried out in respect of Mr Charlton during this period.
- (72) Sometime between 1600 and 1745 hours, Mr Charlton decided to attempt suicide. This was principally due to the breakdown in his relationship with Ms Tait. He opened the window in his cell, placed a blue bed sheet around the head of the left-hand small window so that it formed a ligature and placed this ligature around his neck. He then transferred his weight to the ligature, which would have jammed the window tight against the window frame, and ended his life.
- (73) At around 1746 hours, Officer Fyfe opened Mr Charlton's cell door and saw that he was hanging from a blue bed sheet that had been tied to the bar of his cell window. He alerted other officers and went to Mr Charlton's body to take the weight off it. Mr Charlton was not breathing and had no pulse. Officer Dube arrived and they removed the ligature, laid Mr Charlton on the floor and Officer Dube tried to resuscitate him.

- (74) Shortly thereafter, Nurse Katie Bell, Dr Grace Campbell and Nurse Lauren McCloseky attended at Mr Charlton's cell and tried to resuscitate him. They were unable to do so and determined that he was dead at 1800 hours.
- (75) During the attempted resuscitation of Mr Charlton, an officer advised Dr Campbell that another officer had reported that Mr Charlton had said that he intended to kill himself but subsequently said that he had changed his mind.
- (76) At an unknown time and date, Officer Dube inaccurately completed the MORS documentation in respect of Mr Charlton, documenting that visual observations were carried out every 15 minutes between 1330 and 1600 hours on 28 October 2019.
- (77) At the time of Mr Charlton's death, an assessment of the ligature risks in standard cells at HMP Barlinnie had not been completed. The failure to carry out such an assessment was a defect in the SPS's system of preventing suicides within HMP Barlinnie, as hanging from a ligature is a common cause of suicide in prison.
- (78) A subsequent post-mortem identified Mr Charlton's cause of death as hanging.
- (79) After determining that Mr Charlton was intoxicated from taking an illegal substance, it was a reasonable precaution for officers to have observed him every 15 minutes, between 1600 and 1745 hours, on 28 October 2019, in

accordance with healthcare staff's instructions and MORS. If this precaution had been taken it might realistically have avoided his death.

- (80) It was a reasonable precaution for Mr Charlton's personal data, that he could not attend a visit with Ms Tait because he was "under the influence", not to be shared with Ms Tait when she visited HMP Barlinnie, in accordance with the SPS's policies in respect of the Data Protection Act 2018 and GDPR. If this precaution had been taken it might realistically have avoided his death.
- (81) It was a reasonable precaution for officers at HMP Barlinnie to have initiated TTM in respect of Mr Charlton, at around 1530 hours on 28 October 2019, or when he said to an officer that he intended to kill himself, whichever occurred sooner. If this precaution had been taken it might realistically have avoided his death.
- (82) The following defects in the SPS's system of working in respect of MORS at HMP Barlinnie contributed to Mr Charlton's death: (a) to not require a specific officer to carry out the observations, and complete the observation documentation, for prisoners that had been placed on MORS; (b) to not require officers to provide a handover at break times to officers coming on duty, informing them of the prisoners that had been placed on MORS, as well as the frequency and type of observation that required to be undertaken in relation to them; (c) to fail to provide officers with suitable and sufficient training in relation to the MORS; (d) to have not adequately

checked and monitored that MORS was being complied with; and (e) that the MORS and TTM systems did not interact in a manner that prevented officers from attributing the warnings signs of suicide that Mr Charlton was exhibiting to his intoxication.

### **Circumstances following Mr Charlton's death**

- (83) In relation to any death of a prisoner in a Scottish prison, the SPS carry out a DIPLAR. One of the main purposes of this system is to identify the cause of the death and to take steps to avoid similar deaths occurring. The DIPLAR in respect of Mr Charlton's death took place on 13 December 2019 and a report setting out the findings from this is dated 13 March 2020.
- (84) The DIPLAR in relation to Mr Charlton was not a full and thorough investigation of the circumstances of his death as: (a) it failed to investigate which officer said to Dr Campbell that Mr Charlton had informed an officer that he intended to kill himself but subsequently said that he had changed his mind; (b) it failed to investigate why Mr Charlton was not placed on TTM after informing an officer that he intended to kill himself; (c) it failed to investigate, identify and address the poor practices that officers were employing in relation to MORS at HMP Barlinnie; (d) it failed to identify that Mr Charlton had been removed from association between 26 and 28 October 2019 without authority; (e) it failed to identify that officers at HMP Barlinnie removed prisoners from association if they were placed on MORS even though this policy does not authorise this; (f) it failed to

identify that observations were not carried out after 1600 hours on 28 October 2019, incorrectly concluding that this failure commenced at 1630 hours; (g) despite the documentation showing that observations were not completed after 1600 hours, it did not investigate and identify that they had not been undertaken every 15 minutes prior to this; (h) it did not ascertain that the MORS documentation had been completed by Officer Dube incorrectly so that it appeared that observations had been carried out every 15 minutes prior to 1600 hours; (i) it failed to identify that no verbal observations were recorded after 1315 hours; (j) it failed to identify that a ligature risk assessment had not been undertaken in Mr Charlton's cell; and (k) it failed to identify that staff had not been adequately trained in respect of MORS. The information that was needed to make these findings was readily available at the time of the DIPLAR.

- (85) In relation to the failings that the DIPLAR did identify, the only recommendation was that "Staff must be fully aware of their responsibilities with regards carrying out observations". The only action was that "FLMs must ensure all staff fully understand the MORS policy and their responsibility with regards carrying out observations". The DIPLAR does not specify how these matters were to be addressed.
- (86) There is no record of any steps being taken at HMP Barlinnie to address the recommendation and action in the DIPLAR in respect of Mr Charlton's death.

- (87) Although the DIPLAR does not state that disciplinary action was to be taken in respect of officers involved in Mr Charlton's death, disciplinary charges were initiated in respect of officers Dube, Fyfe and Templeton.
- (88) The outcome of this disciplinary process in respect of Officer Templeton was that the charge was not upheld. The outcome of the disciplinary process for officers Dube and Fyfe was that the charge was upheld, and they received a verbal warning. In the letter that Mr Stoney, the Governor of HMP Barlinnie, sent to Officer Dube, advising her of the outcome of this disciplinary process, he (amongst other things) states:

"I was satisfied that the method of carrying out MORS checks on Mr Charlton whereby you recorded on MORS documentation the physical checks made by your colleagues, was designed to be in his best interests. It emerged Mr Charlton was not well disposed towards you and became agitated when you interacted with him. Therefore, a collective decision was taken to proceed with your colleagues directly engaging with Mr Charlton whilst you updated records and maintained a physical distance. This dynamic risk assessment and application of a practical solution was accepted as being the most effective outcome in all the circumstances at that time. Indeed, even when offered the opportunity to move Mr Charlton onto a different flat your considered view was that he was better served by being with officers who knew and could relate well with him. You were aware your colleagues knew him closely from previous periods Mr Charlton had spent in our care. You did not take an easy solution you acted in Mr Charlton's best interests.

I was made aware of the absence of any formal training provided for you on the Management of an Offender at Risk due to a substance (MORS) and accepted that."

- (89) An almost identical letter was sent on the same date by Governor Stoney to Officer Fyfe.

- (90) The method that officers Dube, Fyfe and Gemmel used to observe Mr Charlton was not the most effective at the time. It is inconsistent with MORS, which requires the officer that has undertaken an observation to complete the observation documentation.
- (91) Although Governor Stoney determined that the lack of formal training that officers Dube and Fyfe had received was a mitigating factor in the disciplinary processes concerning them, no steps were taken to provide these officers with formal training in respect of MORS. At the time of the inquiry, they had not attended formal training in respect of MORS.
- (92) There was a formal training programme that officers Dube and Fyfe could have attended prior to the inquiry, although this is ordinarily only offered to new recruits and officers that have been promoted. This training covers the role and responsibilities of officers, including how to complete the necessary documentation.
- (93) On or around 24 January 2023, an audit was carried out at HMP Barlinnie in relation to MORS by Ms Alison Malone and others. The report from this audit was issued on 9 February 2023, to Governor Stoney, the Deputy Governor at HMP Barlinnie at that time, Mr Sean McFederation, the SPS's Chief Executive, Director of Operations, Director of Strategy and Stakeholder Engagement and to the members of the SPS's Risk Monitoring and Audit Committee (RMAC).

- (94) The report from this audit refers to “observation sheets which did not correlate with the observation period”. This is defined in the report as a high risk, and it states that FLMs were to “reaffirm to the staff group the correct and consistent manner observation sheets should be completed”. The report mentions there being issues with the care plan documentation, including 6 cases in which the frequency of observations was not recorded. It also refers to “1 case where the Care Plan stipulated 30-minute observations and observations sheets evidenced hourly observations” and another case in which “the Care Plan stipulated 15-minute observations, and the observations sheets evidenced 30 minutes and then hourly with no explanation”.
- (95) The result of this audit was that limited assurance was given in respect of HMP Barlinnie’s compliance with MORS, which it defined as:
- “Systems of internal control that are satisfactory in part, but contain a number of weaknesses that are likely to undermine the achievement of (sic) systems objectives and leave them vulnerable to material error / abuse or threatening risk”.
- (96) Following the MORS audit at HMP Barlinnie in January 2023, Ms Malone sent an email to the MORS policy owners, Ms Sharon Holloway and Ms Susie Calder, to make them aware of the outcome of the audit and to raise concerns about the risks that it had identified.
- (97) A subsequent virtual meeting took place between Ms Malone, Ms Holloway and Ms Calder in which Ms Malone reiterated her concerns

regarding HMP Barlinnie's compliance with MORS. After this discussion, Ms Holloway sent an email to HMP Barlinnie, offering her help in relation to any issues they were having with MORS. She has no record of HMP Barlinnie responding to her and she took no further action in relation to this.

(98) A follow up MORS audit was carried out at HMP Barlinnie on 8 June 2023.

The report from this audit states that the outcome of the audit was that the risk rating remained high and only limited assurance could be provided.

The report further states that:

"Observation sheets were completed in all cases, however there were still gaps in recording and inconsistencies in 11 cases...observation sheets records reflect no observation being conducted for some hours, with 2 in particular with a gap of 4 hours".

(99) In relation to GGHB's refusal to undertake aspects of MORS the report states:

"This would still appear to be the case. We discussed this with the Deputy Governor and Residential Unit manager who will contact the Policy Owner at Head Quarters to seek guidance and support for this ongoing issue which impacts the application of the MORS policy at HMP Barlinnie".

(100) The report also states:

"We conducted the audit review of the MORS strategy at HMP Barlinnie on the 7<sup>th</sup> June 2023. We identified significant shortfalls and consequent risks in the following areas: poor completion of care plans and observation sheets, and cases where full details of MORS incidents were not recorded accurately on PR2."

