SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2017] FAI 23

B2127/16

DETERMINATION

BY

SHERIFF PRINCIPAL C D TURNBULL

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES (SCOTLAND) ACT 1976

into the death of

COLIN DONALD PENROSE

11 October 2017

DETERMINATION

The Sheriff Principal, having considered the information presented at the inquiry, determines in terms of section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 that:-

[a] Colin Donald Penrose, born 12 June 1991, then a prisoner within HMP Barlinnie, Lee Avenue, Glasgow, died on 20 March 2014 within cell 4/4 of E Hall, HMP Barlinnie.

[b] Colin Donald Penrose was murdered by John Clark who bound his hands with a shoelace, placed a ligature around his neck and strangled him. The cause of the death was ligature compression of the neck.

[c] A reasonable precaution, whereby the death of Colin Donald Penrose might have been avoided, would have been for a bullying marker to have been added to John

Clark's Risks and Conditions on the SPS PR2 system as a consequence of the assault he perpetrated at HMYOI Polmont on 30 July 2012.

[d] A defect in any system of working which contributed to the death of Colin Donald Penrose was that, prior to his death, no adequate guidance or training was available to SPS staff in relation to the recording of entries within a prisoner's Risks and Conditions on the SPS PR2 system.

[e] The other facts which are relevant to the circumstances of the death of Colin Donald Penrose are as follows:-

1. By no later than May 2013, by way of the report prepared by their operational auditors, Geoff Storer and Andrew Davidson, SPS were aware of problems across their PR2 computer record system in relation to the quality of entries on prisoners' Risk and Conditions records. SPS were aware that the problems were most acute in relation to bullying where entries were generally very poor.
2. SPS did not act in relation to those failures prior to the death of Colin Donald Penrose.

NOTE

1. Introduction

[1] An inquiry under and in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (hereinafter referred to as "the 1976 Act"), was held into the death of Colin Donald Penrose, who died on 20 March 2014 whilst in legal custody at HMP Barlinnie (hereinafter referred to as "Barlinnie"), Glasgow. This determination is made up of 22 parts, namely:

2. The Inquiry Process

[2] Preliminary hearings took place on 6 October, 16 November and 12 December; all 2016. Thereafter, the inquiry heard evidence from 20 witnesses over 13 days between January and April 2017. The witnesses who gave evidence are detailed in Appendix 1 below.

[3] Closing submissions were made on 28 April 2017. At that time the means by which the inquiry was to receive the evidence of two further witnesses (in relation to whom statements had been produced and referred to) was still to be finally determined. In that regard, further hearings took place on 6 July and 7 August 2017. On 7 August 2017, as all parties who were represented at the inquiry agreed to their admission, in terms of rule 10 of the Fatal Accidents and Sudden Deaths Inquiry Procedure (Scotland)

Rules 1977, I admitted in place of the oral evidence of those witnesses (who are detailed in Appendix 2 below) written statements signed by them and sworn to be true before a notary public.

[4] Parties entered into three separate joint minutes of admission, the relevant terms of which are reflected in this determination. In addition, as directed by me, the prison experts for the Crown and for the Scottish Prison Service (who I hereinafter refer to as "SPS") identified the areas of dispute between them. These are reproduced in Appendix 3 below.

[5] The public interest in the inquiry was represented by Mrs Ross, senior procurator fiscal depute; Mr Scullion, solicitor advocate appeared on behalf of SPS; Mr Adams, solicitor appeared on behalf of the Prison Officers Association (Scotland)(who I refer to as "POAS"); Miss Davie, advocate appeared on behalf of NHS Greater Glasgow & Clyde (who I refer to as "NHS"); Mr Cameron, solicitor advocate appeared on behalf of John Clark; and Mr Gillies, solicitor advocate appeared on behalf of William McDonald (the SPS employee who investigated the Polmont Incident referred to below). I wish to record my thanks to counsel and the solicitors appearing in the inquiry for their valuable and professional contributions.

3. The Legal Framework

[6] In terms of section 1 of the 1976 Act, where a person who has died was, at the time of his death, in legal custody the procurator fiscal for the district with which the circumstances of the death appear to be most closely connected is required to investigate

and apply to the sheriff for the holding of an inquiry into those circumstances. For the purposes of section 1, a person is in legal custody if he is detained in, or is subject to detention in, *inter alia*, a prison.

[7] In terms of section 6(1) of the 1976 Act, at the conclusion of the evidence and any submissions thereon, or as soon as possible thereafter, the sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction:

(a) where and when the death and any accident resulting in the death took place;

(b) the cause or causes of such death and any accident resulting in the death;

(c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;

(d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and

(e) any other facts which are relevant to the circumstances of the death.

[8] The procurator fiscal represents the public interest. In terms of section 4(1) of the 1976 Act, the procurator fiscal is compelled to adduce evidence with regard to the circumstances of the death which is the subject of the inquiry. An inquiry under the 1976 Act is an inquisitorial process. It is not the purpose of such an inquiry to establish civil or criminal liability.

4. Colin Penrose

[9] Colin Penrose was born on 12 June 1991. He was 22 when he died. Material within his prison records suggests that his early childhood was stable and uneventful. He first came to the attention of the Scottish Children's Reporter Administration at the age of 11; committed a number of offences between 2004 and 2005; and was placed in a secure school at the age of 14 to address his sexualised behaviour.

[10] His first adult conviction was for theft by housebreaking in April 2008; he was sentenced to probation and community service. In May 2008 he was convicted of a breach of the peace and two contraventions of sections 52(1) & (3) of the Criminal Law (Consolidation) (Scotland) Act 1995 (vandalism); he was fined and compensation orders were imposed. In June 2008 he was convicted of a breach of the peace; he was again sentenced to probation. Also in June 2008, he was convicted of theft by housebreaking; he was again sentenced to community service. In November 2008, he was convicted of reset; and in December 2008 of failing without reasonable excuse to comply with a bail condition, aggravated by the fact that he was on bail at the time. In respect of both these offences he was sentenced to two months detention. In January 2009 he breached his probation, the probation order was revoked and he was sentenced to a further three months detention. In June 2009, he was again convicted of failing without reasonable excuse to comply with a bail condition. On this occasion, he was fined. In January 2010 he was convicted of an assault to injury whilst on bail; he was sentenced to seven months 14 days detention. In July 2010 he acquired his first sheriff and jury conviction, a contravention of section 6 of the Criminal Law (Consolidation)(Scotland) Act 1995

(indecent behaviour towards girl between 12 and 16) for which he was sentenced to 15 months detention.

[11] On 13 December 2011 he pled guilty to an offence in contravention of sections 28 and 29 of the Sexual Offences (Scotland) Act 2009. Those sections create offences of having intercourse with an older child; and of engaging in penetrative sexual activity with or towards an older child. For the purposes of those sections, an older child is one who is over the age of 13, but under the age of 16. The offence was committed on 26 February 2011; only eight days after Mr Penrose had been released on licence following the July 2010 conviction referred to in the preceding paragraph.

[12] In relation to the conviction referred to in the preceding paragraph, on 21 March 2012 Mr Penrose was made the subject of an extended sentence of three years two months, consisting of a custodial term of one year eight months and an extension period of one year six months. He was also made subject to the notification requirements of the Sexual Offences Act 2003 for an indefinite period. A Sexual Offences Prevention Order was also imposed prohibiting him from approaching, speaking or communicating in any way, either directly or indirectly, with any female child under the age of 16 years and from entering any children's play areas, children's leisure areas, schools or nursery grounds.

[13] Following the imposition of the custodial term referred to in the preceding paragraph, Mr Penrose was admitted to HMP Greenock on 22 March 2012. He was transferred to HMYOI Polmont (hereinafter referred to as "Polmont") on 26 March 2012 and then to HMP Glenochil on 3 September 2012. He was thereafter transferred to

Barlinnie on 23 October 2012 where he remained until his release on non-parole licence on 18 January 2013.

[14] On 6 March 2013 police officers carried out an unannounced visit to Mr Penrose's home. As part of their visit, they checked a laptop which was in the possession of Mr Penrose. An examination of the laptop revealed that Mr Penrose had been accessing pornographic sites. The titles of the sites gave cause for concern and indicated that Mr Penrose may have been viewing child images. On 26 March 2013 Mr Penrose's non-parole licence was revoked under section 17 of the Prisoners and Criminal Proceedings (Scotland) Act 1993. Mr Penrose was admitted to HMP Greenock on 27 March 2013. He had been at liberty for just over two months.

[15] On 2 April 2013 Mr Penrose was transferred from HMP Greenock to Barlinnie, where he remained until the date of his death on 20 March 2014. He was in legal custody as at the date of his death.

[16] On 10 December 2013 Mr Penrose pled guilty to a contravention of section 52(1)(a) of the Civic Government (Scotland) Act 1982 (taking, or permitting to be taken, or making any indecent photograph or pseudo-photograph of a child). He was sentenced to eight months imprisonment and was made subject to the notification requirements of the Sexual Offences Act 2003 for a period of ten years.

5. John Clark

[17] John Clark was born on 25 August 1991. Material within his prison records suggests a difficult and troubled childhood. Both his parents had addiction issues.

Mr Clark and his sister were known to social services due to concerns regarding the level of care provided to them. He completed his secondary education at a specialist resource centre for disaffected young people. He declined further offers of assistance. He has never been in employment. By the time of his High Court conviction (see paragraph [19] below), he had been addicted to heroin for approximately two years.

[18] Mr Clark's first adult convictions were for two contraventions of section 27(1)(a) of the Criminal Procedure (Scotland) Act 1995 (failing without reasonable excuse to appear at court, having been granted bail) in November 2009. Following a deferral of sentence, he was sentenced to 12 months' probation on 30 March 2010; that probation order was subsequently revoked and on 10 September 2010 he was sentenced to 60 days' detention. In December 2009 he was convicted of theft by housebreaking, whilst the subject of a bail order. Following a number of deferrals of sentence, on 30 March 2010, he was sentenced to 12 months' probation. In March 2010 he was convicted of two charges of theft by shoplifting, in respect of which he was ultimately admonished. In September 2010 he was convicted of breach of probation. The probation order was revoked and he was admonished. In January 2011 he was admonished in relation to charges of theft by shoplifting; a contravention of section 150(8) of the Criminal Procedure (Scotland) Act 1995 (failing without reasonable excuse to attend any diet of which he had been given due notice); and a contravention of section 52(1) & (3) of the Criminal Law (Consolidation) (Scotland) Act 1995 (vandalism).

[19] On 25 March 2011 at the High Court in Edinburgh, Mr Clark pled guilty to an offence of assault to injury and robbery using a knife, in respect of which he was made

the subject of an extended sentence of seven years eight months, consisting of a custodial term of four years eight months (to run from 20 October 2010) and an extension period of three years. This offence was committed in the early hours of 18 October 2010. Mr Clark was arrested the following morning.

[20] Following the imposition of the custodial sentence referred to in the preceding paragraph, Mr Clark was admitted to HMP Kilmarnock on 25 March 2011. He was transferred to Polmont on 28 March 2011; then to HMP Low Moss on 3 April 2013; then to HMP Shotts (hereinafter referred to as "Shotts") on 22 April 2013; and to HMP Edinburgh on 10 July 2013. Mr Clark was transferred to HMP Addiewell on 21 November 2013. He was released from there, on non-parole licence, on 28 November 2013.

[21] Only 11 days later, on 9 December 2013, Mr Clark was arrested by officers of Police Scotland. The following day, he appeared from custody on summary complaint at Ayr Sheriff Court and pled guilty to charges of theft of a motor vehicle, and contravening section 163(1) & (3) of the Road Traffic Act 1988 (failure to stop a vehicle on being required to do so by a police officer), section 143(1) & (2) of the Road Traffic Act 1988 (driving without insurance); and section 2 of the Road Traffic Act 1988 (dangerous driving). Bail was refused and he was remanded in custody to Barlinnie pending the preparation of a criminal justice social work report. On 6 January 2014 Mr Clark was sentenced to nine months imprisonment, backdated to 10 December 2013, and was disqualified from driving for a period of four years. Mr Clark remained at

Barlinnie until he was moved to HMP Edinburgh following the death of Mr Penrose on 20 March 2014.

[22] On 21 January 2014 Mr Clark's non-parole licence was revoked under section 17 of the Prisoners and Criminal Proceedings (Scotland) Act 1993, as a result of his offending whilst released on license. His earliest date of release was 19 June 2018.

[23] Between 22 November 2010 and 25 November 2010, Mr Clark shared a cell with a prisoner who had been convicted of a sexual offence against a child. Between 31 December 2010 and 1 January 2011, Mr Clark shared a cell with a prisoner who had been convicted of a sexual offence against a child. Between 5 January 2011 and 7 January 2011, Mr Clark shared a cell with a prisoner who had been convicted of a sexual offence. Between 30 January 2014 and 6 February 2014, Mr Clark shared a cell with a prisoner who had been charged with a sexual offence.

6. History Between Colin Penrose and John Clark

[24] Between 8 April 2011 and 4 October 2011, Mr Penrose and Mr Clark shared the same accommodation area within Monro level 4 at Polmont. Between 26 March 2012 and 3 September 2012, Mr Penrose and Mr Clark again shared the same accommodation area within Monro level 4 at Polmont.

[25] DM was a young offender within Polmont between October 2011 and January 2013. In a statement to Detective Constable Moira Fyfe of Police Scotland on 21 March 2014, DM stated that he, Mr Clark and Mr Penrose had worked together within the tea packaging department at Polmont. Additionally he stated that Mr Clark and Mr Penrose

spent recreation time together during which they played pool or the X Box. Neither the period or periods during which DM, Mr Clark and Mr Penrose worked together within the tea packaging department at Polmont, nor the frequency of Mr Clark and Mr Penrose socialising (if they did, in fact, socialise) during recreation time at Polmont were explored in the evidence before the inquiry.

7. Circumstances of Colin Penrose's Death

[26] Barlinnie has six different halls. One of them is Echo Hall, commonly referred to as E Hall. E Hall has four floors. On each floor there are approximately forty cells. E Hall is a protection hall for those prisoners who require protection from other prisoners. At the time of Mr Penrose's death, the prisoners located there were either offence protection prisoners (i.e. sex offenders) or non-offence protection prisoners (i.e. prisoners who required protection from other prisoners for reasons other than the nature of the offences they had committed).

[27] In the circumstances more fully described below (see part 17), on 14 March 2014 Mr Penrose and Mr Clark were allocated to share cell 4/4 in E Hall. At that time, and as at 20 March 2014, Mr Penrose was an offence protection prisoner (i.e. a sex offender) and Mr Clark was a non-offence protection prisoner.

[28] On 19 March 2014 at 20:14 hours Mr Clark telephoned his grandmother. During the telephone call he stated that he was sharing a cell with Mr Penrose. Mr Clark's grandmother asked what Mr Penrose was in for. Mr Clark stated that he did not know

but that they were the same age. Mr Clark told his grandmother that he wanted a single cell as he was fed up sharing a cell with people who were only in for a few months.

[29] On 19 March 2014 at 21:00 hours prison officer Graham Sleith commenced night shift within E Hall. At 21:30 hours Mr Sleith carried out a prisoner check within E Hall and confirmed that every prisoner was within their cell.

[30] Within each cell there is a call bell system whereby prisoners can alert prison officers if they require anything. The prisoners can press a button within their cell which lights up a light situated outside their cell and also lights up a panel within the main reception desk on the ground floor.

[31] At just before 02:00 hours on 20 March 2017 there was no light illuminated on the panel in the main reception desk to indicate that any prisoner in E Hall wanted anything. At approximately 02:00 hours Mr Sleith carried out another patrol. As he passed cell 4/4 he noted that the bell light was on. Cell 4/4 was that occupied by Mr Clark and Mr Penrose.

[32] Mr Sleith lifted the spy hole for cell 4/4 and observed Mr Clark standing near to the cell door and facing the door. Mr Sleith asked what was wrong. Mr Clark replied "*he's deid*." Mr Sleith observed Mr Penrose lying on the floor towards the right hand side of the cell. Mr Penrose showed no signs of life. Mr Sleith immediately called for assistance. He radioed the nightshift manager, said that he had a "*non-responder on the top flat of E hall*" and that he required assistance. A "non-responder" call is an urgent call. Mr Sleith could see Mr Penrose lying on his back, with his hands clasped, fingers intertwined, and tied tightly at the wrists. Whilst waiting for assistance, Mr Sleith

maintained observations on the cell through the spyhole and observed Mr Clark sit down and start watching television.

[33] Prison officers Alan Beaton, Iain Muir, Patrick Neal, Gerald Gallagher and a nurse, Katherine Allan, immediately responded to the call for assistance and attended at cell 4/4. Mr Sleith had a sealed pack in his possession which contained a ligature cutter and a key which opened every cell in E Hall. Prison protocol is that the door to a cell occupied by two prisoners cannot be safely opened until there are three or more prison officers present. Upon the arrival of other staff, Mr Sleith opened the sealed pack and used the key to open the cell door, finding both Mr Clark and Mr Penrose within. Prison officers Ian Muir and Patrick Neil cut a ligature from the neck of Mr Penrose, using the ligature cutter, and commenced CPR. Katherine Allan administered oxygen. CPR was continued until paramedics arrived.

[34] Mr Clark was asked to leave the cell and wait in the hallway. Upon leaving the cell he said "*murder*". Mr Clark stated to prison officers Alan Kilpatrick, Ashley Richardson and Alan Beaton "*ah strangled him*" before then stating "*ah did it because he was a beast*" and "*he showed me his paperwork, well I found his paperwork*." When asked how long ago it had happened he said "*about half an hour*". Mr Clark was thereafter taken to the ground floor and placed in an interview room pending the arrival of police officers.

8. Medical Involvement

[35] At approximately 02:05 hours on 20 March 2014, Alan Thom and David Paton were tasked to attend at Barlinnie in their capacity as paramedics with the Scottish

Ambulance Service. Upon their arrival at 02:12 hours they attended at cell 4/4 and found Mr Penrose lying motionless on his back on the cell floor. He appeared lifeless and was blue in colour. His hands were bound together using a shoelace. His hands were clasped with the fingers interlocked. His hands were resting just below the chest at his abdomen.

[36] Mr Thom attached the defibrillator to Mr Penrose's chest however there was no output. He noted that Mr Penrose had what looked like a very tight elastic band around his neck and that there was a definite strangle mark on his neck. Life was pronounced extinct by Mr Paton at 02:20 hours on 20 March 2014.

9. John Clark's Detention and Arrest

[37] Mr Clark was lawfully detained at Barlinnie on 20 March 2014 at 04:02 hours. He was transferred to Helen Street police office and was detained there until 20:46 hours.

[38] Mr Clark was interviewed at Helen Street police office by Detective Constable Alan Moir and Detective Constable Donald MacIntyre on 20 March 2014 at 15:17 hours. Mr Clark made no comment to all questions put to him. Mr Clark was re-interviewed at 20:13 hours and again made no comment to all questions put to him.

[39] Mr Clark was arrested on 20 March 2014 at 20:46 hours.

10. Pathology

[40] On 20 March 2014 a post mortem examination of the body of Mr Penrose took place at the Southern General Hospital in Glasgow.

[41] The findings of the pathologists were that Mr Penrose was seen to have a mark around his neck in keeping with the application of a ligature, such as the shoelaces seen, and which resulted in prominent asphyxia signs which would be in keeping with causing his death. The ligature mark came to a slight "suspension point" to the right side of the back of the neck such that the appearance would be in keeping with ligature strangulation or suspension of the neck i.e. hanging. There were marks around both wrists in keeping with the application of the ligature but with no significant associated injury other than the marks. There was no evidence of any significant recent injury elsewhere to the body. Toxicology identified only codeine and paracetamol in keeping with therapeutic administration of co-codamol. There was no evidence of any natural disease that would have caused or contributed to the death.

[42] The cause of death of Colin Penrose was established as 1a: Ligature compression of the neck.

11. John Clark's Trial

[43] On 19 November 2014 Mr Clark was found guilty following a trial at the High Court in Glasgow of the murder of Colin Penrose. The charge he was convicted of read:-

> "between 19 March 2014 and 20 March 2014, both dates inclusive within cell 4/4, E Block, HMP Barlinnie, 81 Lee Avenue, Riddrie, Glasgow you John Clark did assault Colin Penrose, E Hall HMP Barlinnie, 81 Lee Avenue, Riddrie, Glasgow and did bind his hands with a piece of rope, place a ligature around his neck and strangle him and you did murder him."

[44] Mr Clark was sentenced to life imprisonment.

12. The Issues

[45] The application by the Procurator Fiscal for the holding of this inquiry identified a number of issues for consideration. These issues are set out in paragraphs [46] – [49] below.

[46] On 14 March 2014 Mr Penrose and Mr Clark were allocated to share cell 4/4 in E Hall in Barlinnie. At that time, Mr Penrose was an offence protection prisoner and Mr Clark was a non-offence protection prisoner. A cell sharing risk assessment was completed prior to Mr Clark being allocated to Mr Penrose's cell. The first issue was to establish whether it was appropriate and reasonable to co-locate Mr Penrose and Mr Clark.

[47] An incident occurred in Polmont in July 2012 in the course of which Mr Clark assaulted another young offender. I will refer to this incident as "the Polmont Incident". A further incident occurred in Shotts in June 2013 in the course of which Mr Clark started a fire in his cell. I will refer to this incident as "the Shotts Incident". These incidents were not known to the prison officer who made the decision to co-locate Mr Clark and Mr Penrose.

[48] A number of issues arise from the Polmont Incident and the Shotts Incident, namely (i) why these events were not recorded within the appropriate section of Mr Clark's prison record in March 2014 when the decision to co-locate Mr Clark and Mr Penrose was made; (ii) was there a failure by SPS to operate an effective system of recording all the relevant information within Mr Clark's prison record; and (iii)

whether, had this information been known to the prison officer who made the decision to co-locate the two prisoners, a different decision might have been made.

[49] In the circumstances more fully described in part 16 below, on 10 March 2014, Mr Clark referred himself to the mental health team at Barlinnie. This gives rise to three issues, namely, (i) whether the referral was appropriately actioned by the nurse practitioner; and (ii) whether it would have been reasonable and appropriate for Mr Clark to have been assessed by a mental health nurse; and (iii) whether such action may have prevented Mr Penrose's death.

[50] A number of other matters were considered in the course of the inquiry that are worthy of comment. These are considered in parts 18 to 21 below.

[51] In relation to each of the issues and other matters of relevance which arose during the course of the inquiry, I will consider and discuss the relevant evidence and submissions of the parties before setting out the conclusions I have reached. I do not propose setting out the participants' submissions in full in this determination, however, for the avoidance of any doubt, I have had regard to the full terms of each submission made. It is first appropriate to explain the backdrop against which these issues fall to be considered.

13. Cell Sharing Risk Assessment and Risks and Conditions

[52] The origins of cell sharing risk assessment can be found in the death of Zaid Mubarek at Feltham YOI on 21 March 2000. Mr Mubarek was murdered by his cell mate, a known white racist who had a track record of violence towards other prisoners.

Mr Mubarek's death gave rise to a number of inquiries, culminating in that chaired by Mr Justice Keith, whose report was published on 29 June 2006.

[53] In 2002, in response to Mr Mubarek's murder and as a result of its own internal investigation, the prison service in England and Wales instituted a cell sharing risk assessment, with the aim of preventing the co-location of prisoners who presented a serious risk to each other. Cell sharing risk assessment was first introduced in Scotland in May 2005. This was done by way of Governor and Managers Action number 18A/05 dated 23 May 2005 ("GMA 18A/05"), which came into effect on 30 May 2005 and applied only to circumstances in which prisoners were required to share a cell on their first night in custody.

[54] Changes were subsequently made by SPS to their process and guidance for cell sharing risk assessment and prisoners' risks and conditions. This was done by way of Governor and Managers Action number 26A/08 dated 7 October 2008 ("GMA 26A/08"). These changes came into effect on 10 October 2008. The cell sharing risk assessment process was extended to cover all occasions upon which a prisoner was required to share a cell. The recording and assessment was moved from a paper based system to PR2 (the SPS computerised record system) which integrated it with the "Risk and Conditions" sections of PR2 (those which recorded information in relation to each prisoner). The conduct and recording of the cell sharing risk assessment became the responsibility of the residential officer tasked with locating the prisoner.

[55] GMA 26A/08 was that which regulated cell sharing risk assessment and prisoners' risks and conditions at the time of Mr Penrose's death on the 20 March 2014

In support of GMA 26A/08, SPS issued guidance (referred to as desktop instructions) on how to carry out a cell sharing risk assessment on PR2.

[56] The primary requirement of the revised cell sharing risk assessment was to identify any prisoner who had a history of homophobia, sectarianism, racism, violence against a cell mate or being a bully or the subject of bullying. The Risks and Conditions field within PR2 was amended to include these characteristics. For completeness, the revised process also required the review of any "linked prisoners". As no issue associated with linked prisoners arises in relation to this inquiry, I do not propose to explore that further.

[57] It is appropriate to set out in full the final sentence of paragraph 3 of GMA 26A/08. That is as follows:

> "For the revised system to deliver reliable conclusions, therefore, it is absolutely crucial that all establishments have in place systems to ensure that all appropriate risks, when they emerge, are recorded within the 'Risks and Conditions' and 'Linked Prisoners' fields to which all staff have access."

[58] In May 2013, Geoff Storer and Andrew Davidson, both operational auditors with SPS, produced a report the purpose of which was to inform the SPS's Director of Operations, Deputy Director and Assistant Director of issues which had been identified during audits of cell sharing risk assessments. Mr Storer gave evidence to the inquiry. He spoke to the report prepared by him and Mr Davidson in May 2013. He spoke also of a briefing paper he wrote on SPS policy relative to cell sharing risk assessment in March 2015.

[59] In their May 2013 report, Mr Storer and Mr Davidson identified a number of matters of concern. They had audited four SPS establishments during February 2013. They gave reasonable assurance assessments to three; but could only give a limited assurance assessment to the fourth. Limited assurance meant a significant risk which the organisation required to address. It is appropriate to record that the establishments audited in February 2013 included neither Polmont nor Barlinnie. If an establishment was assessed as being of limited assurance it would be audited again the following year. The auditors would also return three months after their assessment to ensure that appropriate action was being taken in respect of the unsatisfactory items.

[60] The authors noted that the process of cell sharing risk assessment was not difficult to operate. It was one which the authors had been auditing across SPS for the previous four years. They did not see a reasonable assurance rating as acceptable (far less a limited assurance one) and were of the opinion that all establishments should be capable of achieving substantial assurance for cell sharing risk assessment. The results of their audit gave them cause for concern.

[61] The report went on to note that the cell sharing risk assessment process was designed to ensure that all relevant information was made available to the officer making the assessment. It noted that the system was designed to be easy to use but had to be carefully and correctly applied to give "100% assurance". The authors noted that, during their audit, staff had described how they carried out the process and it was clear to the authors that the majority of staff took a professional pride in their work. Notwithstanding this, however, the authors found evidence of significant gaps in

processes and a poor understanding by staff of what they should record when, despite potential adverse factors, they allocated a prisoner to a shared cell.

[62] Of direct relevance to this inquiry were the authors' comments in relation to the use of Risks and Conditions. The terms of paragraph 5.4 of the report of May 2013 merit repeating:

> "There is a serious problem across PR2 in the quality of entries on the Risk and Conditions records. Many older entries have nothing more than a flag and thus give no background to the entry. Many staff members do not fully understand how to put information onto the Risk and Conditions records and many more do not bother. 2 years ago we discovered an intelligence unit in one establishment which never put anything onto the Risk and Conditions records. (That has now been rectified). The problem is most acute in relation to bullying where entries are generally very poor. Entries which refer the user to consult with the IMU would in many cases be advisable. Bullying and violence against cell mates are serious issues when considering cell sharing and it is essential that staff should have full information on which to make cell sharing decisions."

[63] In conclusion, the authors invited the Director of Operations to note the risks associated with the issues identified during the audit, all of which appeared to be within his policy or operational area of responsibility. The observations made by Mr Storer and Mr Davidson in their report of May 2013 are of particular relevance to the Polmont Incident which is considered in detail at part 14 below.

[64] Mr Storer has over 40 years' experience of working for SPS. Whilst he retired in 2010, since that time he has continued to be employed by SPS on a part-time basis as a senior operational auditor. That role involves analysing the performance of SPS establishments against policies to ensure that targets are met. Mr Storer was previously Deputy Governor at HMP Inverness; Operations & National Contingency Manager;

Governor-in-Charge of the Shotts Unit and National Induction Centre; Head of Operations at Polmont and HMP Perth; and Head of Offender Outcomes at HMP Perth.

[65] Mr Storer explained, by reference to the May 2013 report, that he and his colleague had not been satisfied that information was being adequately recorded in the Risks and Conditions section of PR2 and that information held elsewhere on the system was not readily available to officers carrying out cell sharing risk assessments. Mr Storer explained that prison staff expected their establishment's intelligence management unit (hereinafter referred to as "IMU") to add entries to the Risks and Conditions section of PR2. IMUs seemed to have a similar understanding, however, checks disclosed that IMUs were inconsistent in what they were applying.

[66] Mr Storer was asked whose responsibility it was to update Risks and Conditions at the time of his report (i.e. May 2013). His view was that this was somewhat of a grey area. His evidence was that, officially, it was everyone's responsibility, however, he was not aware of any policy setting this out. At that time, updating Risks and Conditions was done by residential staff in some cases and by IMU in others. Mr Storer and his colleague had found instances of not recording risks where it would have been appropriate to do so, with failures by both residential staff and IMU.