(101) It was a failing by the SPS following these audits at HMP Barlinnie

(hereafter referred to as the 2023 audits) to not investigate if the reason why

officers were not completing the documentation correctly was because they had not carried out the required observations.

(102) Following the 2023 audits, an action plan was put in place at HMP Barlinnie to address the issues identified. Mr McFedries met with the FLMs to discuss the issues. FLM John McDavitt and the Office Manager were tasked with working on the MORS paperwork. It was agreed with GGHB that the SPS would use this organisation's care plan documentation. It was also agreed that FLMs would sign the first part of the MORS observation documentation as an extra level of assurance that it had been completed correctly. The SPS provided HMP Barlinnie with two additional FLMs, FLM Geoffrey Weaver and FLM Gordon Crinean. FLM Crinean spoke to the policy owner in relation to MORS and provided training on MORS to officers at HMP Barlinnie. Notwithstanding this role, he did not attend the SPS's MORS formal training.

(103) On 20 February 2024, FLM Crinean sent an email to the senior managers at HMP Barlinnie in which he (amongst other things) states:

"Recently we have seen a rise in MORS documents returned without Case Conference and/or NHS Care Plan Also there is a massive variation in observation sheets".

(104) On 29 March 2024, FLM Crinean sent an email to staff at HMP Barlinnie in which he (amongst other things) states:

"Something that has crept in to the recording of observations – when asked for Visual or verbal response - the response of NO or No Sleeping is not acceptable in any way. Your purpose, while the prisoner is on OBS

whether it be Talk to Me or MORS is to get a response (and annotate this response). If no response is forthcoming then a physical check may have to be pursued after authorisation from your FLM. If you are not getting a response how can you be sure that prisoner is safe, alive or not deteriorating?"

(105) An annual report for 2023 / 2024 of the RMAC was issued on 19 April 2024,

and states:

"Of the 23 audits completed at establishments only one audit attracted a limited assurance rating. Limited assurance was provided for the follow up review of the Management of Offenders at Risk due to Substance (MORS) Policy at HMP Barlinnie. The initial limited assurance assessment for the MORS policy at Barlinnie, which resulted in the requirement for a follow up review, was primarily due to NHS Greater Glasgow and Clyde's refusal to engage fully with the MORS policy and this issue was escalated to the appropriate Policy Owner and Director. The NHS position at the time of the follow up review had not changed, and this resulted in another Limited Assurance assessment. Copies of the MORs audit reports at Barlinnie were requested by the Procurator Fiscal, as was a statement from one of the auditors to be used as evidence in an upcoming Fatal Accident Inquiry."

(106) This statement does not disclose that a significant issue identified in the

2023 audits was the failure by officers at HMP Barlinnie to accurately complete the MORS documentation.

(107) The SPS has an excel spreadsheet that lists outstanding actions for its

prisons, such as the action plan that was put in place at HMP Barlinnie

following the 2023 audits. The actions on this document are monitored by

the Operations Directorate at SPS headquarters, which is managed by the

Operation Director. This a key part of the SPS's system for ensuring that its

prisons comply with its policies and procedures.

- (108) In relation to the action points that were placed on this spreadsheet following the 2023 audits, these were removed as the Operations Director was assured by staff at HMP Barlinnie that they had been addressed.
- (109) It was a defect in the SPS's system for ensuring that its prisons comply with its policies and procedures, to have concluded that the issues identified in the 2023 audits had been resolved because of assurances provided by staff at HMP Barlinnie, without any objective information (such as a further audit) that confirmed the accuracy of these assurances.
- (110) The statement that the issues at HMP Barlinnie had been addressed was inaccurate, as HMP Barlinnie had not, as they had undertaken to following the 2023 audits, sought and obtained guidance from the MORS policy holders.
- (111) The issue regarding the observation documentation had also not been resolved. On 23 April 2024, FLM Weaver sent an email to staff at HMP Barlinnie in which he (amongst other things) states:
- “Firstly, thanks for your hard work. We have seen a dramatic improvement in the compliance with the MORS policy over the past few weeks. For the first time we are receiving paperwork that is fully compliant, however, this appears to be when the MORS pack that has been developed has been used. When this has not been used we are still noting a large amount of mistakes. For example today we received 3 forms for prisoners who had been on MORS for just under 72 hours. 2 of these used the pack provided and were 100% accurate, however, the other did not use our paperwork and has almost a total of 48 hours of observations missed. This highlights the importance of have these packs available.”

(112) On 1 April 2025, FLM Weaver sent an email to all staff at HMP Barlinnie in which he (amongst other things) states,

“Of late the quality of the MORS observations have dropped significantly. The image below is an example of how far the quality has fallen. Should a prisoner pass away, the paperwork will be requested for the FAI. When completing make sure you comply with the following 4 points.”

(113) Despite this continuing failure of staff at HMP Barlinnie to complete the MORS documentation correctly, no investigation was undertaken to determine whether the necessary observations were carried out, and no disciplinary action was taken against the officers that were responsible for the failures identified.

(114) During the inquiry, officers at HMP Barlinnie did not understand that MORS does not automatically require verbal and visual observations to be carried out, and that healthcare staff completing the initial assessment should specify the type of observation that is to be undertaken in the prisoner’s care plan.

(115) At the time of the inquiry, the SPS’s staff that had not joined, or been promoted after 2022, had not received any formal training in respect of MORS.

(116) At the time of the inquiry, the informal system at HMP Barlinnie in respect of MORS had been changed so that a meeting takes place at the start and end of patrol periods, between residential and patrol officers, which is led by the desk officer, and attended by the FLM. During these meetings, the

officers present advise the incoming officers of the prisoners that have been placed on MORS and the frequency of the observations that require to be undertaken in relation to them.

## STATUTORY FINDINGS

[27] My findings in respect of sections 26(2)(a) to (d) of Act were agreed by the participants and require no further elaboration.

[28] In relation to sections 26(2)(e), (f) and (g) of the Act, the participants proposed various findings. I address the findings that I have made (albeit in slightly different terms to that proposed) and set out the participants' position in relation to them, as well my reasons for making them. I then address any findings that were proposed and that I rejected in the same manner.

### **Section 26(2)(e) of the Act – findings that I have made**

*Finding 1 - It was a reasonable precaution for officers at HMP Barlinnie to have observed Mr Charlton every 15 minutes, between 1600 and 1745 hours, on 28 October 2019, in accordance with healthcare staff's instructions and MORS.*

[29] The Crown and family of Mr Charlton invited me to make this finding. GGHB adopted a neutral position in relation to this issue. Officer Templeton and the Scottish Ministers accepted that it was open to me to make this finding.

[30] The only participant that opposed this finding was the POA, who submitted that:

*“The breadth of the word 'reasonably' is encapsulated by the oft-quoted passage from MacPhail - 'A precaution might realistically have prevented a death if there is a real or likely possibility, rather than a remote chance, that it might have done so.' It is*

submitted that the departure from the MORS observation levels cannot be said to have contributed to Mr Charlton's death. It is inarguable that, in terms of the two-stage test as above, monitoring Mr Charlton rigidly as per the care plan would have been an inherently reasonable precaution to take. Thus, the first stage of the test is satisfied. However, dubiety may arise where it is suggested that had that precaution been taken, there existed anything more than a remote chance Mr Charlton's death may have been avoided."

[31] The POA contended that that "dark logic" suggests that a suicidal person may seek to avoid detection when they attempt suicide. It founded on Dr Skilling's evidence that there is a "narrow window" in which it is possible to stop a prisoner taking their own life. He gave evidence as a skilled witness with expertise in relation to forensic psychiatry. He is an NHS consultant in forensic psychiatry and has been on the General Medical Council Specialist Register since 2009. He has worked in various forensic services, including prisons, and is currently a visiting psychiatrist at HMP Glenochil.

[32] I do not accept the POA's submission in relation to this issue. Dr Skilling's evidence did not support its submission. In his report, which he adopted during his evidence, he was asked to address the following question:

"Did any inadequacies or issues identified contribute in any way to Mr Charlton's death (ie had things been done differently, or had different systems been in place, might this realistically have resulted in his death being avoided)?

[33] Dr Skilling's response to this question is as follows:

"The most obvious issue identified was the failure of SPS staff to carry out /and or record the agreed MORS 15-minute observations. There were several gaps in the recording of these observations, most notably for a period of 1 hour and 45 minutes prior to Mr Charlton being discovered suspended in his cell. Had these observations been carried out as intended, it is possible, though not certain, that Mr Charlton's death may have been avoided. It would still have been possible for Mr Charlton to suspend himself by a ligature in the 15-minute period

between staff observations, though the likelihood of him being interrupted or discovered sooner would have been higher”.

[34] It is clear from this response that Dr Skilling does not consider that the precaution of observing Mr Charlton every 15 minutes only provided a remote possibility of avoiding his death. I consider that this response, and his evidence, satisfies the test for making a finding under this section of the Act.

[35] Mr Wheatley also gave evidence in relation to this issue as a skilled witness with expertise in prison management. He has had a lengthy career working in prisons, including roles such as the Deputy Governor and Governor of prisons in England. At the time of his retirement, he was the Director General of the English Prison Service. Following his retirement, he has provided advice to prison services across the world, including Her Majesty’s Chief Inspector of Prisons for Scotland in relation to its review into the handling of deaths in prison.

[36] In Mr Wheatley’s report, which he adopted in his evidence, he states:

“Even without identifying his suicide risk, if his MORS monitoring had been carried out as required every 15 minutes the chances of discovering him quickly during, or immediately after, attempting suicide would have been very much higher. This would have significantly increased the chances of successful intervention so that his death might have been prevented.”

[37] It is plain from this that Mr Wheatley does not consider that the precaution of carrying out 15-minute observations of Mr Charlton only provided a remote possibility of avoiding his death.

[38] I accept Dr Skilling and Mr Wheatley’s evidence in relation to this issue. Both skilled witnesses considered the uncertainty in relation to when Mr Charlton started the

process of suicide. Although I accept that it is possible that he did so (possibly intentionally) at the start of the 15-minute period between observations, it is at least equally possible that he did not and his death could have been avoided.

[39] I am therefore satisfied that if the officers had carried out 15-minute observations of Mr Charlton, as they were required to by healthcare staff and MORS, this precaution provided a real and likely possibility of avoiding his death.

*Finding 2 - It was a reasonable precaution for Mr Charlton's personal data, that he could not attend a visit with his partner, Ms Tait, because he was "under the influence", not to be shared with Ms Tait when she visited HMP Barlinnie, in accordance with the SPS's policy in respect of the Data Protection Act 2018 and GDPR.*

[40] The Crown, family of Mr Charlton and Officer Templeton accepted that it was open to me to make this finding. GGHB adopted a neutral position in relation to this issue. The POA considered that it would be more appropriate to make a finding in relation to this issue under section 26(2)(g) of the Act.