[67] In Mr Storer's opinion GMA 26A/08 did not provide specific guidance to staff as to who was responsible for updating Risks and Conditions. He was unsure as to whether the matters set out in paragraph 3 (see paragraph [57] above) were intended to be an exhaustive list. Mr Storer's view was that the test staff should apply was whether the information in question was relevant for cell sharing. When the responsibility for

the completion of cell sharing risk assessments moved in 2008, from front line managers to residential officers, the updating of prisoners' Risks and Conditions became all the more important. Residential officers (unlike front line managers) did not have access to intelligence.

[68] Mr Storer's conclusion was that in May 2013, at the time of his report, there were systemic problems within SPS in relation to cell sharing risk assessment and the updating of Risks and Conditions. That conclusion was accepted by Kenneth MacAskill, the current Head of Operations & Public Protection at SPS and by SPS in their closing submissions to the inquiry.

[69] The report by Mr Storer and his colleague was submitted to the then Director of Operations at SPS, Dan Gunn. Mr Storer attended a meeting to discuss the concerns raised in the report by him and Mr Davidson. Mr Storer's recollection was that the conclusion of the meeting was that Mr Gunn would look to see what could be done to address the concerns. As far as Mr Storer was aware, no action was taken. That was confirmed by Alan Craig in the report he prepared for SPS dated 30 May 2014 (see paragraph [103] below. Mr Craig described the failure to respond to the concerns raised by Mr Storer and Mr Davidson, other than by letting due process take its course, as a significant failing. Mr Storer was summoned to meet with the Chief Executive of SPS to discuss his May 2013 report the morning after Mr Penrose's death.

[70] As set out above, Mr Storer has considerable experience of working within SPS. He gave his evidence in a measured way. His conclusion that there were systemic problems within SPS in relation to cell sharing risk assessment and the updating of Risks

and Conditions as at May 2013 was not challenged (no party to the inquiry cross-examined Mr Storer); it was accepted by Mr MacAskill; moreover, it was entirely consistent with the evidence to the inquiry of the three officers from the IMU at Polmont (as more particularly set out below in paragraphs [85] – [96]).

[71] I have no hesitation, whatsoever, in accepting Mr Storer's conclusion. Mr Storer and Mr Davidson identified what was clearly a defect in an SPS system of working. When GMA 26A/08 was introduced, SPS recognised that, for the revised system to deliver reliable conclusions, it was absolutely crucial that all establishments had in place systems to ensure that all appropriate risks, when they emerged, were recorded within the relevant prisoner's Risks and Conditions. The report by Mr Storer and Mr Davidson highlighted failures to achieve this within four SPS establishments. Those four establishments did not include Polmont. The evidence of the three officers who worked in the IMU at Polmont in July 2012 confirmed that a similar problem existed there at that time. For the reasons set out below, I am satisfied that this defect contributed to the death of Mr Penrose.

[72] By no later than May 2013, by way of the report prepared by their operational auditors, Geoff Storer and Andrew Davidson, SPS were aware of problems across their PR2 computer record system in relation to the quality of entries on prisoners' Risk and Conditions records. SPS were aware that the problems were most acute in relation to bullying where entries were generally very poor. SPS did not act in relation to those failures prior to the death of Mr Penrose. These other facts are relevant to the circumstances of Mr Penrose's death.

14. The Polmont Incident

The Evidence

[73] Between March 2011 and April 2013, Mr Clark was detained within Polmont. Mr Clark was involved in an incident which took place there on 30 July 2012 at or around 15:15 hours (hereinafter referred to as the "Polmont Incident").

[74] In evidence, Mr Clark was not asked questions in relation to the Polmont Incident. The three other young offenders (whom I refer to by their initials only) involved in, or present during, the incident were not led as witnesses. The incident was investigated by William McDonald who gave evidence and spoke to the report he prepared. The inquiry also heard from three officers who worked within the IMU at Polmont in July 2012, namely, Claire Wilson, Donna Marie Simpson and Jonathon McTavish. In addition, the views of a number of other witnesses to the inquiry were sought on whether the Polmont Incident should have resulted in a bullying marker being applied to John Clark's Risks and Conditions.

[75] Mr McDonald is a very experienced prison officer. He has been employed by SPS for over 30 years. He has always been based at Polmont. He is presently the programmes manager there, having previously been a residential prison officer and first line manager. He investigated the Polmont Incident as he was the manager responsible for the area in which it took place. The terms of paragraphs [76] to [82] below are drawn from Mr McDonald's report of the incident.

[76] The incident took place in an art class located within one of the activities buildings at Polmont. Mr McDonald was asked to attend there at or around 15:30 hours on 30 July 2012. On arrival, Mr McDonald found one of the young offenders, DM, with a scrape to his face, seated outside the art class. DM told Mr McDonald that one of the other young offenders in the art class had approached him with what appeared to be a screw like weapon and had scraped him across the face with it. DM refused to name his assailant. Mr McDonald entered the class and found three young offenders there, one of whom was Mr Clark. Initially, no-one was prepared to say who was responsible for the assault, however, Mr Clark admitted to it shortly afterwards. The art class was searched and a picture hook was found on the floor. This was identified by DM as the weapon used against him. Mr McDonald had the rest of the hooks removed from the art equipment storage cupboard, from where Mr Clark had taken the one he used as a weapon. Mr McDonald's enquiries suggested that the incident occurred whilst the lecturer had been on his break, at which time the young offenders had not been appropriately supervised by the responsible prison officer. In the course of his subsequent investigation, Mr McDonald questioned all four young offenders who had been present during the incident. Their respective accounts, given to Mr McDonald, are as follows.

[77] The victim, DM, stated that he believed he had been assaulted by Mr Clark as a result of him (i.e. DM) being located within the sex offender section of Monro 4 (an accommodation area at Polmont). DM stated that he had been getting verbal abuse from Mr Clark within the art class. DM stated that was because he was a sex offender. The

verbal abuse had been going on for weeks, ever since DM had started attending the art class. DM stated that Mr Clark had been giving him abuse and that he, in turn, was doing likewise to Mr Clark. DM stated that he went to a cupboard to get a book and when he turned round Mr Clark scraped his face with a weapon, without warning. DM stated that Mr Clark had just walked up in front of him and drawn the hook across his face. DM stated that the verbal abuse had worsened since the sex offenders and the non-offence protection prisoners had been separated within Monro 4.

[78] Mr Clark stated that during the break in the art class all four young offenders present had been carrying on and scratching each other with broken paint brushes and screws. Mr Clark stated that he had scratched DM and another of the young offenders present (PM) but that it was just a carry on and that he had also been scratched. Mr Clark stated that he thought that it was DM who had scratched him on the neck which was why he had retaliated and scratched DM on the face. Mr Clark maintained that it was all just a carry on and had nothing to do with DM being a sex offender.

[79] The third young offender present, PM, stated that he was carrying on with DM first but that they were not scratching each other, however, that was how the carry on between Mr Clark and DM had started. PM stated that Mr Clark and DM were punching each other. He maintained that he did not see Mr Clark scratching DM, however, he did witness Mr Clark unscrewing the hook from the paint cupboard. When asked by Mr McDonald why he thought Mr Clark had scratched DM, PM replied that he did not know but that it was possibly because DM was so weak.

[80] The fourth young offender present, TM, stated that Mr Clark and DM were arguing when the teacher went out for his break. TM maintained that he did not see either Mr Clark or DM scratch the other. He stated that he thought it was all "a laugh" between Mr Clark and DM.

[81] Based upon his investigation, Mr McDonald drew certain conclusions. Those conclusions, in so far as they relate to the incident itself, merit being set out in full:

> "There is no doubt that John Clark carried out the assault on (DM) using what appeared to be a curtain hook which John Clark unscrewed from inside the art equipment cupboard.
>
> I believe there had been a carry on between the four YO's left in the art class after the teacher went for his break which was clearly as a result of poor or no supervision of the class after the teacher left for his break. (DM) informs that he has been the victim of verbal abuse relating to his sex offences, abuse which he states has got worse since the separation of YO's within Monro 4.
>
> Whether the abuse he receives is actually as a result of being a sex offender or as a result of him being an extremely weak individual is unclear, my belief is that it is a culmination of both."

[82] In the subsequent paragraph of his conclusion, in which Mr McDonald makes recommendations to avoid further conflict between Mr Clark and DM, Mr McDonald observed as follows:

> "I believe his (i.e. DM's) standing is extremely low as it stands which is probably why he is the target for abuse."

[83] Mr McDonald made no entry within Mr Clark's Risks and Conditions. He submitted his report to the IMU at Polmont. He was not involved further. His evidence was that he had virtually no recollection of the Polmont Incident. He understood that his report would go to the IMU so that they could log any information and update PR2.

His opinion was that the Polmont Incident should not have been recorded.

Mr McDonald's view was that DM had suffered abuse because he was a sex offender, however, the assault was a "carry on". There was no allegation by DM that Mr Clark had abused him that day. Mr McDonald's position was that he had no evidence that DM was being abused by Mr Clark. He had asked Mr Clark if he had scratched DM because he was a sex offender. Mr Clark said that he had not.

[84] Mr McDonald maintained that he had no evidence to verify DM's claims. He had flagged the matter up with the IMU and believed that they would start a profile of Mr Clark to see if there were other incidents involving him. His understanding of the position in July 2012 was that it would probably be the IMU, and possibly the residential first line manager, who would update prisoners' Risks and Conditions. Mr McDonald had updated prisoners' Risks and Conditions when he was a first line manager. He could not say if the IMU did so. His position was that if he were to submit a similar report now, he would not update a prisoner's Risks and Conditions. He stated that he had questioned himself about what he had done and could not say that he would do anything differently today.

[85] Claire Wilson is employed by SPS as an intelligence analyst, based at Polmont. She has been in that role for just over five years. She had previously worked for SPS for more than ten years as an administrative assistant based in the Activities Buildings at Polmont. She holds an SQA diploma in intelligence analysis which was awarded in 2014. This is now a mandatory qualification for IMU staff.

[86] Miss Wilson explained that the role of an intelligence analyst was to identify patterns, trends and behaviour; to reduce violence; to detect and prevent crime; and to deal with partner agencies. An IMU also provides information to the establishment's senior manager team.

[87] As at July 2012, the IMU at Polmont comprised a manager, Jonathon McTavish, Miss Wilson and another full-time analyst, Denise Paterson. At the beginning of July 2012 Miss Paterson went on long-term sick leave (she was off until the end of September 2012). Miss Wilson was due to finish for leave on 18 July 2012. At that time, Donna-Marie Simpson was employed in the security unit at Polmont. It was decided that Ms Simpson would cover the IMU whilst Ms Wilson was on leave. As matters transpired, Ms Simpson stayed in the IMU until Ms Paterson returned to work. The IMU at Polmont had been supported by an administrative assistant, however, she had left in or around May 2012 and was not replaced until January 2013. At the point Ms Wilson went on leave on 18 July 2012 she was, in effect, doing three jobs, namely, her own, that of Miss Paterson and that of the administrative assistant. Prior to departing on leave, Miss Wilson and Miss Simpson had a two or three day handover.

[88] At the time Mr McDonald submitted his report, Miss Simpson was the only analyst working within the IMU at Polmont. Miss Wilson was asked questions about the intelligence entry prepared by Miss Simpson as a consequence of Mr McDonald's report. Miss Wilson would have included more information. Miss Wilson accepted that the incident report essentially accepted Mr Clark's account of events notably, in relation to the suggestion that the incident has been a "carry on". If Miss Wilson had prepared

the entry she would have included much more by way of explanation around this to make it clearer. The report prepared by Mr McDonald could only be accessed by the IMU. If someone needed sight of it, it could be provided to them by the IMU.

[89] In relation to the updating of Risks and Conditions as at 2012, Miss Wilson said she was not really aware as to who was responsible for this. She did not think anyone had sole responsibility at that time. She explained that when she started in the IMU in October 2011 the analyst she had taken over from told her to update Risks and Conditions if an incident related to racism, homophobia or sectarianism. On that basis, as the Polmont Incident related to none of these matters, in July 2012 Miss Wilson would not have updated Mr Clark's Risks and Conditions in relation to the Polmont Incident.

[90] Miss Wilson accepted that, as at 2012, she did not really have an understanding of Risks and Conditions and how important they could be. She spoke of the changes brought in by SPS in 2014 and, in particular, the secondary assurance role now held by IMU in relation to updating Risks and Conditions. In Miss Wilson's view, if the IMU received the report of the Polmont Incident now, Mr Clark would have a bullying marker added to his Risks and Conditions and DM a victim of bullying marker added. IMU would add these markers if they had not already been added. In practice, however, Miss Wilson anticipated that the IMU would have to add the markers as people knew that IMU would do this if they did not and, therefore, tended not to update Risks and Conditions. Even if there is no support for (or corroboration of) an allegation, Risks and Conditions are now updated.

[91] Donna-Marie Simpson has been employed by SPS for just over six years. She is currently the parole assurance manager at Barlinnie. She previously worked at Polmont. In her time there, she covered a period of absence in the IMU, that from mid-July until the end of September 2012. Her role there was to input intelligence reports to the PR2 system. She would extract the main points of the report and anything she deemed significant and enter that into the system.

[92] In July 2012, whilst performing the role of intelligence analyst, Miss Simpson said that she was really only doing the basics. She had never been in the role before. She had prepared the intelligence entry in relation to the Polmont Incident. Miss Simpson could not recall making an entry in Mr Clark's Risks and Conditions section of PR2 in relation to the Polmont Incident. She did not recall being given any guidance in relation to this. She could not recall whether updating Risks and Conditions formed part of her role in the IMU at Polmont.

[93] Jonathon McTavish has been employed by SPS for over 25 years. He is currently the training delivery manager at the SPS College at Polmont. Amongst his previous roles, he had been the manager of the IMU at Polmont for approximately 2½ years, leaving there at or around the beginning of 2013.

[94] Mr McTavish recalled the Polmont Incident. In his view it was horseplay. He said he quite clearly remembered a member of the security staff telling him that it was horseplay. He could not say which member of staff.

[95] Whilst now familiar with Risks and Conditions, Mr McTavish's evidence was that he would not have had a clue about them in 2012. He said that if they existed

(then), he was unaware of them. He did not accept that part of the role of the IMU in 2012 was to update prisoners' Risks and Conditions. He was not aware of the IMU analysts at Polmont updating Risks and Conditions.

[96] Initially, Mr McTavish's evidence was that the Polmont Incident should have been recorded. It would be recorded now. His evidence was that in 2012 the IMU was in its infancy and people were still learning. Mr McTavish's evidence was that if an incident resulted in a governor's report charge, it should be recorded. In cross-examination, Mr McTavish accepted that bullying was a serious matter. He accepted that staff should take any allegation of bullying seriously. If a prisoner had told him they were being bullied, he would take it seriously. Under cross-examination by the solicitor advocate for the SPS, Mr McTavish's position was that on the basis of Mr McDonald's report, a bullying marker should not have been applied to Mr Clark as a result of the Polmont Incident. However, under re-examination by the procurator fiscal depute, Mr McTavish reverted to the position he had adopted in evidence in chief, namely, that the incident should have been recorded.