[41] The Scottish Ministers opposed this finding on the basis that the information had not been disclosed to Ms Tait, and even if it had, the taking of this precaution would not have realistically avoided Mr Charlton's death.

[42] Ms Tait was certain in her evidence that an officer disclosed to her that Mr Charlton could not attend the visit as he was "under the influence". She said that the officer refused to tell her what substance he had taken but suggested it might have been a legal high.

[43] The Scottish Ministers invited me to reject Ms Tait's evidence in relation to this issue. They referred to the police statements of officers Hunstone and Ryan Remilard, that were on duty within the visitor's area at HMP Barlinnie when the alleged disclosure was made, as well as the oral evidence of Officer Hunstone.

[44] Although neither officer could remember an interaction with Ms Tait, Officer Remilard states in his police statement that he would not inform a visitor that a prisoner was under the influence. In his oral evidence, Officer Hunstone said that if a prisoner could not attend a visit because they had been placed on MORS, he would only have said to a visitor that the prisoner is "not fit to attend".

[45] In respect of Ms Tait's evidence, the Scottish Ministers submitted that prior to the visit she was suspicious that Mr Charlton had taken an illegal drug, and when she was told that it could not take place, assumed that this was the reason. They submitted that this is consistent with her accusing Mr Charlton of taking drugs, when she said that the officer had not confirmed this. They referred to her saying that she "assumed drugs because she knows him". They therefore contended that these inconsistencies meant that Ms Tait was not a reliable witness in relation to this issue.

[46] I accept Ms Tait's evidence in relation to this issue as I consider that it is more likely than not that Officer Hunstone made this disclosure to her when she attended at HMP Barlinnie. Ms Tait's evidence is consistent with the statement that she provided to the police. It is also consistent with what she said to Mr Charlton during her telephone call with him immediately after this visit, as she refers to being informed that he was "under the influence".

[47] In relation to the alleged inconsistencies in Ms Tait's evidence, they did not cause me to doubt her reliability. Her explanation for accusing Mr Charlton of taking an illegal drug (even though this had not been confirmed to her) was reasonable due to her experience of him doing so during their relationship.

[48] In contrast, I found Officer Hunstone's evidence unconvincing. It supported rather than undermined Ms Tait's account of what occurred when she attended at HMP Barlinnie. When he provided a statement to the police on 20 May 2025 he stated:

"If the prisoner was under the influence, he wouldn't be allowed a visit. The desk officers within the hall would contact the visit desk to inform officers that this visit isn't happening. If this was the case, I would take the family member or friend aside and explain that on this occasion they wouldn't be getting a visit as the prisoner was under the influence, this would normally provoke them to ask for more detail. I wouldn't be able to provide them with any further information."

[49] The similarities in relation to what Officer Hunstone says in this statement, and Ms Tait's evidence of what occurred when she visited HMP Barlinnie, are striking. Officer Hunstone also uses the phrase "under the influence" on more than one occasion in his police statement, which further supports the conclusion that this is what he said to Ms Tait. He would have been aware of the importance of providing accurate information to the police and his attempt to depart from this during his evidence was unpersuasive.

[50] Ms Whitcombe is employed by the SPS as its Head of Information Management. In her statement, she states that the sharing of this information would be contrary to the SPS's Protecting the Personal Data of Individuals Held in Custody policy, if it was done without the consent of the prisoner. As Mr Charlton did not consent to this information

being provided to Ms Tait, she accepts that this would be a breach of this policy as well as the Data Protection Act 2018 and GDPR. She further states that the SPS provides training to its staff to prevent this type of disclosure being made. I am therefore satisfied that it was a reasonable precaution for Officer Hunstone not to have made this disclosure to Ms Tait, which was accepted by all the participants.

[51] I am also satisfied that the failure to take this reasonable precaution was a causal factor in respect of Mr Charlton's death. Dr Skilling states in his report that:

"It is very likely that the relationship difficulties between Mr Charlton and his girlfriend in the run up to his suicide were a key trigger or precipitant for his distress. Whilst I think that the sharing of information by SPS staff was a factor in Mr Charlton's distress, it is impossible to say to what extent it contributed to his death."

[52] Although it is unclear what Mr Charlton was thinking at the exact moment he decided to end his life, I do not accept that it is impossible to reach a conclusion on the likelihood of the breakdown of his relationship with Ms Tait being a causal factor in his death.

[53] In Dr Skilling's report, he states that the Royal College of Psychiatrists (2020) highlighted red flags that a person is at a heightened risk of attempting suicide, which include "Stressful life events (e.g. recently bereaved, debt/financial worries, loss of attachment/major relationship instability, job loss, moving house)." The breakdown of a relationship, such as that between Mr Charlton and Ms Tait, is therefore a recognised cause of suicide.

[54] It was only after the visit with Ms Tait did not go ahead, and she spoke with Mr Charlton on the telephone on 27 October 2019, informing him that their relationship

was over, that he started to behave aggressively and show clear signs of being distressed. Officer Dube said in her police statement that prior to his he appeared well, despite being intoxicated. Furthermore, Mr Charlton informed Ms Tait shortly before his death that he was going to kill himself when it became clear that he could not persuade her to continue with their relationship. These facts evidence the connection between the breakdown of this relationship, his distress and his decision to end his life.

[55] I am satisfied that it is reasonable to infer from these facts that the disclosure to Ms Tait that Mr Charlton was “under the influence”, and consequent breakdown in his relationship with Ms Tait, was a causal factor in his death. I also conclude that if the reasonable precaution identified in this finding had been taken, it might realistically have avoided his death.

*Finding 3 - It was a reasonable precaution for officers at HMP Barlinnie to have initiated the SPS's suicide prevention system, TTM, in respect of Mr Charlton, at around 1530 hours on 28 October 2019, or when he said to an officer that he intended to kill himself, whichever occurred sooner.*

[56] The Crown and family of Mr Charlton invited me to make a finding that it was a reasonable precaution for officers to have initiated TTM in respect of Mr Charlton. Officer Templeton accepted that it is open to me to make this finding. GGHB adopted a neutral position in relation to this issue.

[57] The Scottish Ministers submitted that the officers had not failed to initiate TTM in respect of Mr Charlton unless he said to an officer that he intended to kill himself. If

he did not make this statement, they contended that the officers acted reasonably and relied on Dr Skilling's evidence in relation to this issue.

[58] The POA also opposed this finding on this basis and submitted that the officers could not have known that Mr Charlton was having relationship difficulties.

[59] In Dr Skilling's opinion, Mr Charlton should have been placed on TTM if he said that he intended to kill himself to an officer. If he did not do so, he said that the officers acted reasonably and would not criticise them in this situation. He also said that the "cues and clues" in TTM should not be used as a "tick box exercise" and urged caution in relation to including intoxication as a specific risk factor for suicide. This is because the level of substance use in prisons is high and it might have serious implications for the prison regime if potentially large numbers of prisoners are placed on TTM because they are intoxicated.

[60] If TTM had been initiated in respect of Mr Charlton, Dr Skilling states in his report that:

"The TTM process would in theory have facilitated a more consistent and robust care plan of observations and case conferences involving mental health staff and consideration of additional risk management strategies, such as placement of Mr Charlton in an anti-ligature cell and the use of anti-ligature clothing and bedding."

[61] Mr Wheatley gave evidence in respect of whether TTM should have been initiated in respect of Mr Charlton and if this might have avoided his death. He agreed with Dr Skilling that TTM should have been initiated if Mr Charlton said that he intended to kill himself to an officer. Even if he did not do so, Mr Wheatley considered that TTM should have been initiated due to Mr Charlton's history of mental health

issues, history of drug and alcohol abuse, mood change, angry behaviour, reaction to his relationship with Ms Tait breaking down and because he was displaying signs of distress. He states in his report that:

“It must have been obvious at the very least that he was in distress at the failure of this relationship and very angry with prison staff for telling his partner that he had been abusing drugs in prison. In all these circumstances it would have been prudent to place him on Talk to Me and to begin to adopt an approach to his care that might reduce...an obvious elevated risk. Instead, he was held in isolation because he was on MORS.”

[62] If TTM had been initiated in respect of Mr Charlton, Mr Wheatley states in his report that:

“Supportive interventions might have improved his mood, and if not, it would have been possible to locate him in a safer cell where the means of committing suicide had been removed, thus safeguarding his life until the crisis was over.”

[63] I am satisfied that Mr Charlton stated to an officer that he intended to kill himself. I accept Dr Campbell’s evidence that an unknown officer said to her that another officer informed them that Mr Charlton said that he was going to kill himself, but subsequently said he had changed his mind. Dr Campbell is unlikely to be mistaken about this. It is also unlikely that the unknown officer misspoke, and this did not occur, due to the specific information that they provided in respect of Mr Charlton saying that he had changed his mind about killing himself. Based on Dr Skilling and Mr Wheatley’s evidence, it was therefore a reasonable precaution for officers to have initiated TTM in respect of Mr Charlton prior to his death.

[64] I am also satisfied that this reasonable precaution might realistically have avoided Mr Charlton’s death. While some matters will never be known - such as what

he might have said if an assessment of his mental health was undertaken - and there were limitations to this due to him being intoxicated, I accept Mr Wheatley's evidence that this would have led to measures being put in place that would have realistically avoided his death. That is the purpose of the measures that are considered and utilised as part of TTM.

[65] Although this is sufficient to make the above finding, I will address the alternative factual position that I have rejected, which is that Mr Charlton did not inform an officer that he intended to kill himself, as I consider that the officers should have initiated TTM in respect of him in this scenario.

[66] I do not accept the POA's submission that officers were unaware of Mr Charlton's relationship with Ms Tait breaking down. It is clear from the discipline report that Officer Dube completed that she was aware of this. It should also have been obvious to the officers that he was in crisis due to difficulties in his relationship with his partner, from his repeated telephone calls and behaviour after them. The officers appear to have appreciated this, as they allowed him to make telephone calls to lessen his distress, which was not ordinarily permitted if a prisoner had been placed on MORS at HMP Barlinnie.

[67] In relation to whether it was a reasonable precaution for TTM to be initiated in respect of Mr Charlton in this scenario, I accept Mr Wheatley's evidence regarding this issue. All the factors that he refers to in justifying his opinion are listed in TTM as being signs that a person is at risk of attempting suicide.

[68] Although Dr Skilling has more expertise than Mr Wheatley in assessing mental health issues, Mr Wheatley has more expertise in relation to how officers should respond to certain situations, including the application of TTM in Scottish prisons. In any event, although I generally found Dr Skilling's evidence to be of assistance, I do not accept his evidence in relation to this issue for the following reasons.

[69] In framing the issue as whether the officers acted reasonably, it is clear from the Inner House's decision in *Dr Karen Duncan v Lord Advocate* that Dr Skilling asked himself the wrong question. As a result, he appears to have focussed on whether the officers were at fault. In approaching this issue in this way, he applied the language and principles of negligence which are irrelevant for the purposes of this inquiry.

[70] I do not accept that the consequences of multiple prisoners being placed on TTM, and this potentially causing a difficulty in relation to the management of a prison, is relevant to the assessment of whether a prisoner is at risk of attempting suicide.

[71] I reject the proposition that initiating TTM in respect of prisoners in the same position as Mr Charlton, would result in large numbers of prisoners being subject to this system merely because they are intoxicated. Mr Charlton was displaying warning signs of suicide that went well beyond those that a prisoner might exhibit merely from being intoxicated. It was the combination of his intoxication, and the warning signs listed in the "cues and clues" section of TTM, that required this system to be initiated.

[72] I therefore conclude that TTM should have been initiated in respect of Mr Charlton, prior to his death, either when he said that he intended to kill himself, or after he made numerous calls to Ms Tait and was observed to be distressed at around

1530 hours on 28 October 2019, whichever occurred sooner. I am also satisfied that this was a reasonable precaution that might realistically have avoided his death.

**Section 26(2)(e) of the Act – proposed findings that I have rejected**

*“There is no record before the Inquiry confirming that Mr Charlton’s person or cell was searched following his being placed on MORS on 26 October 2019. There is evidence before the Inquiry that Mr Charlton was displaying behaviours consistent with being under the influence of an unknown substance between 26 and 28 October 2019. There is also evidence before the Inquiry that reducing the period in which an Mr Charlton’s thinking was disturbed by drug abuse could have altered the course of events and made suicide less likely. It would have been reasonable to search Mr Charlton’s person and cell for illicit substances.”*

[73] This finding was proposed by the Crown and family of the Mr Charlton. GGHB, the POA and Officer Templeton adopted a neutral position in relation to this proposed finding.

[74] The Scottish Ministers opposed this proposed finding on the basis that the evidence did not establish that Mr Charlton and his cell were not searched. Moreover, even if they were not searched, such a precaution would not realistically have avoided his death.

[75] The Scottish Ministers referred to the evidence of Officer Dube, who believed that she had searched Mr Charlton, and his cell, when she placed him on MORS on 26

October 2019. She said that this is the “first thing you do” and that a cell search is done at the same time as a personal search.

[76] I accept Officer Dube’s evidence in relation to this issue and do not consider that her reliability was undermined by the searches not being recorded on PR2. Her evidence that she did not do this, probably due to being too busy, is consistent with her other evidence in relation to completing documentation.

[77] I also do not consider that Officer Dube’s evidence in relation to this issue was undermined by Officer Colin Reid’s evidence that he was working with her on 26 October 2019 and cannot recall searching Mr Charlton and his cell. This is because Officer Reid did not state that that it could be inferred from this that these searches were not undertaken.

[78] In any event, although there was evidence that Mr Charlton was intoxicated between 26 and 28 August 2019, it is not reasonable to infer from this that he continued to take drugs during this period. It is unclear what type of drug Mr Charlton took on 26 October 2019, and it is possible that he had taken a Novel Psychoactive Substance (NPS), which has become a commonly used drug within prison. FLM Crossan said during her evidence that prisoners can remain intoxicated from taking this drug for multiple days. This is consistent with the evidence of Dr Sayers, who is a GP and has been employed as the clinical lead for prison healthcare in Forth Valley since 2000. He said that 48 hours of intoxication following taking a NPS is not uncommon. Dr Campbell also said that these drugs caused some prisoners to be “unwell for longer periods of time.” Mr Charlton’s

continued intoxication could therefore have been as a result of taking a NPS on 26 October 2019, rather than continuing to take an illegal substance.

[79] As the evidence did not establish the alleged failure in this proposed finding, or that it contributed to Mr Charlton's death, I have not made the finding.

*“Mr Charlton used the window within his cell as a ligature anchor point. Reducing the risk presented by the window as an obvious ligature point is a precaution which could reasonably have been taken. Had this been addressed, in simplistic terms, Mr Charlton's death would have been avoided as it would not have been possible to suspend himself from the window. Taking a different approach, the precaution might realistically have resulted in Mr Charlton's death being avoided as an obvious ligature point with the cell would have been removed, thus making it more difficult for Mr Charlton to take his own life.”*

[80] This finding was proposed by the Crown. The family of Mr Charlton invited me to make a similar finding and submitted that the following step could have been taken:

*“The existing openable windows within standard cells within HMP Barlinnie to be sealed and the glass replaced with mesh ventilation panels”.*

[81] These proposed findings were opposed by the Scottish Ministers. GGHB, Officer Templeton and the POA adopted a neutral position in relation to this issue.

[82] The family of Mr Charlton relied on the evidence of Mr Alex Taggart in relation to their proposed finding. He gave evidence as a skilled witness in relation to health and safety. He is a Chartered Member of the Institute of Occupational Safety and Health and has provided reports for cases in relation to self-harm and suicide in secure

environments for around 15 years. He accepted that he has limited experience of health and safety issues in prisons.

[83] In Mr Taggart's opinion, the SPS should have carried out an audit at HMP Barlinnie that identified the ligature risks in its cells and the measures that could have been put in place to remove them. He further states in his report that:

"In this case if Mr Charlton had shown signs however small of possible suicidal death, then the process in the risk assessment application would have been relatively straight forward. A person with suicidal ideation should never be placed within a secure unit where there are ligatures and ligature anchor points. Therefore, in this case the risk assessment would dictate he would not have been placed in cell (3) 20 but be placed in a cell which was adapted with either all ligature anchor points removed that I have previously described or be placed in a cell which has been replaced with anti-ligature fixtures and fittings."

[84] Mr Taggart does not consider that every cell at HMP Barlinnie required to be adapted in this manner and states in his report that:

"It is of course not everyone who enters the prison system who will during their stay have thought of suicide and therefore it is not necessary to convert all cells within the existing prison estate. A percentage of cells could be easily converted bearing in mind there are likely to be only two or three ligature points in a cell such as the one Mr Charlton occupied."

[85] In relation to the cells that he suggested should be adapted, he said that the windows could be modified so that they could not be opened and used as a potential ligature point. He suggested that a bespoke mesh flyscreen could be installed to provide the necessary ventilation in these cells, which he estimated would cost around £100.

[86] All the participants did not dispute Mr Taggart's evidence that the SPS ought to have carried out an assessment of the ligature risks in the cells at HMP Barlinnie prior to

Mr Charlton's death. They also accepted that suicide by hanging from a ligature point was a known risk at the time of his death.

[87] In relation to Mr Taggart's evidence that the SPS should have modified the windows in some of the cells at HMP Barlinnie, and installed a mesh flyscreen, the Scottish Minister's submissions identify a fundamental flaw in his evidence: there were safer cells at HMP Barlinnie at the time of Mr Charlton's death that had been adapted to remove the ligature points that Mr Taggart identifies in his report. Furthermore, other measures would have been considered if Mr Charlton had been placed in one of these cells, such as providing him with anti-ligature bedding. Significantly, the windows in these cells could not be opened.

[88] I therefore accept the Scottish Minister's submission that Mr Taggart did not identify a reasonable precaution that might realistically have avoided Mr Charlton's death. The SPS had taken suitable and sufficient measures to address the risks that he identifies in his report. It is unclear why Mr Taggart chose to examine Mr Charlton's cell, instead of the safer cells at HMP Barlinnie, in these circumstances.

[89] This addresses the way this issue was approached during the inquiry.

Notwithstanding this, the Crown and family of Mr Charlton invited me to make a finding that is inconsistent with the evidence of Mr Taggart; that the ligature points on the windows in all the cells at HMP Barlinnie should have been removed. The Crown did not specify what (if any) adaptations should be made to the cells to provide the necessary ventilation. The family of Mr Charlton submitted that a mesh flyscreen could have been installed.

[90] The Scottish Ministers submitted that this would not have been reasonable a precaution. They relied on the evidence of Mr Greg Pearson in relation to this issue, who is a qualified architect and is employed by the SPS as its Head of Professional and Technical Services.

[91] Mr Pearson said that the SPS would not install a mesh flyscreen in standard cells at HMP Barlinnie, as it could be tampered with, used as a weapon and to self-harm. He explained that although windows in modern prisons cannot be opened, and have been fitted with a mesh ventilator, the same product could not be used at HMP Barlinnie because the windows are smaller. The installation of a mesh flyscreen would also reduce the natural light in the cells at HMP Barlinnie to an unacceptable level and would be contrary to current building standards. He was concerned that this would result in the cells being unacceptably cold during winter and they would not have sufficient ventilation.

[92] In relation to the cost of installing a mesh flyscreen on the windows in the cells at HMP Barlinnie, Mr Pearson said that this would cost significantly more than £100 per window and estimated that the total cost would likely be “in the millions”. He referred to the SPS having to source a bespoke product that presently does not exist, that the work would require scaffolding and there would be costs associated with relocating prisoners when the work was being undertaken.

[93] In respect of the cost of installing a mesh flyscreen in all cells at HMP Barlinnie, I accept Mr Pearson’s evidence. Mr Taggart’s estimate that it would cost around £100 per window was made without any reference to a similar bespoke product and did not take

account of the cost of installing this product, such as scaffolding costs. In contrast, Mr Pearson's estimate of the costs was based on his experience of instructing similar work and seemed far more realistic.

[94] I also accept Mr Pearson's evidence in relation to inappropriateness of installing a mesh flyscreen on the windows of the cells at HMP Barlinnie, including the detriment to the welfare of prisoners from the loss of light, poor ventilation and heating, as well as the risks from the potential for it to be used as a weapon and to self-harm.

[95] I do not therefore consider that the proposed findings by the Crown and family of Mr Charlton, identify a reasonable precaution that the SPS could have taken prior to Mr Charlton's death. Accordingly, I have not made these proposed findings.

#### **Section 26(2)(f) of the Act – findings that I have made**

*Finding 1 – It was a defect in the system at HMP Barlinnie in respect of MORS, to not require a specific officer to observe prisoners who had been placed on MORS and complete the observation documentation.*

[96] The Crown and family of Mr Charlton invited me to make this finding. Officer Templeton accepted that it was open to me to make this finding and GGHB adopted a neutral position in relation to this issue.

[97] The Scottish Ministers and the POA opposed this finding. They submitted that the approach of officers to carrying out observations, and completion of the observation documentation, did not contribute to Mr Charlton's death.

[98] I do not accept the Scottish Ministers and POA's position in relation to this issue. It is obvious that in the dynamic environment of a prison hall, such as Delta Hall North

Upper at HMP Barlinnie, with staff going in and out of prisoners' cells, and being outwith each other's presence for periods, as well as having to deal with unexpected exigencies, that sharing the responsibility for observing Mr Charlton was likely to result in officers incorrectly assuming that another officer was carrying out the necessary observations. This is what happened in respect of Mr Charlton's death; Officer Fyfe said, "I think we all made assumptions that he'd been checked." FLM Crossan also accepted that when multiple officers are involved there is greater scope for confusion.