[97] In addition to the evidence given by Mr McDonald and by those working within the IMU at Polmont in July 2012, a number of witnesses at the inquiry were asked for their views on whether or not the Polmont Incident should have resulted in a bullying marker being added to Mr Clark's Risks and Conditions.

[98] David Brooks is presently the residential first line manager within E Hall at Barlinnie. He has been with SPS for 28 years, all of that time spent within Barlinnie. He has been a first line manager since 1995. His evidence was that the Polmont Incident

was of the type one would expect to see recorded in a prisoner's Risks and Conditions. Under cross-examination by SPS, his position altered to agreeing with the proposition that a bullying marker should not be added, based on one uncorroborated report. When re-examined on this subject he stated that he was unclear as to what had taken place (on reading Mr McDonald's report) and had been led to believe that the incident was horseplay. Mr Brooks would have expected there to be evidence for a bullying marker to be added. Finally, Mr Brooks agreed that officers should err on the side of caution when updating Risks and Conditions.

[99] Finlay Laird was acting up as the unit manager responsible for E Hall in Barlinnie at the time of Mr Penrose's death. His view was that he would have recorded the Polmont Incident within Mr Clark's Risks and Conditions. The assault by Mr Clark was a matter of admission. In relation to DM's allegation that he was being bullied for being a sex offender, Mr Laird suggested that a comment could be added to the Risks and Conditions to help people understand what the issues were. If Mr Clark had previously had an issue with a sex offender that may give an officer cause to pause as to whether it would be appropriate for Mr Clark to subsequently share a cell with another sex offender.

[100] Geoff Storer, an SPS senior operational auditor, expressed the view that the Polmont Incident ought to have been recorded as bullying, with an entry in the notes field to the effect that the bullying was directed against a sex offender. He added that, having regard to his knowledge of the system at that time, his view was that it was unlikely that such an incident would have been recorded in a prisoner's Risks and

Conditions in 2012. His view was that in 2012 SPS were not presenting staff with the full information they ought to have had to allow them to make sensible decisions about cell sharing. It is pertinent to add that Mr Storer had not audited cell sharing risk assessment at Polmont as there was no cell sharing there at that time.

[101] Kenneth MacAskill has been the head of operations and public protection at SPS since 2015. Prior to that he was head of operations at Barlinnie; deputy governor at HMP Dumfries; and head of offender outcomes at Barlinnie. His long career with SPS commenced as a residential officer at HMP Low Moss. His current remit includes policy for cell sharing risk assessment and the recording of Risks and Conditions. His view was that the Polmont Incident should not have led to a bullying marker being applied to Mr Clark's Risks and Conditions. In his view it was a fairly minor incident in a young offenders' institution. He described it as a "*carry on*". When pressed on the issue he described it as a very minor incident. It had gone to the IMU; they had decided that it was not relevant and had not applied a marker.

[102] Mr MacAskill was particularly asked about the conclusions reached by Mr McDonald in his report (see paragraph [81] above). His position, in evidence, was to the effect that if DM had been assaulted because he was a sex offender he would have had more than a scratch on his face. If the violence had occurred because DM was a sex offender, it would have been quite different. Mr MacAskill did accept that there was a systemic problem within Polmont in 2012 in relation to the recording of Risks and Conditions.

[103] Alan Craig is a very experienced former prisoner governor from Northern Ireland. He was commissioned by SPS to review their cell sharing risk assessment process following Mr Penrose's death. He started work on 1 April 2014 and reported on 30 May 2014. Mr Craig's evidence was that the Polmont Incident should have been recorded. In simple terms, if an officer is asked to make a decision in respect of cell sharing risk assessment, he or she ought to have all the available information so that it can be considered in context, in light of the prisoner officer's knowledge of the individuals concerned. That would permit an informed decision to be made. It is not appropriate to make important decisions without all the necessary information. It is better to record and evaluate in context. That leads to an informed decision and, thus, a safer process. In Mr Craig's opinion it is best practice to record. If there is any doubt about the relevance of an incident, it should be recorded. Mr Craig commented that he had never been criticised for telling somebody something, however, he had been criticised for not telling somebody something.

[104] Roy Breslin started work with SPS in 1998. He is currently their prison records systems manager. On the basis of Mr McDonald's report and the intelligence entry, Mr Breslin's view was that a bullying marker should not have been applied. He did not see there being any clear bullying.

[105] Philip Wheatley was the prison expert for the Crown. He has 46 years' experience in prison management, including seven years as head of the Prison Service in England and Wales. He was the deputy director of the Prison Service at the time of the Zaid Mubarek murder (see paragraph [52] above) and director at the time of the Keith

Inquiry, to which he gave evidence. Mr Wheatley also gave evidence to the fatal accident inquiry relative to the last homicide in a Scottish prison (the 2015 inquiry into the death of Michael Cameron[1], who died in June 2006). Mr Wheatley's evidence was that the Polmont Incident should have been recorded. Only if it had been could future misconduct be assessed against it. He described it as an important incident, one of bullying which involved the use of a weapon and which was directed against someone who was a sex offender. That was all relevant information which should have been known to an officer carrying out a subsequent cell sharing risk assessment. Notably, when Mr Wheatley was asked his view in relation to a position taken by a number of SPS witnesses in evidence that because there was only evidence from the victim (DM) that he had been bullied by Mr Clark this did not amount to sufficient evidence that could be recorded, Mr Wheatley's response was that there is often incomplete information in prisons. If prison authorities were to wait until matters were proved beyond reasonable doubt, in his view that would make prisons very dangerous places. His view was that the investigation by Mr McDonald had been a careful one, which should have resulted in a bullying marker being applied to Mr Clark.

[106] John Podmore was the prison expert for the SPS. He has more than 32 years' prison experience, during which time he held a number of senior positions within the Prison Service in England and Wales. His view was that the incident was not one of bullying by Mr Clark. In his view, bullying is habitual, repeated behaviour. His view

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[1] http://www.scotcourts.gov.uk/search-judgments/judgment?id=e1f115a7-8980-69d2-b500-ff0000d74aa7

was that Mr McDonald had reached reasonable conclusions and that there was nothing particularly violent about the incident. He described it as a one-off incident which was not one of bullying.

Submissions

[107] In relation to the Polmont Incident, in summary, the submissions of the parties were as follows.

[108] The Crown's submission to the inquiry was that if the Polmont Incident had been recorded within Mr Clark's Risks and Conditions, it would have been considered at the time of the cell sharing risk assessment relative to Mr Clark and Mr Penrose in March 2014 and Mr Clark would not have been co-located with Mr Penrose. They submitted that, had this incident been recorded, there is a lively possibility that Mr Penrose's death may have been avoided. They submitted that it would have been a reasonable precaution to record the Polmont Incident and that the recording of that incident might have prevented Mr Penrose's death.

[109] The Crown also submitted that there was a defect in a system of work in relation to this matter. They contend that in 2012 there was no adequate guidance or training for the IMU at Polmont regarding their role in the recording of Risks and Conditions. They submit that had there been clear guidance similar to that subsequently issued in September 2014 (see paragraph [242] below) then it would have been clear that the IMU had a secondary role with regard to the application of Risks and Conditions; the IMU at Polmont would have recorded the Polmont Incident within Mr Clark's Risks and

Conditions; and Mr Holligan would not have co-located Mr Clark and Mr Penrose. They submit that this defect contributed to the death of Mr Penrose.

[110] SPS submitted that, in relation to the Polmont Incident, no finding should be made in terms of section 6(1)(c); (d); and (e). They contended that the Polmont Incident is a "*red herring*"; and is not relevant to the circumstances of the death of Mr Penrose. They contended that the application of Risks and Conditions is necessarily a judgement call for the individual who is in receipt of the relevant information. They rely on the position adopted by Mr McDonald in evidence, namely, that he did not consider that this incident on its own amounted to bullying and that he would still not update the Risks and Conditions section of PR2 if he had submitted the same report in respect of Mr Clark at the time he gave evidence to the inquiry.

[111] SPS invited the inquiry to prefer the evidence of Mr Breslin, Mr MacAskill and Mr Podmore over that of the remaining witnesses who gave evidence of opinion in relation to this matter. SPS accepted that the system for the application of Risks and Conditions "*was not working perfectly*" in Polmont at the time of the Polmont Incident and that there was evidence that staff were unclear as to who was responsible for the marking of Risks and Conditions. Nevertheless, they rejected the contention that had a better system been in operation, or more training given to staff, the Polmont Incident would have been recorded. They say that the evidence of their officer, Mr Holligan, in relation to the effect of the failure to record the Polmont Incident whilst clear and considered, displayed "*hindsight bias*" based on what subsequently happened.

[112] POAS also submitted that the Polmont Incident ought not to have been recorded in Mr Clark's Risks and Conditions. Should the inquiry conclude otherwise, they contended that the failure to record the incident was a systemic one, not one which should be attributed to the officers involved. They argued that prior to the death of Mr Penrose, the training and guidance provided to prison officers regarding the use of Risks and Conditions at both national and establishment level was insufficient. They maintained that were the court to determine that the incident should have been recorded, in order for it to be causally linked to the death the court also must determine that the staff in Polmont IMU would have known to record the incident; and, had they done so, that the decision taken by Mr Holligan to co-locate Mr Clark and Mr Penrose would have been different.

[113] Mr McDonald submitted that no officer received training on the use of Risk and Conditions and cell sharing risk assessment prior to the death of Mr Penrose. He contended that there was a real mix of evidence in relation to Risks and Conditions and commented upon that (as did the Crown). His submissions placed reliance on the fact that Mr Penrose's murder was unforeseeable. He asserted that the application of a bullying marker was an exercise of judgement and, in essence, that it would be wrong for the court to "*second guess*" such an exercise of judgement in the context of any finding under section 6(1)(d). Mr McDonald drew attention to the report by Mr Storer and Mr Davidson in May 2013 and the implementation of Risks and Conditions and the cell sharing risk assessment process, highlighting the absence of training provided to officers in the application of Risks and Conditions.

[114] Neither the NHS nor Mr Clark made submissions in relation to the Polmont Incident.

Discussion

[115] A consideration of the Polmont Incident begins with the terms of GMA 26A/08. The first question to ask is whether Mr Clark ought to have had a bullying marker added to his Risks and Conditions within PR2. The unequivocal answer to that question is that he should have.

[116] The prison experts Mr Wheatley and Mr Podmore both agreed that the investigation carried out by Mr McDonald was a thorough one. Mr McDonald's conclusion (which he adhered to in evidence) that there had been a "*carry on*" underpins the position he took in evidence, a position supported by a number of witnesses from SPS (i.e. Mr Breslin and Mr MacAskill) and their expert, Mr Podmore. There are two observations that require to be made in relation to this.

[117] Firstly, whilst, if one accepts the accounts given to Mr McDonald by Mr Clark and PM, the incident might legitimately be termed a "*carry on*" at the outset, on any view, it very quickly descended into something far more sinister. The account given to Mr McDonald by TM falls to be disregarded. All TM maintained he saw was an argument when the teacher went for his break. TM's conclusion that he thought it was all a laugh between John Clark and DM is somewhat difficult to reconcile with the remainder of the account he gave. His account provides no basis upon which one could legitimately draw the conclusion he did.

[118] PM witnessed Mr Clark unscrewing the hook from the paint cupboard. The hook in question was recovered from the floor of the art class and was identified by DM as the weapon used against him. Mr Clark admitted assaulting DM with the hook.

[119] However one elects to categorise the nature of the incident at its outset, the only conclusion supported by Mr McDonald's investigation is that it culminated in a premeditated attack by Mr Clark upon DM with an improvised weapon. Mr Clark acquired the weapon by going to the paint cupboard and unscrewing the hook. His actings cannot be categorised as spontaneous. It was not a case of lifting something readily to hand in the course of an altercation.

[120] Secondly, the accounts given by DM and PM, and the conclusion drawn by Mr McDonald, are redolent of something other than a "*carry on*". Leaving the assault perpetrated by Mr Clark to one side, the conclusion drawn by Mr McDonald was that DM had been the victim of abuse as a result of him being both a sex offender and an extremely weak individual. Mr McDonald's conclusion suggests, clearly and simply, that Mr Clark was bullying DM. The evidence of DM and of PM unequivocally supports that.

[121] As noted above, only Mr McDonald, Mr Breslin, Mr MacAskill and Mr Podmore contended that the Polmont Incident should not have been recorded in Mr Clark's Risks and Conditions; the remaining witnesses, who included two from within the IMU at Polmont; SPS' own senior operational auditor; and the expert instructed by SPS to review their cell sharing risk assessment process in the aftermath of Mr Penrose's death, maintained that it should have been recorded.

[122] I prefer the evidence of those witnesses who maintained that the Polmont Incident should have been recorded. I do not accept the evidence of those witnesses whom SPS invited me to prefer. In light of my analysis of the available evidence, and my conclusion that it clearly demonstrates bullying behaviour on the part of Mr Clark towards DM, in relation to the views expressed by Mr McDonald, Mr Breslin and Mr MacAskill I need say little more than their interpretation of the events is one I simply cannot accept. Mr Podmore's evidence on this issue was more equivocal. His position was that it was a judgement call for the individual in receipt of the information. He would not have criticised someone who chose to record it, nevertheless, his evidence was that the incident did not amount to bullying. As stated above, that is an interpretation of events that I simply cannot accept.

[123] Mr MacAskill's evidence was unsatisfactory in a number of respects. The observations he made in relation to levels of violence, set out in paragraph [102] above, are not what one would expect of someone holding a senior role within SPS. Mr MacAskill's understanding of what happened within IMU in relation to the Polmont Incident was simply wrong and inconsistent with his quite proper acceptance that there were systemic failures at that time in respect of the application of Risks and Conditions. Whilst Mr McDonald's report had gone to the IMU; the clear evidence is that they had not understood Risks and Conditions at that time, rather than made a conscious decision that the Polmont Incident was not relevant.

[124] SPS guidance at the time of Mr Penrose's death was far from clear as to who precisely was responsible for the application of Risks and Conditions, however, whether

one regards it as Mr McDonald or the IMU at Polmont there is, in my view, no question of judgement, whatsoever in the circumstances of this case. The circumstances of this case are quite different from the type considered by Lord Armstrong in *Sutherland v Lord Advocate* 2017 SLT 333 at paragraph [34], to which I was referred. I am satisfied that the circumstances of Mr McDonald's decision, not to apply the bullying marker to Mr Clark's Risks and Conditions, were not of the type envisaged by Lord Armstrong. Mr Clark was bullying DM. Mr McDonald's own evidence distinguished the abuse from the assault. On Mr McDonald's interpretation of events, the assault was not the first act of bullying. Mr Clark had previously verbally abused DM. Separate from their erroneous categorisation of the Polmont Incident, that, in itself, exposes the fallacy propounded by those witnesses to the inquiry who said the Polmont Incident ought not to have been recorded. They each relied upon there being no prior incidents. Mr McDonald's evidence was that the verbal abuse preceded the bullying.

[125] As observed by Mr McTavish in evidence (see paragraph [96] above) bullying is a serious matter. It is a matter SPS say they take seriously. Accepting that to be the case, the evidence given by Mr MacAskill is quite remarkable. It discloses a worrying lack of understanding as to what bullying is. A similar criticism can be levelled against Mr McDonald, Mr Breslin and Mr Podmore.