[99] The risk of this system breaking down was exacerbated by there being no system at HMP Barlinnie for alerting officers that the period for carrying out an observation had elapsed. Officer Fyfe said that officers needed to remember this or set an alarm on their watch, if they had one. I consider that it was less likely that they would do this if they were not solely responsible for observing Mr Charlton.

[100] The effectiveness of this system was further undermined by Officer Dube completing the observation documentation for the observations that officers Fyfe and Gemmel undertook. This documentation discloses that Officer Dube recorded that visual observations were completed exactly every 15 minutes. This was inaccurate, as the CCTV shows that they were carried out at irregular intervals. For example, Mr Charlton was visually observed at 1420 hours, which meant that the next visual observation should have taken place at 1435 hours. It did not, as the next visual observation took place at 1446 hours (26 minutes later). For this period, the observation documentation completed by Officer Dube records observations being undertaken at

1415 and 1430 hours. Therefore, in addition to recording an observation that did not take place, she recorded an inaccurate time for the observations that were undertaken.

[101] It can be inferred from this that officers Fyfe and Gemmel did not inform Officer Dube of the precise time that they completed the visual observations of Mr Charlton and were observing him approximately every 15 minutes, rather than strictly adhering to his care plan. This was inadequate, as healthcare staff specifically selected the period of 15 minutes because they considered that this was necessary to preserve his life. Furthermore, if officers Fyfe or Gemmel had asked Officer Dube when the next observation required to be completed, she would likely have provided them with inaccurate information regarding this, creating a further risk that he would not be observed in accordance with these instructions.

[102] I therefore consider that the multiple errors that occurred on the day that Mr Charlton died were the consequence of a defective system. The failures identified in the 2023 audits support this conclusion. As do the emails that FLMs Weaver and Crinean sent to staff at HMP Barlinnie, seeking to address the continuing issues of non-compliance with MORS at this prison.

[103] These issues should not arise if a specific officer is given the responsibility of observing a prisoner that has been placed on MORS and completing the observation documentation in relation to them. If this had been part of the system on the day that Mr Charlton died, that officer would not have incorrectly assumed that another officer would undertake these tasks. They would also have known the precise time when the observations were completed and when the next observation required to be undertaken.

It would also have allowed managerial staff to more effectively supervise that officer's performance of these tasks, as they would not have assumed that other officers were completing them. For example, if the manager realised that the officer was about to commence a task that would take longer than 15-minutes, this should have caused them to question how they would be able to do that and carry out the observations.

[104] The fact that this is a more effective method of implementing MORS is supported by the evidence of Officer Dube who accepted that it would be better if a specific person was responsible for observing prisoners, as they would be able to focus on this instead of also enforcing the regime for prisoners. Officer Fyfe was of a similar view and said that it would result in a more structured approach.

[105] I appreciate that there might be situations when it will not be possible for a specific officer to retain the responsibility for these tasks throughout an entire shift (sickness, problems with another prisoner etc.). This does not mean that this precaution is impractical, as it should be possible for that officer to expressly agree with another officer that they take over the responsibility and to inform their manager of this. That will ensure that it is clear to the officer, and their manager, who has this responsibility, to avoid the misunderstandings that resulted in Mr Charlton not being observed.

[106] This change to the MORS system does not prevent more than one officer being allocated the responsibility of observing prisoners, for example by allocating prisoners that require to be observed to different officers, if this is the most effective way managing the work that requires to be undertaken. This system is therefore sufficiently flexible to deal with the various issues that officers require to address during their shifts.

[107] I am therefore satisfied that the defect identified in this finding contributed to Mr Charlton's death.

*Finding 2 – It was a defect in the system at HMP Barlinnie in respect of MORS, to not require officers coming on duty to be informed by the outgoing officers of the prisoners that had been placed on MORS, as well as the frequency and type of the observation that required to be undertaken in relation to them.*

[108] The Crown, family of Mr Charlton, Mr Templeton and Scottish Ministers accepted that it was appropriate for me to make this finding. The POA and GGHB adopted a neutral position in relation to this issue.

[109] Although measures were taken at HMP Barlinnie to ensure that patrol officers were made aware of the prisoners that required to be observed in accordance with MORS, they were ineffective on the day that Mr Charlton died. For reasons that are unclear, the desk officer was unaware of Mr Charlton being placed on MORS, so this was not written on the desk behind them, and Officer Templeton was not advised of this when he took over responsibility for Delta Hall North Upper from officers Dube, Fyfe and Gemmel.

[110] At the time of Mr Charlton's death, there was no procedure whereby the officers would provide a handover to patrol officers, informing them of the prisoners that had been placed on MORS, as well as the frequency and type of observation that require to be undertaken in relation to them. This is now part of the system at HMP Barlinnie, and checks are also undertaken to ensure that accurate information is provided to during these handovers.

[111] This is self-evidently a more effective system. If this system had been in place at the time of Mr Charlton's death, Officer Templeton should have been aware that he had been placed on MORS and required to be observed every 15 minutes. Officer Templeton should have also reminded the officers returning from their break of the need to observe Mr Charlton, making it more likely that they would have done so. As the failure to carry out these observations was a cause of Mr Charlton's death, I am satisfied that this defect contributed to his death.

*Finding 3 – It was a defect in the SPS's implementation of MORS, to have failed to provide officers with suitable and sufficient training in relation to this policy and the system that it sought to create.*

[112] The Crown and family of Mr Charlton invited me to make this finding. Officer Templeton accepted that it is open to me to make this finding. GGHB and the POA adopted a neutral position in relation to this issue.

[113] The Scottish Ministers accepted that there was a defect in relation to the SPS's implementation of MORS because of the failure to formally train staff. In this regard, they accepted that:

“There is a risk of inconsistent approaches among those who have been formally trained and those who have learned ‘on the job’ at different establishments. It also gives rise to a concern that those who have received formal training will return to establishments to work under officers who may be more experienced but who have not been formally trained on MORS. This creates a possible tension in approach.”

[114] Notwithstanding this concession, the Scottish Ministers submitted that this lack of formal training did not contribute to Mr Charlton's death because:

“Officers knew where to access the policy and associated paperwork. They were aware of the policy and how to implement it. The paperwork was in fact completed on 26 and 27 October.”

[115] I do not accept the Scottish Minister’s submission in relation to this issue. It is inconsistent with Governor Stoney’s decision in the disciplinary proceedings concerning officers Dube and Fyfe, that the lack of formal training that they received mitigated their failure to observe Mr Charlton in accordance with MORS.

[116] Officers might have been aware of MORS, but they were not provided with suitable and sufficient training to enable them to implement it in a manner that achieved its objectives. This is apparent from the lack of understanding by officers of MORS and poor practices that they adopted on the day of Mr Charlton’s death, including the collective approach to carrying out observations and completing the observation documentation. If the officers had been properly trained, they would have known that these practices undermined the effectiveness of the system.

[117] This lack of understanding of the requirements of MORS extended to senior managers at HMP Barlinnie, which is demonstrated by FLM Crossan stating that the collective approach was appropriate as staff have “a degree of discretion”. Governor Stoney also condoned this approach during the disciplinary process in respect of officers Dube and Fyfe. This lack of formal training therefore resulted in senior managers at HMP Barlinnie not identifying the poor practices of officers that undermined the effectiveness of the system.

[118] It should have been an essential part of the SPS’s plan in relation to MORS to provide officers with suitable and sufficient training concerning their role and

responsibilities in relation to this policy. Due to the number of officers that would require to undertake this training, an e-learning package could have been created and provided to officers when MORS was implemented. This would have allowed officers to quickly undertake this training and assisted senior managers at HMP Barlinnie to put in place suitable and sufficient measures to address the practical aspects of MORS.

Subsequent training could then have been provided to officers that considered any issues that officers were encountering with the policy and system that it sought to create.

[119] Another important aspect of training officers in relation to MORS was that this should have confirmed the importance of complying with the policy and made officers aware that there might be serious consequences if they do not do so. The impression that I formed from the evidence of some of the officers that gave evidence to the inquiry, was that they considered that it was acceptable to broadly comply with the policy. This is apparent from the evidence of some officers that Mr Charlton was adequately observed prior to 1600 hours, on 28 October 2019, even though he was not observed in accordance with MORS. I do not consider that it is in any way acceptable to broadly comply with one of the main objectives of a policy, the purpose of which is to preserve the lives of prisoners.

[120] I am therefore satisfied that lack of suitable and sufficient training that was provided to officers contributed to the failure by officers to observe Mr Charlton every 15 minutes. I therefore conclude that this defect contributed to his death.

*Finding 4 – It was a defect in the system at HMP Barlinnie in respect of MORS, to have failed to adequately check and monitor that it was being complied with.*

[121] The Crown, family of Mr Charlton and Officer Templeton accepted that it was open to me to make this finding. GGHB and the POA adopted a neutral position in relation to this issue. The Scottish Ministers opposed this finding.

[122] It is an important aspect of any system that steps are taken to check and monitor that it is being complied with. If these steps are not taken, even the most carefully devised system might prove to be ineffective, especially since the practical application of a system may lead to the identification of issues that had not been anticipated.

[123] There was no evidence during the inquiry of there being any system to check and monitor compliance with MORS at HMP Barlinnie between 30 December 2014 and 28 October 2019. This meant that the SPS were unaware of the poor practices that staff were employing in relation to MORS at this prison and were unable to address them. This included the collective approach to undertaking observations.

[124] One way in which this could have been addressed was to have carried out audits in relation to MORS at HMP Barlinnie. In relation to a policy of the significance of MORS, I consider that it should have been part of the SPS's plan to implement the policy to require its prisons to complete a standardised audit, which could have been sent to its prisons with the policy. It should also have been a requirement for its prisons to provide the results of these audits to the MORS policy holders to consider any issues arising. That should have quickly identified that GGHB were not prepared to undertake aspects of the policy in 2014, rather than this seemingly coming to light almost 9 years later

following the 2023 audits. Furthermore, if these internal audits suggested that there was an issue at a prison, an external audit (such as the 2023 audits) could have been undertaken to more fully assess the cause of the issue.

[125] The other way this could have been achieved was by managers carrying out sporadic, and unannounced checks, during shifts, to make sure the observations were being completed. This would have affirmed to officers the importance of undertaking these tasks and should have identified that they were not effectively implementing MORS.

[126] I am satisfied that this defect in the SPS's system in relation to MORS contributed to the poor practices that led to the officers failing to observe Mr Charlton every 15 minutes on the day that he died. It was therefore a defect that contributed to his death.

*Finding 5 – It was a defect in the MORS and TTM systems that they did not interact in a manner that prevented officers at HMP Barlinnie from attributing the warnings signs of suicide that Mr Charlton was exhibiting to his intoxication.*

[127] The Crown and family of Mr Charlton invited me to make this finding. Officer Templeton accepted that it is open to me to do so. GGHB and the POA adopted a neutral position in relation to this issue. The Scottish Ministers accepted that the MORS and TTM systems should be amended so that they better interact with each other, but were opposed to a finding being made regarding this, as they contended that this did not contribute to Mr Charlton's death.

[128] I have set out above my reasons for concluding that TTM should have been initiated in respect of Mr Charlton. Officer Dube's evidence, even with hindsight, was that Mr Charlton was not exhibiting signs that he may attempt suicide. When Officer Fyfe was referred in his evidence to the "cues and clues" in TTM, he acknowledged that if he had considered them at the time of Mr Charlton's death, he would have placed him on TTM.

[129] I consider that a material factor in these officers failing to recognise the warnings signs that Mr Charlton might attempt suicide was that the TTM and MORS systems do not interact with each other and are therefore entirely separate processes. This encouraged officers to view Mr Charlton's needs through separate lenses, which does not recognise the dynamic nature and potential interplay between the risk of suicide and intoxication.

[130] Dr Skilling gave evidence in relation to this issue and said that the TTM and MORS policies should be revised so that they clarify how they are to interact with each other.

[131] Ms Siobhan Taylor also addressed this issue in her evidence. She is employed by the SPS as its Policy Manager for Suicide Prevention. In her statement she states:

"There has been a recent reported increase in the number of prisoners who have been under the influence and then self-harmed and /or attempted suicide. There have been recent incidents where prisoners have seriously self-harmed whilst they were under the influence and under the MORS policy. This is despite the fact that some of these prisoners were never previously assessed as being at risk and having not made comments about any intention of hurting themselves or completing suicide. I agree that any revised version of the TTM policy should refer to the risk of a prisoner completing or attempting suicide whilst they are

under the influence and there being increased reference to this during training staff.

Moving forward, I believe that there should not be separate paperwork for prisoners on TTM or MORS. If a prisoner has to be put on both policies at the same time, it is confusing having different styled forms and paperwork requiring to be completed by the prison officer.

My team, the Health Team is committed to the introduction of generic care or support plan documentation that is used for a prisoner where there are concerns about them, not specifically limited to concerns about them being under the influence or having suicidal thoughts. So for example the prisoner might start out with a generic support plan, where allow level of support is required. In the event concerns arose and the TTM or MORS policy required to be initiated, the support plan would be upgraded or enhanced with this information”.

[132] I accept Dr Skilling and Ms Taylor’s evidence in relation to these matters. Acting irrationally, and out of character, are commonly accepted features of intoxication. It is therefore understandable that the officers made this connection in relation to the behaviours that Mr Charlton was exhibiting. This is why I consider that it is essential for the MORS and TTM systems to interact in a manner that causes officers to recognise that a prisoner that is intoxicated, and acting in a similar matter to Mr Charlton, is at risk of attempting suicide.

[133] I appreciate that this may not be straightforward and that a policy cannot be tailored to the specific circumstances of one person, such as Mr Charlton, particularly in relation to suicide prevention, which is a complicated issue. Notwithstanding this, it should be possible to revise these policies, and the training that underpins them, so that officers do not attach less weight to the warning signs of suicide that Mr Charlton was exhibiting because he was intoxicated.

[134] If this had been done prior to Mr Charlton's death, the officers should have recognised that TTM required to be initiated in respect of him. As that would have provided a realistic possibility of avoiding his death, I am satisfied that the defect identified in this finding contributed to his death.

**Section 26(2)(f) of the Act – proposed findings that I have rejected**

*“That it was a defect in the system in place within HMP Barlinnie at the time of Mr Charlton's death that there was a breakdown in communication between GGHB and SPS which resulted in GGHB withdrawing engagement with the MORS policy.”*

[135] The family of Mr Charlton invited me to make this finding. The Crown, POA and Officer Templeton adopted a neutral position in relation to this proposed finding. GGHB and the Scottish Ministers opposed this proposed finding on the basis that the evidence did not establish that the alleged defect contributed to Mr Charlton's death.

[136] The family of Mr Charlton's submissions set out several reasons why it was a defect in the MORS system for the MDCC not taking place in respect of Mr Charlton. They do not, however, identify how this defect contributed to Mr Charlton's death.

[137] I accept that the failure by the SPS to implement a significant part of MORS at HMP Barlinnie was a defect in the system. In relation to whether this defect contributed to Mr Charlton's death, there was no evidence that any of the steps that would have been taken at a MDCC would have prevented his death.

[138] I am not therefore satisfied that the failure to comply with this aspect of MORS contributed to Mr Charlton's death and have not made this proposed finding.

*"Mr Charlton was unlawfully confined to his cell from 0815 hours on 26 October 2019 until 28 October 2019 at 1431 hours. The evidence before the Inquiry is that there was this defect in the system at HMP Barlinnie to manage those at risk due to any intoxicant which resulted in Mr Charlton being isolated within his cell for a protracted period without any consideration or assessment being carried out as to the impact on him. Had there been such a system, it would have been reasonable to suggest that the risk of cellular confinement would have been properly recognised and assessed."*

[139] The Crown and family of Mr Charlton invited me to make this finding. GGHB and Officer Templeton adopted a neutral position in relation to this issue.

[140] The Scottish Ministers accepted that Mr Charlton was confined to his cell for a period, prior to a Rule 95 Order being made on 28 October 2019, without this being authorised. They accepted that this was due to a defect in its system at HMP Barlinnie and that confining a prisoner to their cell has the potential to negatively affect their mental health.

[141] Notwithstanding these concessions, the Scottish Ministers opposed this proposed finding, as they submitted that it was necessary for Mr Charlton to be confined to his cell for his and others safety. They also submitted that there was no evidence that confining Mr Charlton to his cell without authorisation was a causal factor in his death.

[142] I accept the Scottish Minister's position in relation to these issues. Although the correct procedure was not followed, I am satisfied that if a Rule 95 application had been made at the time that Mr Charlton was placed on MORS, and confined to his cell, it would have been granted. This was due to the risk that he posed to himself and others due to his intoxication. The failure to follow the correct procedure did not therefore lead to a different outcome for him.

[143] In any event, I am not satisfied that confining Mr Charlton to his cell for period without authority contributed to the decline in his mental health. While some prisoners may be negatively affected by this, Mr Charlton was not distressed on 26 and 27 October 2019, despite being confined to his cell, until his visit with Ms Tait did not take place and she informed him that their relationship was over. For the reasons that I have provided, I consider that this was principal reason for his decision to end his life. The evidence does not therefore support the conclusion that confining him to his cell was a causative factor in his death. Accordingly, I have not made this proposed finding.

*"There was no system in place within SPS at the time of Mr Charlton's death to regularly audit and action risks posed by ligature anchor points in the physical cell environment. The TTM Strategy did not then, and does not now, address reduction of ligature points within standard cells. There was then, and remains now, no ligature toolkit available to allow staff to carry out a proper and regular audit of the risks presented by ligature audit points across the SPS estate. There was then, and is now, no system or programme in place to consider risks found during such audits and prioritise/action them accordingly. A system of this nature could and should have been*

*in place prior to 2019. Had there been such a system, it is reasonable to suggest that the risk presented by the window would have been formally identified, prioritised and resolved. As such, this defect contributed to Mr Charlton's death."*

[144] The Crown and family of Mr Charlton invited me to make this finding. GGHB, the POA and Officer Templeton adopted a neutral position relation to this issue. The Scottish Ministers opposed this proposed finding.

[145] Although I accept many of the criticisms in this proposed finding, for the reasons that I provide for rejecting the finding that it was a reasonable precaution to prevent the windows from closing in standard cells at HMP Barlinnie, and install a mesh flyscreen, I do not consider that it was a defect in the SPS's system to have not "resolved" (which I understand to mean remove) the ligature point in Mr Charlton's cell. I have not therefore made this proposed finding.

#### **Section 26(2)(g) of the Act**

*Finding 1 – The SPS's planning and implementation of MORS at HMP Barlinnie was defective due to the failure to ensure that GGHB would implements aspects of this policy.*

[146] The family of Mr Charlton invited me to make this finding under section 26(2)(f) of the Act. The Crown, POA, GGHB and Officer Templeton adopted a neutral position in relation to this issue. The Scottish Ministers acknowledged that this was a failing but opposed this finding.

[147] I am satisfied that the SPS did not obtain the consent of GGHB to fulfil key aspects of MORS prior to attempting to implement it at HMP Barlinnie. The reasons for this are unclear, but this must have been known by those involved in preparing the policy.

[148] Self-evidently it makes no sense to ask a prison to implement a policy which relies on an organisation to undertake aspects of it, without that organisation having consented to fulfilling this role. This has resulted in MDCCs not taking place for prisoners at HMP Barlinnie, or care plans being completed in accordance with the policy, since December 2014.

[149] It is essential that the SPS takes steps to ensure that it obtains the consent of an organisation to undertake aspects of a policy prior to its implementation, so that this mistake is not repeated. It should therefore make this an essential part of its system in relation to the implementation of its policies. If it does not do so, this could result in the unnecessary death of prisoners.

***Finding 2 - Officers at HMP Barlinnie removed prisoners from association without authority as they incorrectly believed that this is authorised by MORS.***

[150] The Crown and family of Mr Charlton invited me to make a finding in relation to the defect identified in this finding under sections 26(2)(f) and (g) of the Act. I have set out above why I have not made a finding in this regard under section 26(2)(f). In respect of section 26(2)(g), Mr Templeton and the Scottish Ministers accepted that it was open to me to make this finding. The POA and GGHB adopted a neutral position in relation to this issue.

[151] I consider that it is appropriate to make a finding under this section in relation to this defect in the system at HMP Barlinnie, which has resulted in numerous prisoners being removed from association, without proper authority, since MORS was introduced on 30 December 2014.

[152] Although Mr Beaton, the Acting Deputy Governor of HMP Barlinnie, sought to address this by sending an emails to staff at HMP Barlinnie on 2 and 16 September 2025, setting out the correct procedure that should be followed, this does not appear to have resolved the issue, as FLM Luke said in his evidence (after these emails were sent) that MORS provided authority for removing prisoners from association. This suggests that further steps might require to be taken to address this issue.

[153] As this defect can negatively affect the mental health of prisoners when they are vulnerable because of taking an illegal substance, this has the potential to cause the unnecessary death of other prisoners if this leads to them ending their life.