[126] The Collins English Dictionary definition of a "*bully*" is "*a person who hurts, persecutes or intimidates weaker people*". Mr McDonald's conclusions set out at paragraphs [81] and [82] are telling in this context. Most, if not all, public sector organisations maintain policies that address matters such as bullying. The relevant policy of the

Scottish Courts and Tribunals Service is, I suggest, clearly within judicial knowledge. That policy (the SCTS "Dignity at Work Policy") adopts the ACAS definition, which is that bullying may be characterised as offensive, intimidating, malicious or insulting behaviour or misuse of power through means that undermine, humiliate, denigrate or injure the recipient. One assumes that SPS have a similar policy, however, that was not a matter that was spoken to in evidence and I say no more on it. The fact that a number of SPS employees (some holding senior positions) do not regard the Polmont Incident as bullying is a matter of considerable concern. My clear impression was that they each failed to see the seriousness of a premeditated assault upon a weak young offender with an improvised weapon. Simply because the incident took place in a young offenders institution does not mean it should be viewed any differently from an assault in the street. Mr Podmore's conclusion that there was nothing particularly violent about the incident is alarmingly misconceived.

[127] The recording of Risks and Conditions is to assist staff in the management of prisoners. Recording should not disadvantage prisoners in any way. There was no evidence before the inquiry of "*over recording*". GMA 26A/08 emphasised that it was *"… absolutely crucial that all establishments have in place systems to ensure that all appropriate risks, when they emerge, are recorded within the 'Risks and Conditions' ..."*. The evidence of those who worked within the IMU at Polmont clearly demonstrated the absence of any such system as at July 2012.

[128] For the reasons I have set out above, I am satisfied that the Polmont Incident ought to have resulted in a bullying marker being added to John Clark's Risks and Conditions following the Polmont Incident on 30 July 2012.

The Issues

[129] The issues for the inquiry to address in relation to the Polmont Incident are set out at paragraph [48] above.

[130] The first issue to address in relation to the Polmont Incident is why it was not recorded in the appropriate section of Mr Clark's prison record. From the evidence of Miss Wilson, Mr McTavish and Miss Simpson, it is clear that as at July 2012 SPS had failed to give adequate guidance or training to their staff in relation to the recording of entries within a prisoner's Risks and Conditions. As I have determined, this was a defect in a SPS system of working which contributed to the death of Mr Penrose.

[131] Equally, in respect of the second issue, the evidence of Miss Wilson, Mr McTavish and Miss Simpson from the Polmont IMU, coupled with that of Mr Storer, clearly demonstrates that there was a failure by SPS to operate an effective system of recording all the relevant information within Mr Clark's prison record. The Polmont Incident ought to have been recorded. It was not.

[132] In relation to the third issue, for the reasons set out below in part 17, I am satisfied that had the Polmont Incident been known to Mr Holligan (the officer who made the decision to co-locate Mr Clark and Mr Penrose) a different decision might well have been made in relation to the co-location of Mr Penrose and Mr Clark.

Conclusion and Recommendation

[133] The failure to record the Polmont Incident was a defect in an SPS system of working which contributed to the death of Mr Penrose.

[134] A reasonable precaution, whereby the death might have been avoided, would have been for a bullying marker to have been added to John Clark's Risks and Conditions on the SPS PR2 system as a consequence of the assault he perpetrated at Polmont on 30 July 2012.

Recommendation 1

[135] Having regard to the conflicting views amongst SPS employees as to what constitutes bullying, and to remove any question of judgement in the recording of incidents of violence against prisoners other than the assailant's cell mate, I recommend that SPS revise their cell sharing risk assessment to include as a marker "violence against another prisoner" (that as a category separate from the existing "violence against cell mate"). I envisage that such a marker would be added where a prisoner is found guilty of a breach of discipline under either paragraph 1 (commits any assault) or paragraph 2 (fights with any person) of schedule 1 to The Prisons and Young Offenders Institutions (Scotland) Rules 2011, or any subsequent provision which supersedes those paragraphs, in circumstances where the victim or person they are found to have fought with is not their cell mate.

15. The Shotts Incident

The Evidence

[136] Between 22 April and 10 July 2013, Mr Clark was a prisoner within Shotts. On 14 June 2013, Mr Clark was located alone within cell 35 on level 3 of South Allanton Hall there. There is no cell sharing at Shotts. At or around 03:35 hours, the fire alarm within Mr Clark's cell was activated. The prison officers attending discovered that Mr Clark had set a small fire which, by the time of their arrival, appeared to have been extinguished by the cell's fire suppression system. The fire and rescue service were called, attended promptly and confirmed that the fire had, indeed, been extinguished. I refer to this as the "Shotts Incident".

[137] In relation to this part, the inquiry heard evidence from Mr Brooks and Mr Breslin. In evidence, Mr Clark was not asked questions in relation to the Shotts Incident. The terms of the SPS Incident Report relative to this matter were a matter of agreement between the parties. It records that staff at Shotts reported that Mr Clark had provided no explanation for his actions other than to state that he wanted out of Shotts.

[138] Mr Brooks was asked about the Shotts Incident in cross-examination by SPS. He indicated that wilful fire-raising was not uncommon among people with mental health issues or those who were childlike or immature. Others did it for what Mr Brooks described as "*pure devilment*"; they would light a newspaper and waft it under the suppression system. Prisoners might also do it for their own reasons, for example to obtain medication they were not getting or to force a move.

[139] Mr Breslin explained that a wilful fire-raiser marker had been applied to Mr Clark's Risks and Conditions on 6 September 2013. Mr Clark was subsequently liberated on 28 November 2013. At that time, a wilful fire-raiser marker did not remain on a prisoner's record indefinitely. Accordingly, when Mr Clark was released the marker was automatically removed. Mr Breslin could not explain why the marker was only added in September 2013 when the incident had taken place some three months earlier. This was the only marker which was automatically removed from the PR2 system at that time. That issue has since been rectified. All markers that are applied at the point in time of a prisoner's liberation will now remain active on the system.

[140] Mr Breslin's view was that the Shotts Incident was very minor and, unfortunately, quite a regular occurrence for SPS. He explained that, in this particular instance, the matter was reported to the police due to the cost of damage occasioned. There was a cost threshold beyond which matters were reported to the police, albeit Mr Breslin could not indicate what that threshold was. If it was a single person cell with no-one else involved it would be the cost threshold that determined whether it was reported. If the fire caused potential danger to life it would be reported, irrespective of the cost of damage. Mr Breslin's view was that matters such as this should be considered in the context of a cell sharing risk assessment. Staff should be aware if someone has previously been flagged as a wilful fire-raiser. It would then be the assessing officer's decision as to whether the individual in question would be permitted to share a cell. It would not necessarily prevent them from sharing a cell.

[141] The Shotts Incident was reported to the police. A summary prosecution was subsequently commenced in Hamilton Sheriff Court. The charge against Mr Clark was that:

> "(001) on 14th June 2013 at HMP Shotts, Newmill and Canthill Road, Shotts you JOHN CLARK did wilfully set fire to quantities of paper and cloth within a cell there and the fire took effect thereon and damaged said cell."

On 17 April 2014 (less than four weeks after Mr Penrose's death), Mr Clark pled guilty as libelled to that charge. He was sentenced to six months' imprisonment, which sentence was to run consecutively to the period of imprisonment then being served by him.

Submissions

[142] No submissions were made in respect of the Shotts Incident directly by the Crown; the NHS; Mr McDonald; or Mr Clark. Passing references were made to it by SPS (who described it as a "*red herring*") and by POAS, primarily in the context of the evidence the inquiry heard in relation to the NOMS Cell Sharing Risk Assessment PSI 09/2011 (a matter upon which the Crown made submissions), which is considered below in part 20.

Discussion

[143] The lack of submissions made in relation to the Shotts Incident is demonstrative of the significance of that incident in the context of the death of Mr Penrose. I comment

in relation to the NOMS Cell Sharing Risk Assessment PSI09/2011 below, however, it is pertinent to observe at this stage that the Shotts Incident cannot fairly be described as a "*red herring*". It served to highlight a defect in the SPS system relative to the recording of Risks and Conditions with PR2 and an unexplained delay in the marker being applied to Mr Clark in the first place.

The Issues

[144] The issues for the inquiry to address in relation to the Shotts Incident are set out at paragraph [48] above.

[145] The evidence of Mr Breslin confirmed that the wilful fireraiser marker was applied to Mr Clark's Risks and Conditions within PR2. It was automatically removed when Mr Clark was liberated in November 2013, due to a programming issue which only affected that particular marker. That is why the relevant marker in relation to the Shotts Incident was not recorded in the appropriate section of Mr Clark's prison record as at the date of the cell sharing risk assessment relative to the co-location of Mr Penrose and Mr Clark.

[146] To that limited extent, the answer to the second issue is that there was a failure by SPS to operate an effective system of recording all the relevant information within Mr Clark's prison record. That failure has been identified and corrected subsequent to Mr Penrose's death. No reasons were offered to the inquiry for the delay in applying the wilful fire-raising marker to Mr Clark's prison record in the first place. The delay is a not

insignificant one, particularly when one considers that the SPS Incident Report relative to this matter was prepared on 14 June 2013.

[147] In relation to the third issue, for the reasons set out below in part 17, I am satisfied that had the Shotts Incident been known to Mr Holligan (the officer who made the decision to co-locate Mr Clark and Mr Penrose) it would not have affected the decision he actually took.

Conclusion

[148] The automatic removal of the wilful fireraiser marker within Mr Clark's prison record relative to the Shotts Incident was a defect in an SPS system of working, however, it did not contribute to the death of Mr Penrose.

16. The Mental Health Referral

The Evidence

[149] On 10 March 2014, Mr Clark, whilst within Barlinnie, completed a Multi-Disciplinary Mental Health Team (MDMHT) Referral Form which read:

> "I would like to speak to the mental health team about my curent mental helth as to be adviesd on how to deal with curent situations before I do something I regret and make my situations worse."

[150] In relation to this part, the inquiry heard evidence from Mr Clark; Grant Morrison (the nurse who saw Mr Clark on 10 March 2014); Margaret Miller (the clinical manager responsible for mental health at Barlinnie at the time of Mr Penrose's death); Jacqueline Corrigan (the clinical manager now responsible for mental health at

Barlinnie); Caroline Kenny (the nursing expert for NHS) and Dr Alex Quinn (a consultant forensic psychiatrist, led as an expert by the NHS).

[151] Mr Clark's evidence was that he submitted the MDMHT Referral Form as he had not been prescribed the correct medication and wished to be allocated a single cell. His position was that he ought to have been prescribed Mirtazapine upon his admission to Barlinnie in December 2013, but was not. Mr Clark had discussed the matter with his then cell mate, Prisoner R, who told him to submit a MDMHT Referral Form. Mr Clark completed the form. Mr Clark's recollection was that he saw the mental health team after the form had been submitted. He could not say how long after. He mentioned two days or a week but conceded that he did not have a clue and could not remember. Mr Clark's position was that he saw a male nurse and that there were a couple of female nurses in the room during the consultation. He hoped to be put on Mirtazapine and to be allocated his own cell, albeit he conceded in evidence that the mental health team could not help him in relation to a cell change.

[152] Mr Clark's evidence was that he had told the male nurse he was depressed. The male nurse repeatedly asked Mr Clark if he was suicidal. Mr Clark's evidence was that he said to the male nurse that he would rather do something to someone else, rather than to himself to "*get the digger*" (that is, to be placed in segregation). Mr Clark told the male nurse that he wanted his own cell. He told him that he would end up doing something stupid to get away from everyone. Asked about the terms of the MDMHT Referral Form and what he meant by "*current situations*" he stated that he did not like being in a double cell. He described this as "*pure depression*". Asked if his reference to

doing something he regretted meant he would hurt someone else, he confirmed that was his position. Mr Clark's evidence was that his meeting with the male nurse had been very short.

[153] Grant Morrison is employed by the NHS as a nurse practitioner within Barlinnie. He qualified as a nurse in 1995 and has worked in Barlinnie for 14 years. Mr Morrison was the nurse practitioner on duty in E Hall on the evening of 10 March 2014. At or around 20:00 hours that day, in the usual way, Mr Morrison unlocked the referral box located outside the nurses station on the ground floor of E Hall. He checked the forms within the box to see if any were concerning. The MDMHT Referral Form completed by Mr Clark raised concerns. The box is opened twice each day (at 12:00 hours and 20:00 hours). The box is emptied each day at around 20:00 hours.

[154] Mr Morrison was concerned by the terms of the MDMHT Referral Form completed by Mr Clark. His concern was for Mr Clark's wellbeing. As a consequence, Mr Morrison asked to see Mr Clark. He arranged with the residential officer on duty on the fourth floor of E Hall to have Mr Clark brought down to him. This happened almost immediately. Mr Morrison estimated that he saw Mr Clark at or around 20:05 hours on 10 March 2014. Mr Morrison's evidence was that only he and Mr Clark were present when the MDMHT Referral Form was discussed. Mr Morrison's concern was that Mr Clark might attempt to harm himself. Mr Morrison had not dealt with Mr Clark previously. His evidence was that Mr Clark was adamant he was not going to harm himself. Mr Morrison's recollection was that Mr Clark mentioned certain family issues he had no control over. He described Mr Clark as having open body language and

communicating well. He spoke with Mr Clark for around ten minutes. There was nothing to suggest Mr Clark might harm himself. Mr Morrison was happy to allow Mr Clark to return to his cell and to pass the MDMHT Referral Form to the mental health team for assessment.

[155] Mr Morrison's recollection was that Mr Clark did not say he was depressed. He recalled Mr Clark raising concerns regarding family relationships, however, his recollection was that this was more to do with communication and not getting visits. Mr Clark's evidence that he was not thinking of harming himself, rather he may harm someone else so as to be placed in segregation, was put to Mr Morrison. He had no recollection of Mr Clark saying that. He was certain that if it had been said he would have recalled it and would have done something about it. He explained that on occasion prisoners make threats of such a nature in order to try and obtain a single cell. Mr Morrison was certain that on this occasion Mr Clark had neither said he wanted a single cell nor made any threats. Had he done so, Mr Morrison would have reported that to allow appropriate precautions to be taken.

[156] Following his meeting with Mr Clark, Mr Morrison made an entry of the meeting in the NHS Vision computerised record system. That entry is as follows:

> "10/03/02014 consultation submitted MHT form which gave cause for concern. I spoke to John and he denied any thoughts or intensions of suicide or self-harm at this time. Form passed to MHT dept."

[157] Mr Morrison passed Mr Clark's MDMHT Referral Form to the mental health team for assessment. The Referral Form would have been considered by the mental health team the following morning, 11 March 2014. At that time, the mental health team

would have had before them the MDMHT Referral Form and the entry on the Vision system made by Mr Morrison. The mental health team would also take into account Mr Clark's medical history. Had the mental health team deemed the referral to be either urgent or an emergency it would have been actioned at that time and an appropriate entry made on the Vision system. There is no such entry from which it can be inferred that the mental health team concluded that Mr Clark's referral was neither urgent nor an emergency.

[158] Consideration of the referral was continued until the weekly mental health allocation meeting, which next took place on 17 March 2014. At that time, the referral would have been allocated to a member of the mental health team. The database extract recording the outcome of the mental health team meeting on 17 March 2014 produced to the inquiry was, regrettably, that updated to 20 March 2014. As a consequence, rather than showing the member of the mental health team to whom Mr Clark's referral was allocated, the position is noted as "transferred", namely, the transfer of Mr Clark to another establishment (i.e. HMP Edinburgh) following the death of Mr Penrose. Whilst this is unfortunate, it is appropriate to note that there was no evidence before the inquiry of a further mental health related issue relative to Mr Clark arising between 10 March 2014 and the date of Mr Penrose's death.

[159] Margaret Miller is currently employed by the NHS as a clinical manager at HMP Low Moss. She was the clinical manager responsible for mental health at Barlinnie at the time of Mr Penrose's death. In evidence, Mrs Miller described the NHS teams that operated in Barlinnie and their structure. In particular, she described the hours worked

by the mental health team, namely, 8 am to 4 pm, Monday to Friday. The mental health team did not work at weekends. She described the process of dealing with mental health referrals in Barlinnie. They received a fairly high number, she estimated between 50 and 60 each week.

[160] Mrs Miller was asked about the terms of the referral submitted by Mr Clark. She regarded this as being extremely vague and extremely difficult to interpret. Her view was that the practitioner nurse (Mr Morrison) did a good job in speaking to him. Her view was that the referral could mean a lot of things. Mr Morrison had followed best practice. Mr Morrison was a very experienced practitioner nurse. In her experience, vague referrals were not uncommon. If Mr Clark had threatened to harm another prisoner, she would expect Mr Morrison to report that to the first line manager in E Hall and to complete a security form. This sort of thing happened fairly regularly.

[161] Jacqueline Corrigan has been a clinical manager responsible for mental health at Barlinnie since August 2014. She started at Barlinnie after Mr Penrose's death. She explained that the NHS had taken over responsibility for healthcare in prisons in 2011. She described how the referral system in Barlinnie operated. She rejected Mr Clark's allegation that he had made several referrals that had not been actioned. She described the system as being very robust and that prisoners often made allegations of this nature to try and circumvent the process and be seen sooner.

[162] Mrs Corrigan had seen referrals similar to that made by Mr Clark. It is not uncommon for prisoners to make vague referrals. A nurse's first thought is the possibility of self-harm. Once that possibility had been excluded, Mrs Corrigan would

expect the nurse to ask wider questions. Her evidence was that the entry made by Mr Morrison in the Vision system was of the type she would expect. She explained the process that would have operated in relation to the referral the day after Mr Morrison met with Mr Clark. In relation to Mr Clark's allegation that he had said to Mr Morrison he was more likely to harm someone else rather than himself, Mrs Corrigan said that she came across such allegations perhaps once or twice each week. In such circumstances a nurse would obtain more information from the prisoner; speak to hall staff; highlight the issue to the nurse in charge; complete a security form which would be emailed to the IMU; and add an appropriate entry on the Vision system. She would expect a referral of the type made by Mr Clark to have been dealt with in no more than 28 days from the date it was received. In all probability, it is likely that such a referral would be dealt with between 14 and 21 days.

[163] Caroline Kenny currently works within the department of clinical neurosciences at the Western General Hospital in Edinburgh. Prior to that she worked at HMP Edinburgh. She started there as a primary care nurse practitioner before being promoted to manager. She was led as an expert witness by the Crown, having regard to her experience of performing the same role as Mr Morrison. Mrs Kenny continues to do agency bank shifts three or four times a month as a nurse practitioner at HMP Edinburgh.

[164] Mrs Kenny spoke to the terms of the report prepared by her. She had listened to the evidence of Mr Clark and Mr Morrison earlier in the inquiry. She described the referral form completed by Mr Clark as concerning. She explained that suicide and self-

harm was the only mental health training given to primary care nurses. Her evidence was that, rightly or wrongly, that is what would be at the forefront of a primary care nurse's mind. Mrs Kenny's view was that Mr Morrison had followed best practice by seeing Mr Clark. Her view was that Mr Morrison had gone far enough. Mr Clark had been calm and had made good eye contact during his meeting with Mr Morrison. Mr Clark did not communicate anything else of concern. Mrs Kenny's view was that she did not feel that Mr Morrison obtained an answer to what Mr Clark meant by his referral, however, this did not concern her due to Mr Clark's demeanour. Mrs Kenny was comfortable that matters had been dealt with appropriately and properly referred on. Her view was that Mr Clark did not know what he wanted by way of the referral, other than a single cell and particular medication.

[165] The NHS also led evidence from Dr Alex Quinn. He is presently a consultant forensic psychiatrist working within the Orchard Clinic at the Royal Edinburgh Hospital, a medium secure unit for mentally disordered offenders. He became a consultant in November 2011, at the time of the transfer of health care responsibilities for prisoners from SPS to the NHS. During his first five years as a consultant he was responsible for psychiatric input at both HMP Edinburgh and HMP Addiewell.

[166] Dr Quinn's evidence was that most psychiatric concerns can wait until the following day. Mental health issues in prisons are very high. It was important to have practitioner nurses involved. Dr Quinn's assessment was that what had been said by Mr Clark to Mr Morrison was not something that made him think that Mr Clark had a severe or enduring mental health problem which required urgent attention. Dr Quinn's

view was that it was entirely reasonable to consider the referral as a routine one. Asked about the specific terms of the referral made by Mr Clark, Dr Quinn observed that it was not unlike a large number of referrals that might be received from prisoners. There was nothing in it to think that Mr Clark had a serious issue. His view was that if he saw such a referral today, it would not strike him as a mental health priority.

Submissions

[167] Both the Crown and the NHS invited me to prefer the evidence of Mr Morrison to that of Mr Clark. In their respective submissions, they each articulated a number of cogent reasons to support that position. In the submissions made on behalf of Mr Clark, it was conceded that Mr Clark presented as an extremely reluctant and obstructive witness and that his evidence was afflicted by a number of inconsistencies and difficulties in recollection.

[168] The Crown and the NHS submitted that the referral was appropriately actioned by Mr Morrison. The submissions for Mr Clark were, quite properly, predicated upon his version of events being preferred to that of Mr Morrison. If the inquiry was to accept Mr Clark's account, a number of criticisms could properly be made of the NHS.

Discussion

[169] To determine whether or not the referral was appropriately actioned by Mr Morrison, one must first resolve the factual disputes that exist between him and Mr Clark. As correctly pointed out by the Crown in their submissions, there were clear inconsistencies in Mr Clark's evidence; the manner in which he gave his evidence did not suggest he was being frank and open; and his evidence in relation to certain matters

could, on balance, be accepted as inaccurate. In this regard, the Crown highlighted Mr Clark's assertions that he had made a number of self-referrals and that he had been prescribed Mirtazapine prior to being admitted to Barlinnie. Neither assertion is supported by Mr Clark's medical records. Moreover, Mr Clark presented as an extremely reluctant and obstructive witness. In addition to a number of inconsistencies, he also encountered certain difficulties in recollection and made other assertions which are unsubstantiated (e.g. that a number of female nurses had been present during his meeting with Mr Morrison).

[170] Accordingly, where their respective accounts differ, I prefer the evidence of Mr Morrison to that of Mr Clark. The issue of whether or not the referral was appropriately actioned by Mr Morrison falls to be considered against the backdrop of the evidence given by him, as set out at paragraphs [153] to [155] above.

[171] Preferring, as I have done, the evidence of Mr Morrison to that of Mr Clark, it follows that the submissions made on behalf of Mr Clark in relation to the manner in which the referral was actioned fall to be rejected.

[172] I am satisfied that the MDMHT Referral Form completed by Mr Clark was placed in the box in E Hall at some point between 12:00 hours and 20:00 hours on 10 March 2014; and that Mr Clark was seen by Mr Morrison shortly after 20:00 hours that evening.

The Issues

[173] As set out above (see paragraph [48]), the mental health referral by Mr Clark

gives rise to three issues, namely, (i) whether the referral was appropriately actioned by the nurse practitioner; (ii) whether it would have been reasonable and appropriate for Mr Clark to have been assessed by a mental health nurse; and (iii) whether such action may have prevented Mr Penrose's death.

[174] In relation to the first issue, I am satisfied that the referral was appropriately actioned by Mr Morrison. He dealt with it promptly and probed appropriately. His conclusion that there was no mental health issue such as required urgent or emergency attention was both reasonable and justifiable.

[175] Properly construed, and looking also at the terms of the third issue, the second issue, namely, whether it would have been reasonable and appropriate for Mr Clark to have been assessed by a mental health nurse, must be predicated upon an assessment of Mr Clark having been carried out in the period between the consultation with Mr Morrison and Mr Penrose's death, if not on the evening of 10 March 2014. I address the second issue on that basis. If one does not construe the issue in that way and elects to construe it in accordance with the words used, the answer can only be in the affirmative. From the evidence given by Mrs Corrigan to the inquiry, had Mr Clark not been transferred to HMP Edinburgh, he would have been seen by a mental health nurse. The evidence suggests that it is likely that would have happened between 14 and 21 days after the submission of the referral, and certainly no later than 28 days after its submission.

[176] There was no evidence before the inquiry to suggest that the manner in which the referral was dealt with after it had been passed to the mental health team at Barlinnie

was anything other than appropriate. The timing of Mr Clark's assessment by the mental health team was dictated by its priority (as assessed by the mental health team on the basis of the available information) and the available resources. From the evidence of Dr Quinn, which was of considerable assistance to the inquiry, there is no basis upon which I can conclude that the referral was dealt with in any way which could be described as unreasonable or inappropriate. If one goes on to consider the issue in the manner I have chosen to construe it, again, there is nothing, whatsoever, in the evidence to suggest that steps ought to have been taken either on the evening of 10 March 2014, or thereafter but prior to Mr Penrose's death, to have Mr Clark assessed by a mental health nurse.

[177] Properly construed, the third issue is whether the assessment of Mr Clark by a mental health nurse at a point between 10 March 2014 and Mr Penrose's death, some ten days later, may have prevented Mr Penrose's death. This would depend, to a significant extent, upon what was disclosed by Mr Clark in the course of any assessment. Having regard to the conclusions I have reached in relation to the first and second issues, I have concluded that the assessment of Mr Clark by a mental health nurse in the abovementioned period would not have prevented Mr Penrose's death. The referral was vague. Mr Clark did not appear to know what he wanted, other than a single cell and different medication.

Conclusion

[178] Having considered the evidence and the submissions in relation to this chapter

of the evidence, I am satisfied that the position adopted by the Crown and the NHS is well founded. Accordingly, I make no findings in terms of s.6(1)(c), (d) or (e) of the 1976 Act in relation to the mental health referral. There are, however, two matters which fall short of other facts which are relevant to the death, but which may be of wider relevance, which I propose to comment upon.

[179] Firstly, accepting as I have done that the language used by Mr Clark in completing the form was "*concerning*" (Mrs Kenny) and "*extremely vague (and) extremely difficult to interpret*"(Mrs Miller), and noting that Mr Morrison was sufficiently concerned by the wording of the referral to make arrangements to see Mr Clark immediately, I am troubled that, having eliminated the possibility of self-harm on the part of Mr Clark, the extent of the steps then taken by Mr Morrison to try to get to the bottom of what Mr Clark meant by the form was not recorded in the Vision system and was, therefore, not available to the mental health team when they considered the referral the following day.

[180] I intend no criticism of Mr Morrison for not getting to the bottom of matters with Mr Clark. I accept his evidence that he made considerable efforts in this regard. It is his failure to record those efforts which causes me concern. The NHS nursing expert Mrs Kenny described the entry as "*quite brief*". In light of what Mr Morrison actually did, and having regard to the observations of Mrs Kenny and Mrs Miller in relation to the wording of the MDMHT Referral Form, it is difficult not to conclude that Mr Morrison ought to have said more in his entry on the Vision system relative to Mr Clark. Such

information would have better informed those assessing the referral the following morning.

[181] I should say that there is nothing before me to suggest that, in this instance, the referral would have been dealt with any differently. Nevertheless, accepting as I have the evidence of Mr Morrison in relation to the terms of his consultation with Mr Clark, it is my view that the entry made by Mr Morrison in the Vision system relative to Mr Clark could and should have been more fulsome than it was.

[182] Secondly, the only inference that can be drawn from the evidence before the inquiry as to the basis upon which the cell sharing risk assessment relative to the cell share between Mr Penrose and Mr Clark was carried out is that the fact that there was an outstanding mental health referral relative to Mr Clark was not known to Mr Holligan when he made the assessment. As I have observed in relation to the Polmont Incident, prison officers asked to make decisions in respect of cell sharing ought to have available to them as much relevant information as possible. That can then be considered along with the officer's own knowledge of the prisoners concerned, enabling an informed decision to be made. Looking at the reservations held by Mr Holligan in relation to the co-location of Mr Penrose and Mr Clark (see part 17 below), it is difficult but to conclude that the existence of an outstanding mental health referral relative to Mr Clark may have been relevant to the cell sharing risk assessment. This was not explored with witnesses in evidence therefore it is not a matter that can be considered further. Nevertheless, in my view, it is a matter of potential significance that

SPS should give consideration to when reviewing their cell sharing risk assessment process.

17. The Penrose / Clark Cell Sharing Risk Assessment

The Evidence

[183] On 14 March 2014, in the circumstances more fully described below, prison officer Alex Holligan carried out a cell sharing risk assessment relative to co-locating Mr Clark and Mr Penrose within cell 4/4 of E Hall at Barlinnie. In relation to this part, the inquiry heard evidence from Mr Clark and Mr Holligan. The prison experts, Mr Wheatley and Mr Podmore, both offered opinions on the decision taken by Mr Holligan.

[184] Mr Clark was asked a number of questions about his cell sharing arrangements in Barlinnie in 2014, prior to Mr Penrose's death. He moved into E Hall at Barlinnie on 30 January 2014. Having shared cells there with two other prisoners previously, on 24 February 2014 Mr Clark began sharing a cell with Prisoner R. He shared with Prisoner R firstly in cell 1/25 and thereafter, from 3 March 2014, in cell 4/21.

[185] Mr Clark moved cell on 11 March 2014. He explained that he had decided to start smoking again. Prisoner R was a non-smoker. Mr Clark said that he had asked for a cell on his own. He did not like sharing with people. His evidence was that he was not in the right "*heid space*" to be sharing with people he did not know. He was allocated cell 4/6. He was alone in that cell for two days. On 13 March 2014, Prisoner L was allocated to share cell 4/6 with Mr Clark. At that time, Prisoner L was subject to a

punishment regime in terms of which he was not permitted to have a television. This gave Mr Clark a choice. He either remained in cell 4/6, with Prisoner L but without a television, or he moved to another cell. He decided to move cell. His evidence was that there were only two spaces on the fourth floor of E Hall. One was with Mr Penrose; the other with an older prisoner who Mr Clark did not wish to share with for hygiene reasons. Mr Clark asked if he could share with Mr Penrose. He moved into cell 4/4 with Mr Penrose on 14 March 2014.