*Finding 3 – It was a defect in the SPS’s suicide prevention system to have not carried out an assessment of the ligature risks in standard cells at HMP Barlinnie prior to Mr Charlton’s death.*

[154] The Crown and family of Mr Charlton invited me to make a finding in relation to this failure under sections 26(2)(e) and (g) of the Act. Mr Templeton accepted that it was appropriate for me to make this finding under this section of the Act. GGHB and the POA adopted a neutral position in relation to this issue. The Scottish Ministers did not invite me to make this finding but accepted that the SPS ought to have carried out an

assessment of the ligature risks in standard cells at HMP Barlinnie. They also accepted that this was a defect in the SPS's suicide prevention system at this prison.

[155] As a consequence of not carrying out an assessment of the ligature risks in Mr Charlton's cell, the SPS did not know where the ligature risks were. Death by hanging is known risk of suicide in prisons, so the failure to do this was a defect in its system for preventing suicide. It does not mean that every ligature risk needs to be removed, but an assessment should be completed to determine whether it is reasonably practicable to do so. If this is not addressed, it is possible that ligature risks that ought to be removed are used by a prisoner to end their life.

[156] Following the recommendations made by Sheriff Collins in the *Inquiry into the deaths of Ms Katie Allan and Mr William Brown*, the SPS are taking various steps to identify and address ligature risks within its prisons. It was clear from the evidence of SPS's Deputy Chief Executive, Ms Linda Pollock, that the SPS are taking this matter seriously.

[157] I accept that it is important that this is done a structured and orderly manner, and that a full assessment of the ligature risks in Scottish prisons will take time. The SPS should nonetheless ensure that it carries out a suitable and sufficient assessment of the ligature risks in all cells at HMP Barlinnie and appropriately addresses any risks that are identified as soon as reasonably practicable.

*Finding 4 – The care plans for prisoners that have been placed on MORS at HMP Barlinnie, have not been completed in accordance with this policy, as healthcare staff have not specified the type of observation that is to be completed in addition to the frequency of observations.*

[158] None of the participants invited me to make a finding in relation to this matter, although I raised this as an issue during the inquiry.

[159] FLM Crinean said in his evidence that the care plans that he reviewed at HMP Barlinnie do not contain this information and only specify the frequency of the observations that are to be undertaken. This is unsurprising as the NHS care plan that is used at HMP Barlinnie only requires the frequency of observations to be specified.

[160] I initially considered that this demonstrated a lack of understanding by officers at HMP Barlinnie of MORS and its requirements. On reflection, it is a more significant issue than this, as there may be situations when it would be unnecessary for officers to carry out both types of observation. For example, if a prisoner is sleeping, waking them to obtain a verbal response every 15 minutes, especially if they remain subject to MORS for days (as Mr Charlton was) might be seriously detrimental to their welfare.

[161] It is clear from Mr Crinean's email dated 29 March 2024, that the practice he considers should be adopted is for prisoners to be wakened when they are asleep to obtain a verbal response. I consider that this is something that healthcare staff should consider when specifying the type of observation to be undertaken. For some prisoners,

there may be a medical reason that requires them to be woken for this purpose. For others, this might not be necessary, and it may be better for their health if they are allowed to sleep without interruption.

[162] This is an important issue that I consider has the potential to result in prisoners dying, for example, if a prisoner is unnecessarily wakened for an extended period and this leads to a deterioration in their mental health to the extent that they end their life.

*Finding 5 - The DIPLAR in relation to Mr Charlton was inadequate, as it failed to identify the defects in system at HMP Barlinnie in respect of MORS, the failures by officers in respect of this death, and the steps that required to be taken to prevent other prisoners dying in similar circumstances.*

[163] The Crown and family of Mr Charlton invited me to make a finding in respect of the failings in the DIPLAR in relation to Mr Charlton's death. Officer Templeton accepted that it is open to me to do so. The POA and GGHB adopted a neutral position in relation to this issue. The Scottish Ministers opposed a finding in relation to this issue, although acknowledged that there had been significant failings in this DIPLAR.

[164] The DIPLAR is an essential part of the SPS's system of compliance. It is the system through which it seeks to identify the cause of the death of prisoners so that it can take steps to avoid similar deaths occurring. It is therefore crucial that this system results in a full and thorough investigation of deaths in prison and provides appropriate actions to address any issues that are identified.

[165] The DIPLAR in respect of Mr Charlton was not a full and thorough investigation of this death for the reasons that I provide above. No explanation was provided during

the inquiry for not investigating many of the failures in respect of this death, especially when they were readily apparent at the time of the DIPLAR.

[166] The one action that was identified in the DIPLAR was that “FLMs must ensure all staff fully understand the MORS policy and their responsibility with regards carrying out observations.”

[167] This action does not specify who is responsible for ensuring that FLMs address this. Nor does it specify the steps that the FLMs were to take to achieve this, when this action was to be completed, or provide any mechanism for reviewing and assessing the completion of the action. It was therefore ineffective from a compliance perspective, which is supported by the fact that there is no record of any steps being taken at HMP Barlinnie in relation to this action.

[168] As a result of these failings in the DIPLAR in respect of Mr Charlton, by time of the 2023 audits, not only had the issues that contributed to his death largely persisted, but the circumstances of his death seemed to have been forgotten. This is demonstrated by Mr McFedries being unaware of the relevance of Mr Charlton’s death to the findings in the 2023 audits, despite him being one of the persons tasked with addressing the issues that they identified.

[169] Ms Lindsay Baillie is employed by the SPS as a DIPLAR case worker and provided a statement to the inquiry in which she refers to various improvements that have made to the DIPLAR system since 2019. At no point in her statement does she acknowledge the clear and obvious failings in respect of Mr Charlton’s DIPLAR. She does explain how they would not occur now as a result the improvements that have

been made to the system and focuses on the steps that are taken to ensure that the actions identified in the DIPLAR are addressed. This does not address the fact the DIPLAR in respect of Mr Charlton failed to identify the actions that required to be taken.

[170] Governor Stoney also gave evidence in relation to the DIPLAR concerning Mr Charlton and said that there is now an improved system for ensuring that any actions are addressed. He also did not acknowledge the significant failings in respect of this DIPLAR.

[171] I am concerned by the scale of the failings in relation to this DIPLAR and lack of acknowledgment of them during the inquiry, which suggests they may be the product of a system that is insufficient to achieve its purpose. Due to the importance of the DIPLAR system in ensuring that the SPS learns the necessary lessons from deaths in prisons, it is essential that it takes steps to ensure that the failings in respect of Mr Charlton's DIPLAR are not systemic and likely to be repeated.

*Finding 6 – The SPS's system for ensuring that HMP Barlinnie addressed its failure to comply with MORS was ineffective, as it relied on assurances provided by this prison that it had resolved the identified issues without critically reviewing and verifying the information provided by this prison.*

[172] The Crown, family of Mr and Officer Templeton accepted that it is open to me to make this finding. The POA and GGHB adopted a neutral position in relation to this issue. The Scottish Ministers opposed this finding, although they accepted that there had been a failure to address some of the issues identified in the 2023 audits.

[173] Mr Allister Purdie is a Senior Operational Advisor at the SPS and gave evidence in relation to the steps that were taken by the SPS to ensure that HMP Barlinnie was addressing the issues identified in 2023 audits. At the time of these audits, he was employed by the SPS as its Operation Director and was the person at SPS headquarters that was responsible for ensuring that HMP Barlinnie addressed these issues. In his statement he states:

“I am not aware of there being any culture of non-compliance with the MORS policy in HMP Barlinnie or any of our other establishments. Barlinnie were taking all the appropriate actions to address the shortfall in their audit. They had directed additional local FLM resource to address the audit outcomes. All other FLM’s were attending further training/awareness and discussions sessions with the Deputy Governor, Jim Beaton and feeding this information back to their staff. They were sending the message to their staff of the importance of carrying out actions as per the MORS Policy correctly and completing the paperwork correctly. They were doing focused work with the FLM group who were responsible for overseeing and managing the MORS documents, to provide an additional level of assurance.”

[174] Mr Campbell Rutherford is employed as a Business Manager by the SPS and assisted Mr Purdie in his role as the Operations Director at SPS headquarters in ensuring that HMP Barlinnie addressed the issues identified in the 2023 audits. In his statement he states:

“There has not been any evidence in the business review minute which suggests we required to do a follow up with HMP Barlinnie or provide additional support. We would not require doing a follow up with the establishment if there is assurance that they are doing what is required to be done.

There has been no escalation on our part as we have been assured that HMP Barlinnie had this matter in hand from their entries on Action Plan tracker. Currently at this moment in time, Barlinnie are getting their winter 2025 business review. Looking at their action plan tracker from 6 months ago, there is no mention in the minute of the previous business meeting highlighting any issues.

Therefore, we can assume that the minute is competent and that all matters in the action plan, following the MORS audit report, have been dealt with.”

[175] While it is correct that steps were taken to address the issues identified in the 2023 audits, Mr Purdie was wrong to conclude that HMP Barlinnie were taking all the appropriate actions. One of the actions identified in the 2023 audits was that staff at HMP Barlinnie were to obtain support from the MORS policy holders in relation to the aspects of the policy that GGHB refused to undertake. In terms of Ms Holloway’s evidence, that was not done. While a solution of sorts was agreed with the NHS in relation to this, this should have been discussed with the MORS policy holders, if nothing else, so that they were aware of the position and could take the appropriate steps to address the issue at a national level. If this had been done, the MORS policy holders should have also identified that the NHS care plans do not require the type of observation to be specified and asked for this to be addressed.

[176] The statement that the issues identified in these audits had been addressed was also incorrect, because it is clear from the emails that FLMs Crinean and Weaver sent to staff seeking to address the continuing failure to complete the documentation correctly, that this issue persisted. Given the extent of the failings that were identified in the 2023 audits, with only limited assurance being in relation to a system that is supposed to preserve the lives of prisoners, I consider that a suitable and sufficient system of compliance would have taken steps to objectively verify the assurances that were being provided by HMP Barlinnie. This could easily have been done by carrying out a further audit, which is likely to have established that the issues had not been resolved. In

relation to such a significant policy for which limited assurance had been provided, the SPS's system of compliance should have required further external audits to be conducted until an adequate level of assurance was achieved.

[177] The other significant failing following the 2023 audits was that the SPS's system of compliance did not investigate whether the continuing documentation issue in relation to MORS at HMP Barlinnie was due to officers not carrying out the required observations. This is what occurred in relation to Mr Charlton's death, so the SPS should have been far more alert to this possibility. It is also an obvious conclusion from the 2023 audits that this was likely to be an issue. The SPS's system of ensuring that its prisons complied with its policies and systems therefore lacked the critical review that would be apparent in an effective compliance system.

[178] As a result of the failures of the SPS's system for ensuring that HMP Barlinnie complied with MORS, the full extent of the issues was not identified and addressed. That is likely to have placed lives of prisoners at risk. It is therefore essential that the SPS addresses this shortfall in its system of compliance as soon as reasonably practicable to avoid other prisoners dying in similar circumstances to Mr Charlton.