[186] Alex Holligan has more than 20 years' service with SPS. He presently works in the offender outcome suite in Barlinnie as a through-care support officer, working with offenders after they have been released. Prior to commencing in his current role, Mr Holligan had been a residential officer in E Hall since 2006. At the time of Mr Penrose's death, Mr Holligan was a residential officer on the fourth floor of E Hall. He knew Mr Penrose as a prisoner on that floor.

[187] Mr Penrose was transferred from HMP Greenock to Barlinnie on 2 April 2013. He was located within E Hall the following day, initially on the second floor. He remained on the second floor of E Hall until October 2013. Mr Holligan explained that Mr Penrose had been moved from the second to the fourth floor for "*time out*". Mr Penrose was a very young looking prisoner. He had been exposed to older prisoners. It was thought that he might be being groomed. By reason of the nature of the prisoners in E Hall, Mr Holligan explained that Mr Penrose may have been seen as desirable to older prisoners. Mr Penrose was quite immature and did not know how to respond.

[188] Until August 2013 separate regimes operated in E Hall for offence protection prisoners and non-offence protection prisoners. At that time the hall changed to a single regime. The number of non-offence protection prisoners reduced greatly. Mr Holligan's estimate was that at the time of Mr Penrose's death approximately 80% of the prisoners in E Hall were offence protection prisoners (i.e. sex offenders).

[189] The nature of Mr Holligan's role as a residential officer in E Hall meant that he got to know the prisoners on the floor he was responsible for. Mr Holligan explained that he took pride in knowing the prisoners. He described Mr Penrose as a very introverted, shy boy who did not talk. He was never rude and went about his business quietly. Mr Holligan's recollection was that at first Mr Penrose had been quite intimidated by the prison set-up, however, before he died he had started to mellow and engaged in conversation more often.

[190] Mr Holligan was not responsible for co-locating Mr Clark with Prisoner R. He was, however, familiar with Prisoner R who he described as an "*old hand, doing his time*" and believed would be a stable influence on Mr Clark. Issues had arisen between Mr Clark and the prisoner he shared a cell with when he first came into E Hall. They resulted in Mr Clark being moved from the fourth floor to the first floor for a period of time. From around 3 March 2014, Mr Holligan became aware that Mr Clark and Mr Penrose were associating. He thought they were friends. His evidence was that they both told him that they knew each other from Polmont. Mr Holligan's recollection was that Mr Penrose told him first and then Mr Clark told him. Mr Holligan thought this was too much of a coincidence. He believed that they were colluding.

[191] As at 10 March 2014 Mr Penrose was in cell 4/4 by himself. In Mr Holligan's opinion, Mr Penrose realised that these circumstances were unlikely to persist. He knew he would have to share. He felt that he would rather pick who he shared with. Mr Penrose did not say this to Mr Holligan in terms. Mr Holligan knew it would be the case. In discussing matters, Mr Holligan described Mr Penrose as being "*quite chatty*". Mr Penrose had had difficulties with his previous cell-mate, Prisoner E, who was challenging and, as a consequence, was moved round the hall. Mr Penrose wanted to share with someone less challenging. On 10 March 2014 Mr Penrose asked Mr Holligan if he could share with Mr Clark. This caught Mr Holligan off-guard. Initially, Mr Holligan refused to sanction the move. He explained that this was his usual practice. There could not be a situation in which prisoner officers responded positively to every request made by prisoners. The prison officers needed to retain control.

[192] Mr Holligan explained that Mr Clark's request came the following day, 11 March 2014. His request was different. He used the call bell system in his cell to attract Mr Holligan's attention. Mr Clark asked for a move away from Prisoner R. Mr Holligan's evidence was that the way Mr Clark played it was more "*jail-wise*". Mr Clark was prepared to go a long journey to get to his preferred destination. Mr Holligan described this as standard jail tactics. Mr Clark was a young man in with an older prisoner, who went to bed early. Mr Clark wanted in with someone his own age. Mr Holligan indicated that he was quite friendly towards Mr Clark in response to this request. He was mindful that Mr Clark had had a difficult time but had now stabilised. He asked Mr Clark who he should put him in with. Mr Clark replied

Mr Penrose. Mr Holligan thought "*Here we go*". He refused the request. He thought that Mr Penrose and Mr Clark were trying to engineer a move. That was the reason for the refusal.

[193] Mr Holligan explained that in the context of deciding whether the prisoner should share a cell, the prisoner's wishes can have a certain influence. Ordinarily, if no matter of concern arose, prison officers would be prepared to go along with such a request. Their view being, quite understandably, that the prisoners in question would be living together and if they were happy with the arrangement and it created no issues there would be no difficulty with that. In a perfect scenario, however, prisoners are not moved unless there is an operational requirement.

[194] A further request to move cell was made by Mr Clark later on 11 March 2014. He again activated his call bell system. He indicated that he was changing his smoking preference to smoking. Mr Holligan's view was that Mr Clark was obviously aware of SPS policy. The policy could be overridden if the non-smoker consented. Prisoner R was not prepared to have a smoker in his cell. In Mr Holligan's opinion, Prisoner R assisted Mr Clark with his move.

[195] As a consequence, Mr Holligan required to move Mr Clark, however, rather than move him in with Mr Penrose, he moved him into cell 4/6. Mr Holligan thought that this was an engineered move and decided that whilst Mr Clark would get his move, it would not be in with Mr Penrose. He told Mr Clark that the move was to the same section as that in which Mr Penrose was located and that he would be able to see Mr Penrose at recreation.

[196] Mr Holligan explained that Mr Clark was in cell 4/6 on his own for a short period of time until Prisoner L arrived from A Hall. Prisoner L came from A Hall subject to disciplinary action. Prisoner L's punishment was having his television taken from him. Sometimes, when such circumstances arose, a prisoner's cell-mate would be prepared to stay for the duration of the punishment. Mr Clark was asked. He wanted a television. As a consequence either Mr Clark or Prisoner L required to be moved. Mr Holligan explained that it was more complicated to move Prisoner L to another cell having regard to his punishment. It was easier to move Mr Clark.

[197] Mr Holligan went back to Mr Penrose. He asked Mr Penrose if he wanted Mr Clark to share with him. Mr Penrose did. Mr Holligan then did the necessary cell sharing risk assessment which, in turn, permitted the cell move. Mr Holligan concluded that there was no reason why Mr Penrose and Mr Clark should not share a cell. He described it as a very low end move. He recalled asking Mr Penrose a couple of days later how things were. Mr Penrose was happy; he and Mr Clark went to recreation together. Mr Clark did not go out of his cell much. Mr Clark and Mr Penrose seemed quite happy. There were no concerns on the part of the prison officers.

[198] Mr Holligan was very familiar with the cell sharing risk assessment process. He could do as many as five each day. He understood that if you were putting two people in a cell together there was always going to be a risk of harm, which could only be eliminated by prisoners being in cells alone. When two prisoners were put together one needed to look at their needs and any risks. It was for SPS to manage that risk. When carrying out a cell sharing risk assessment Mr Holligan would look at both prisoners'

Risks and Conditions. He would use these as guidance along with his own personal knowledge and that of his colleagues of the prisoners in question. If there were any real concerns a move would not be facilitated.

[199] Mr Holligan was asked how much consideration he would give to a wilful fire-raising marker which had been removed. In response he indicated that compared to, for example, violence against a cell-mate, he would not regard it as a matter that would stop a move if the behaviour had not been repeated and the marker had been removed. If the marker had still been live, Mr Holligan would contact his first line manager and seek further information in relation to it. If there had been a number of such markers that might raise concerns. A one-off would not.

[200] Risks and Conditions are important in determining whether prisoners should be allowed to share a cell. They are the principal source of logged information for an officer on the floor. They would be looked at in relation to every move. An officer would never move a prisoner without looking at their Risks and Conditions.
Mr Holligan's evidence was that if a matter within Risks and Conditions concerned him it is likely he would simply not approve the move under consideration.

[201] The terms of the Polmont Incident were put to Mr Holligan. He considered the terms of the report prepared by Mr McDonald. His evidence was that if he had been aware of the circumstances of the Polmont Incident he would not have co-located Mr Penrose and Mr Clark. On his reading of Mr McDonald's report, Mr Clark had assaulted a sex offender. There were varying accounts, however, they would have raised enough doubt in Mr Holligan's mind not to co-locate Mr Penrose and Mr Clark.

Mr Holligan was very clear on that position. His experience of E Hall was such that he was quite confident that any officer there faced with the same decision would reach the same conclusion.

[202] Mr Holligan's evidence was that if there had been a live bullying marker within Mr Clark's Risks and Conditions he would not have put him in a cell with another vulnerable prisoner, such as Mr Penrose. Mr Holligan emphasised that, in the circumstances leading up to the co-location of Mr Penrose and Mr Clark, as described by him, the smallest bit of doubt would have been sufficient to "*scupper*" the co-location.

[203] Mr Holligan was asked how he would have regarded an active wilful fire-raising marker being present within Mr Clark's Risks and Conditions. In those circumstances, Mr Holligan would have sought clarification and spoken to the first line manager. The terms of the SPS Incident Report relative to the Shotts Incident were put to Mr Holligan. Mr Holligan's view was that this was an isolated incident. Mr Clark had shared cells with various other prisoners without such incidents. Mr Holligan's view was that if he had been aware of the Shotts Incident it would not have made any difference to his cell sharing risk assessment.

[204] I have commented already upon the reliability of Mr Clark as a witness and the manner in which he gave evidence. The account given by Mr Holligan of the circumstances in which he came to co-locate Mr Penrose and Mr Clark was a full one. In so far as there is any inconsistency between the evidence given by Mr Clark and Mr Holligan, I prefer the evidence of Mr Holligan. He was an impressive witness. He was thoughtful in his answers to questions. He gave measured responses.

[205] No witness to the inquiry was critical of the decision taken by Mr Holligan. Mr Wheatley's view was that, on the information available to him, the decision taken by Mr Holligan was reasonable in the circumstances. Mr Podmore's opinion was that the decision to place Mr Clark and Mr Penrose in the same cell was a reasonable one based on the information available to Mr Holligan. In his report, Mr Podmore goes on to observe that, in his opinion, had absolutely everything known about Mr Clark been made available to Mr Holligan, Mr Podmore would not have expected him to change his decision.

Submissions

[206] The Crown submitted that Mr Holligan was credible in his position that he would have made a different decision on the co-location of Mr Penrose and Mr Clark had he known about the Polmont Incident. They say that his credibility in this matter is enhanced by his candid acceptance that knowledge of the Shotts Incident and the presence of an active fire-raising marker would not have influenced his decision.

[207] SPS say that the evidence of their officer, Mr Holligan, whilst clear and considered, displayed "*hindsight bias*" based on what subsequently happened. In essence, they argue that his evidence of what he would have done was influenced by what had, in fact, happened. They contend that the inquiry should be slow to accept Mr Holligan's evidence.

[208] POAS adopt a similar approach to that of SPS and say that the evidence of their member, Mr Holligan, whilst clear and considered, could be subject to "*hindsight bias*" based on what subsequently happened.

[209] Mr McDonald does not seek to criticise the actings or the evidence of Mr Holligan. He does not advance a position on "*hindsight bias*" similar to that advanced by SPS and POAS, however, he invites a favourable consideration of the observations of Mr Podmore, to the effect that had absolutely everything known about Mr Clark been made available to Mr Holligan, Mr Podmore would not have expected him to change his decision.

[210] Neither the NHS nor Mr Clark made any submissions on this issue.

Discussion

[211] At the time Mr Holligan carried out the cell sharing risk assessment, neither an active bullying marker in respect of the Polmont Incident nor an active wilful fire-raiser marker in respect of the Shotts Incident were applied in the Risks and Conditions section of Mr Clark's prison record. The wilful fire-raiser marker was shown as having been removed.

[212] Both prison experts, Mr Wheatley and Mr Podmore, were of the view that no criticism could be levelled against Mr Holligan for reaching the decision he did. Equally, no other witness to the inquiry was critical of that decision and a number spoke highly of Mr Holligan.

[213] The "*hindsight bias*" argument advanced by SPS and, to a lesser degree, POAS appears somewhat incongruous when one observes that neither of them addressed and discounted the possibility of similar behaviour on the part of Mr McDonald. It also, I suggest, fails to have regard to the obvious reservations held by Mr Holligan through the whole process which culminated in Mr Penrose and Mr Clark being co-located. In addition, it fails to have regard to the fact that Mr Holligan, himself, candidly accepts that knowledge of the Shotts Incident would not have impacted upon his decision.

[214] I found Mr Holligan to be a measured and impressive witness. He clearly is a professional and well regarded officer who reached a decision based on incomplete information. In the conclusion to his report, the SPS prison expert, Mr Podmore, stated that it is reasonable to expect that everything barring sensitive security information should be made available to officers making a cell sharing risk assessment. That position is one echoed by Mr Wheatley and by Mr Craig. It is a position I commend to SPS.

[215] There was no dispute that details of the Polmont Incident or the Shotts Incident were not known to Mr Holligan when he carried out the cell sharing risk assessment. Mr Podmore's proposition that, had absolutely everything known about Mr Clark been available to Mr Holligan, Mr Podmore would not have expected him to reach a different decision seems to proceed on a misconception, namely, that as Mr Clark did not show any evidence of being particularly violent in prison, rather he presented as troubled and manipulative, the tragic events of 20 March 2014 could not have been foreseen. Be that as it may, it simply does not address the evidence of Mr Holligan in relation to the

concerns he held and his clear evidence, which I accept unequivocally, that had the Polmont Incident been known to him he would have reached a different decision and would not have co-located Mr Penrose and Mr Clark. That decision is a quite different issue from the foreseeability of the death.

The Issues

[216] There are two issues relevant to this part of the determination, namely, (a) whether it was appropriate and reasonable to co-locate Mr Penrose and Mr Clark; and (b) whether had information of the Polmont Incident and the Shotts Incident been known to Mr Holligan, a different decision might have been made. I address the former on the basis of the (incomplete) information before Mr Holligan. On that basis, there is no dispute that his decision was both appropriate and reasonable. In addition, it cannot be overlooked that Mr Penrose and Mr Clark wanted to share a cell. Turning to the latter issue, had information of the Polmont Incident and the Shotts Incident been known to Mr Holligan, I am satisfied that a different decision might well have been made.

[217] A number of parties directed my attention to "*Sudden Deaths and Fatal Accident Inquiries*" (3rd ed.) at paragraph 5.75 in which the learned author states:

> "Certainty that the accident or the death would have been avoided by the reasonable precaution is not what is required. What is envisaged is not a 'probability' but a real or lively possibility that the death might have been avoided by the reasonable precaution."