## **RECOMMENDATIONS**

[179] To address the issues that have been identified in this inquiry, I make the following recommendations under sections 26(1)(b) and (4) of the Act.

**Recommendation 1 - As soon as reasonably practicable, the SPS should put in place a written system of work at HMP Barlinnie in relation to MORS that:**

- **Requires a specific officer to observe prisoners that have been placed on MORS and complete the observation documentation.**
- **Requires managers to actively monitor compliance with MORS to ensure that the required observations are carried out during every shift.**
- **Specifies the procedure that is to be followed in relation to the aspects of MORS that GGHB have refused to undertake.**
- **Specifies that MORS does not provide authority for removing prisoners from association and if this is deemed necessary, the appropriate procedure (such as that prescribed under Rules 41 or 95 of the Prison Rules) should be followed.**
- **Requires healthcare staff to specify the type of observation that is to be undertaken for prisoners that have been placed on MORS when completing a prisoner's care plan. This should include the type of observation that requires to be undertaken for prisoners that are sleeping and when it is appropriate to wake them for the purpose of carrying out observations.**
- **Specifies the procedure that is to be followed to ensure that officers coming on duty are made aware of the prisoners that have placed on MORS, as well as the frequency and type of observation that requires to be undertaken in respect of them.**

[180] This recommendation seeks to address the issues in relation to the implementation of MORS at HMP Barlinnie. I consider that this recommendation can be implemented through an SOP being put in place at this prison that addresses these matters.

[181] In respect of the family of Mr Charlton's proposed recommendation that the observation documentation should contain sufficient space for the necessary entries to be made, I don't recall this being an issue that could lead to prisoners dying and have not therefore included it as a recommendation.

**Recommendation 2 - As soon as reasonably practicable, the SPS should ensure that it provides officers at HMP Barlinnie with suitable and sufficient training on this prison's system for implementing MORS.**

[182] If this training is provided by staff at HMP Barlinnie, the persons that provide the training should attend the SPS's formal MORS training.

**Recommendation 3 – As part of the audits that FLMs undertake at HMP Barlinnie in relation to MORS, they should investigate whether the failure by officers to complete the observation documentation is because they have not undertaken the required observations and ensure that any failure to comply with these aspects of the system is appropriately addressed.**

[183] I have set out above that it is likely that some of these documentation errors are because officers have not completed the required observations. This is a serious matter and should be investigated and addressed accordingly.

**Recommendation 4 - As soon as reasonably practicable, the SPS should amend MORS so that:**

- **Requires a specific officer to observe the prisoners that have been placed on MORS and complete the observation documentation.**
- **Ensures that compliance with this policy is actively monitored by managerial staff during every shift.**
- **Interacts with the TTM system in a manner that prevents officers from attributing the warning signs of suicide that Mr Charlton was exhibiting to intoxication.**
- **Specifies that when a prisoner is placed on MORS their person and cell are searched to remove their access to illegal substances.**
- **Specifies the type of observation that requires to be undertaken for prisoners that are sleeping, including when it is appropriate to wake them for the purpose of carrying out observations.**
- **Does not include a requirement for another organisation (such as GGHB) to undertake tasks that they have not consented to undertaking.**

[184] I have set out why I consider that these changes require to be made to the MORS system at HMP Barlinnie. This finding seeks to address the policy as it applies to all prisons.

[185] In relation to the recommendation that MORS should interact with the TTM system to prevent officers from attributing the warning signs of suicide that Mr Charlton was exhibiting to intoxication, I consider that this is principally an issue for the TTM

system. Insofar as MORS is concerned, this might only require to be briefly addressed in the policy and training provided to officers.

[186] I was impressed by Ms Taylor's evidence in relation to this issue and her suggestion that a generic support plan should be introduced for prisoners. This would seem to achieve the objectives of encouraging officers to take a more holistic approach to supporting prisoners and making the task of supporting prisoners less onerous for officers.

[187] In terms of the recommendation that healthcare staff should specify the type of observation that should be completed for sleeping prisoners, I appreciate that this will need to be discussed and agreed with the various NHS health boards and that this is principally a medical issue.

**Recommendation 5 - As soon as reasonably practicable the SPS should ensure that all its staff that are responsible for implementing MORS are provided with suitable and sufficient training in respect of this policy and the system for implementing it within the prison in which they work.**

[188] This is separate training to that I am proposing in respect of the staff at HMP Barlinnie. In terms of the evidence during the inquiry, it is only new recruits and officers that have been promoted, that are able to attend the SPS's formal MORS training. This is insufficient in relation to a policy that it is critical to preserving the lives of prisoners and should be addressed as soon as reasonably practicable.

[189] Furthermore, I have set out amendments that I consider should be made to MORS and officers should be provided with suitable and sufficient training in relation

to any changes that are made to this policy. Given the extent of this task, this might best be achieved by way of an e-learning package, which can be followed up as appropriate with face-to-face training. Any such training should be interactive to the extent of requiring officers to demonstrate their understanding of the system by answering questions.

[190] I also suggest that any learning points identified through this training are provided to the MORS policy holders, and persons responsible for ensuring compliance with this policy and system. If this is done, it would result in a far more connected and robust system.

**Recommendation 6 - As soon as reasonably practicable the SPS should revise its TTM system so that it prevents officers from attributing the warning signs of suicide that Mr Charlton was exhibiting to intoxication.**

[191] There was no dispute that the TTM system should have resulted in Mr Charlton being placed on TTM if he said that he intended to kill himself. This recommendation therefore seeks to address the officers' failure to place Mr Charlton on TTM in the scenario that he did not say this.

**Recommendation 7 - A soon as reasonably practicable the SPS should carry out a suitable and sufficient risk assessment of the ligature risks within standard cells at HMP Barlinnie and eliminate any risks that are identified so as far as is reasonably practicable.**

[192] This is self-explanatory and requires no further elaboration.

**Recommendation 8 – The SPS should consider the failings in the DIPLAR in respect of Mr Charlton’s death to ensure that the DIPLAR system provides a suitable and sufficient method of establishing the cause of death of prisoners, any failings in relation to these deaths, and the actions that require to be taken to ensure that other prisoners do not die in similar circumstances.**

[193] One way this review could be undertaken would be to compare the findings and recommendations in a sample of DIPLARs, to those in the corresponding FAI.

[194] In relation to the issues concerning the DIPLAR system, the Crown proposed the following recommendation:

“The DIPLAR process should be reviewed and issues of physical environment, including ligature points, should be considered as part of the DIPLAR process. Details of every ligature anchor point discussed at the DIPLAR should be passed to Estates for consideration.”

[195] Although I accept that in certain deaths it might be appropriate to consider the physical environment of the prisoner, including ligature risks, this will not be necessary in respect of all deaths. To this extent, this proposed recommendation is unnecessarily onerous.

[196] I agree with the Crown that as part of the review of the DIPLAR system that I suggest should be undertaken, consideration should be given to who should be made aware of the findings in a DIPLAR. In relation to the suicides by hanging, I agree that it should be shared with the persons responsible within the SPS for addressing this risk if this is not already done. This should also occur in relation to any deaths due to intoxication or involving a particular policy or system. For example, the MORS policy

holders should have been made aware of the findings in respect of the death of Mr Charlton and the persons responsible for providing training to officers in relation to this policy. If this had been done, this should have prompted them to take action to address some of the issues that have been identified in this inquiry.

**Recommendation 9 - The SPS should consider its failures in respect of MORS and revise its system for implementing its policies, checking and monitoring that they are complied with and addressing issues of non-compliance identified within its prisons.**

[197] The actions that I identify in this recommendation are essential requirements of an effective compliance system. The SPS failed in respect of each of these requirements in respect of MORS. Moreover, many of the failures identified in this inquiry would still seem to persist at HMP Barlinnie, over 11 years after this policy was introduced.

[198] The SPS is subject to the requirements of the Health and Safety at Work Act 1974. In terms of section 3 of this act, this applies to the actions that it takes in respect of prisoners within its care. The HSE's guidance document Managing for health and safety HSG65 (third edition) (which can be downloaded at <https://www.hse.gov.uk/pubns/priced/hsg65.pdf>) provides useful guidance on the principles of an effective safety system. It recommends that organisations adopt a plan, do, check, act approach to managing health safety, which it defines as follows:

**Plan** - Determining your policy; Planning for implementation

**Do** - Profiling your health and safety risks; Organising for health and safety; Implementing your plan.

**Check** - Measuring performance; investigating accidents and incidents.

**Act - Reviewing performance; Learning lessons.”**

[199] I consider that this guidance, and the steps that it sets out should be taken in relation to the plan, do, check, act approach, provides a useful framework for the SPS to use in relation to the introduction of its key polices and systems. If it had followed this approach in relation to MORS, the failings that been identified in this inquiry should not have occurred.

### **FINAL REMARKS**

[200] All the participants and I expressed our condolences to the family of Mr Charlton during the inquiry. They listened to the evidence in the inquiry with dignity, especially given the extent of the failings that have been identified.

[201] Mr Charlton’s sister, Ms Leanne Charlton, was present during many days of the evidence. She eloquently spoke, without objection, to an affidavit that she prepared. It is an important aspect of this type of inquiry that the family of the person that has lost their life are heard. The best way for me to do that is to set out the terms of

Ms Charlton’s affidavit, which are as follows:

“Michael Charlton was my brother. The point we as a family would like to raise is that we feel the Scottish Prison Service has, on multiple occasions, failed Michael. They have neglected Michael's care and failed to watch him when he was at his most vulnerable and extremely distressed. They failed to provide a standard of care towards him that should be expected, where one would believe prisoners would be safe.

I am not blaming anyone in particular for Michael's death, as in the run up there have been many factors that may have influenced this. It has been heartbreaking to go through a lengthy process. My mum, his children, and our family are

badly affected that Michael is no longer here today. We have to live with this every day, whereas to the people who were looking after him it was just a job.

My other brother also died following failures by the state. He was neglected by police officers who were supposed to be helping him and he took his own life. Our family has suffered two preventable deaths. My mum has lost two sons and I've lost two brothers. We are devastated that Michael was failed so badly.

I cannot believe that officers were saying that they had completed 15-minute checks, when the evidence from camera footage suggests otherwise. They did not do their job correctly, and no other person would get away with this without consequences. If anyone involved in this process thinks it is acceptable to have that standard of care, then that speaks volumes for the health and safety of fellow prisoners and the type of people in power here today.

If I am being honest, the number of deaths in prison is already high by suicide, so we feel as a family that despite this Fatal Accident Inquiry, nothing will change within Barlinnie Prison and it will continue to be the same. How many deaths and families affected does it take? We really do hope things can move forward for prisoners and their families, and that no other family or person must experience this in the future."

[202] I trust that the Scottish Ministers will carefully consider this determination and take the appropriate steps to prevent other prisoners dying in similar circumstances to Mr Charlton.