Conclusion

[218] I have concluded that a reasonable precaution, whereby the death of Mr Penrose

might have been avoided, would have been for a bullying marker to be added to Mr Clark's risks and conditions on the SPS PR2 system as a consequence of the assault he perpetrated at Polmont on 30 July 2012. Had that been done, having regard to the evidence of Mr Holligan which I accept entirely, there would have been a real or lively possibility that Mr Penrose's death might have been avoided had the circumstances of the Polmont Incident been so recorded and known to Mr Holligan.

18. Did John Clark Know Colin Penrose Was A Sex Offender?

[219] The tragic events of 20 March 2014 inevitably give rise to the question as to whether or not the murder of Mr Penrose by Mr Clark was premeditated. Having regard to the evidence adduced at the inquiry, it is appropriate that I address this.

The Evidence

[220] The issue of whether or not Mr Clark knew Mr Penrose was a sex offender was dealt with in cross-examination by counsel for the NHS. In cross-examination Mr Clark's position was that Mr Penrose had told him he was in prison for stabbing his father. He did not know that Mr Penrose was a sex offender. If he had known, he would not have shared a cell with him. He believed that the fourth floor of E Hall was for non-offence protection prisoners.

[221] That cross-examination, in essence, was consistent with the evidence given by Mr Clark at his trial for Mr Penrose's murder. The terms of the transcript of that trial were a matter of agreement between the parties to the inquiry. In the context of the

issue presently being considered, the transcript confirms that Mr Clark's position at trial was that whilst looking for certain personal information after he had tied Mr Penrose up, he found paperwork that said Mr Penrose was a sex offender. At trial, Mr Clark's position was that until the night of Mr Penrose's death he had no idea that Mr Penrose was a sex offender. He stated that he had got on all right with Mr Penrose.

[222] There are two further pieces of evidence which are supportive of Mr Clark's position, namely, the terms of his telephone call with his grandmother on the evening of 19 March 2014 (see paragraph [28] above) and the comments he made to prisoner officers as he was removed from cell 4/4 following the discovery of Mr Penrose's body (see paragraph [34] above). Both are consistent with Mr Clark's position that until that evening he did not know that Mr Penrose was a sex offender.

[223] In evidence, Mr Laird spoke to a report prepared by him and another first line manager, John Naismith, following Mr Penrose's murder. The purpose of their investigation was to consider the prison records of Mr Clark and Mr Penrose to ascertain if any connection could be made which might explain the reason why Mr Penrose's life had been taken. That report concluded that Mr Penrose was a sentenced sex offender and would have been known to Mr Clark as such, having regard to the time they served together in the same accommodation area at Polmont. Mr Laird was asked about this in evidence. His view was that prisoners would know who were offence protection prisoners and who were non-offence protection prisoners. Essentially, the report by Mr Laird and Mr Naismith proceeds on this assumption.

[224] Interestingly, Mr Holligan could not say if Mr Clark knew that Mr Penrose was a sex offender. He did say that it was common knowledge on the floor (i.e. confirming the position explained by Mr Laird) and that a prisoner could find out if he wanted to. In evidence Mr Holligan spoke of a slate board located in the centre of the gallery in E Hall which recorded prisoner details, including whether or not they were offence protection prisoners. Essentially, the information was on the wall for people to look at if they wanted to. That, however, has to be considered in conjunction with Mr Clark and Mr Holligan's evidence that Mr Clark rarely came out of his cell.

[225] There is also the evidence, set out in paragraph [25] above, of DM. DM was not called as a witness. Notably, he did not say in his statement if Mr Clark knew that Mr Penrose was a sex offender. That evidence contradicts Mr Clark's evidence to the inquiry, albeit it is consistent with what was said by Mr Clark to Mr Holligan when he was trying to share a cell with Mr Penrose.

[226] The evidence set out at paragraph [23] above is of limited value. Mr Clark had shared cells with sex offenders prior to him being co-located with Mr Penrose. This evidence was introduced to the inquiry by way of joint minute. The short periods of time involved, in each instance, are noteworthy. Mr Clark was not asked about this. Whilst he may have shared cells with sex offenders, there is no evidence before the inquiry to suggest that he knew whether they were sex offenders. I am unable to draw any conclusions from this particular evidence.

Conclusion

[227] Whilst not free from doubt, I have reached the conclusion that Mr Clark did not know Mr Penrose was a sex offender until the night of 19/20 March 2014.

19. Evidence of Prisoner M

[228] The inquiry heard evidence from Prisoner M who was an inmate within E Hall at Barlinnie from September 2013 until September 2014. In February 2014, Prisoner M was located within cell 4/3 of E Hall, Barlinnie, the cell next to that occupied by Mr Penrose. Mr Penrose was known to Prisoner M.

[229] A short time before Mr Clark moved into cell 4/4 with Mr Penrose, Prisoner M overheard a number of other prisoners talking about Mr Clark. He heard one of them say that Mr Clark was "*going to fly for a beast*" and that he was "*going to kill a beast*". A "*beast*" is prison slang for a sex offender. No prisoner's name was mentioned as a potential victim. Prisoner M maintained that a couple of people had mentioned to him that Mr Clark was saying things. Prisoner M spoke with another prisoner, Prisoner E. It was Prisoner E who maintained that he had spoken to Mr Clark and had heard him make threats of this nature. Prisoner M did not hear Mr Clark make such threats or, indeed, say anything. Prisoner M did not take what had been said by Prisoner E seriously. Prisoner M did not report what he heard to SPS staff.

[230] The evidence of Prisoner M was put to Mr Clark. He denied making allegations of the nature spoken to by Prisoner M. He did not know who Prisoner M was until he

read his statement. His position was that he kept himself to himself; went to no association; only went out for meals; and only knew people he shared a cell with.

[231] Prisoner M was described by Mr Brooks as a "*particularly troublesome prisoner*" who always questioned what prison officers did and who tried to get other prisoners to complain.

[232] The evidence of Prisoner M is of dubious value. Prisoner E did not give evidence, however, he was described as challenging by other witnesses. Prisoner M, himself, agreed that Prisoner E had a "*fertile imagination*". He stated that Prisoner E "*came away with some whopping stories*". In all the circumstances, I cannot accept the evidence of Prisoner M as either credible or reliable. I place no reliance, whatsoever, on the evidence of Prisoner M.

20. NOMS Cell Sharing Risk Assessment PSI 09/2011

[233] In March 2011 the body responsible for prisons in England and Wales, the National Offender Management Service ("NOMS") introduced a new cell sharing risk assessment process by way of document PSI 09/2011. Appendix 1 to that document (at paragraph 1.4) identifies indicators of heightened risk. There was some consideration of this during the inquiry and certain criticisms raised, standing an apparent inability to unearth the research referred to, insofar as relevant to arson and fire setting (wilful fire-raising being the relative Scottish term).

[234] This NOMS PSI was referred to and produced as an appendix to the report prepared by Mr Craig for SPS dated 30 May 2014, part of Mr Craig's methodology being

a review of literature and reports, including a consideration of cell sharing risk assessment policies in other jurisdictions. One of the indicators is "*Arson, fire setting, either in the community or in custody*." The PSI makes a reference to "*extensive research*" having been carried out. In evidence, Mr Craig confirmed in evidence that arson and fire setting are regarded as risk factors in Northern Ireland. Mr Craig could not find any research to support this conclusion, however, indicated that, anecdotally, individuals with that pathology have a general disregard for the property and / or lives of others which, in extreme cases, could have fatal consequences.

[235] In his report on behalf of the Crown, Mr Wheatley made reference to the NOMS PSI, in the context of information sharing between SPS and NOMS relative to policy development; Mr Podmore, in his report, contended that the assertion that research supported this particular indicator was not evidence based, albeit he believed the intention was to draw attention to persons involved in dangerous fire setting where there was loss of life, injury to persons or significant damage to property, whether in the community or in custody. Notably, both Mr Wheatley and Mr Podmore were of the view that NOMS did not amend their PSI's lightly.

[236] The inquiry received evidence by statement from Ronald Elder. Information that NOMS obtained in the course of developing their violence reduction strategy could no longer be traced. Mr Elder, in his statement, spoke of discussions with psychologists within the prison service and understood that arsonists were known to have a lack of empathy with victims which would be a concern where cell sharing was concerned.

[237] Having regard to the conclusions I have reached in relation to the Shotts Incident, and to the evidence of Mr Holligan, I did not find the NOMS PSI to be of any particular relevance to this inquiry. That is not to say that it may not be of relevance to different circumstances.

[238] The areas of dispute between the respective prison experts in relation to this matter fall into two parts. Firstly, whether SPS ought to have channels of communication with NOMS which would enable awareness of the policies in force in comparative prison services throughout the United Kingdom on the risk a history of fire-raising poses to cell-sharing. Secondly, whether SPS ought to have reconsidered their cell-sharing risk assessment process in light of the NOMS revised instruction.

[239] In respect of the former, my view is that SPS should have such channels of communication. The evidence before the inquiry suggests that nothing but informal contact currently operates. In respect of the latter, I would not go so far to say that SPS ought to have reconsidered their cell-sharing risk assessment process in light of the NOMS revised instruction, however, my view is that SPS should constantly keep their cell sharing risk assessment process under review and have regard to any relevant material which would improve that process. I am reinforced in this view standing the fact that it is consistent with those expressed by both Mr Wheatley and Mr Podmore.

21. Developments in Cell Sharing Risk Assessment

Post Colin Penrose's Death

[240] Notwithstanding the failings that subsisted prior to and at the time of

Mr Penrose's death, the steps taken subsequently by SPS in relation to cell sharing risk assessment are worthy of mention and are to be commended.

[241] As referred to above, very quickly after Mr Penrose's death, Mr Craig was engaged to prepare a report. That report made a number of recommendations in relation to the process. It was followed up by a supplementary report from Mr Craig in December 2014. Mr Craig's supplementary report noted evidence of significant progress on the implementation of his recommendations and described progress as being more advanced than he had anticipated.

[242] SPS issued Governors and Managers Action number 52A/14 ("GMA 52A/14") on 18 August 2014 emphasising the importance of cell sharing risk assessments and highlighting areas for improvement within the then current process. New guidance in relation to prisoners' Risks and Conditions was issued in September 2014; and a new cell sharing risk assessment policy statement and desktop instructions were issued in September and October 2015 respectively. Road shows were conducted and staff trained on the new documents.

[243] Against this backdrop, one must consider whether what is now in place is suitable and sufficient. A number of witnesses to the inquiry offered views.

[244] On the one hand, Mr MacAskill's view was that the present guidance was sufficient. He expressed the opinion that it was perfectly clear. Mr Craig's view was that sufficient guidance had now been given. Mr Podmore was supportive of the current SPS guidance, describing it as commendably thorough, clear and concise.

[245] On the other, Mr Storer's view was that the current SPS guidance is still not as tight as he would like; he believed that it could be improved. His view was that SPS needed to remind staff of the importance of risks and of recording them. Mr Wheatley's view was that he had seen nothing by way of guidance to staff as to what was relevant (and, hence, should be recorded). It was left to staff to decide what was relevant. He was sure that they would do their best in this regard, however, that may not be good enough.

[246] The evidence of the officers involved in the day to day application of the new policy painted a somewhat different picture to those who spoke favourably of it. Mr Brooks' understanding was that the responsibility for recording information rested with the IMU. That was Miss Wilson's experience in practice. GMA 52A/14 stipulates that it is the responsibility of the individual in receipt of information to update the prisoner's record accordingly. It appears that there are instances where this is not happening and it is being left to IMUs to decide, contrary to what is envisaged by the guidance in relation to prisoners' Risks and Conditions issued in September 2014, in terms of which IMU staff have a secondary assurance role.

[247] The evidence before the inquiry suggests that, contrary to Mr Craig's view, sufficient guidance may not now have been given to SPS staff. Recognising that evidence, SPS invite me to recommend that they "*review the instructions given to (SPS) staff on who has the responsibility for applying a risk and condition to a prisoner's record; and that … SPS should ensure that all staff are aware of, and act upon, these instructions going forward*."

[248] Mr Breslin told the inquiry that he and others had been given a mandate by SPS to review the system of risks and conditions. I do not believe it would be appropriate to pre-empt the conclusions of that review.

Recommendation 2

[249] Accordingly, whilst sympathetic to the proposed recommendation I am invited to make by SPS, I do not propose to make it. Rather I recommend that SPS commence the review spoken to in evidence by Mr Breslin as soon as reasonably practicable (if they have not already done so); and give effect to the recommendations of that review as soon as reasonably practicable thereafter.

22. Conclusion

[250] The tragic events of the evening of 19 / 20 March 2014, whilst not unique in recent times, are, thankfully, extremely rare, there being only one recorded homicide in a Scottish prison since 2005. That that is the case is in no small part down to the diligence and professionalism of those who work within Scotland's prisons.

[251] Cell sharing is an unavoidable part of the current system. That is unlikely to change without either the building of more prisons or a material change in Scotland's approach to custodial sentences. Whilst the evidence of Mr Craig was that violence in Scotland's prisons is reducing, it must be stressed that such violence is never acceptable. Where circumstances dictate that an individual is deprived of his or her liberty, SPS is under a clear statutory duty to conduct their undertaking in such a way as to ensure, so

far as is reasonably practicable, that prisoners are not exposed to risks to their health or safety (see s.3 of the Health and Safety at Work etc Act 1974). The failures noted in this determination, and the failure to act in response to the report prepared by Mr Storer and Mr Davidson are regrettable.

[252] I conclude by recording my condolences to the family and friends of Mr Penrose.

APPENDIX 1

Witnesses

1. John Clark
2. Grant Morrison
3. Prisoner M
4. William McDonald
5. David Brooks
6. Claire Wilson
7. Donna Marie Simpson
8. Jonathon McTavish
9. Alex Holligan
10. Finlay Laird
11. Geoff Storer
12. Kenneth MacAskill
13. Alan Craig
14. Roy Breslin
15. Margaret Miller
16. Jacqueline Corrigan
17. Philip Wheatley
18. John Podmore
19. Caroline Kenny
20. Dr Alex Quinn

APPENDIX 2

Witnesses who gave evidence by statement

1. Jaclyn Dirkie
2. Ronald Elder

APPENDIX 3

Areas of dispute between prison experts

1. The relevance of the HMYOI Polmont incident to the March 2014 cell-sharing risk assessment.

2. The relevance of the HMP Shotts incident to the March 2014 cell-sharing risk assessment.

3. The combined relevance of these two incidents to the cell-sharing risk assessment.

4. The relevance, in general terms, of fire-raising incidents of the type carried out by Mr Clark in HMP Shotts in June 2013 to cell-sharing risk assessments.

5. Notwithstanding its relevance to the cell-sharing risk assessment, whether the HMYOI Polmont incident ought to have resulted in a risk and condition of bullying being applied to Mr Clark.

6. Whether SPS ought to have channels of communication with NOMS which would enable awareness of the policies in force in comparative prison services throughout the United Kingdom on the risk a history of fire-raising poses to cell-sharing. Thereafter SPS ought to have reconsidered their cell-sharing risk assessment process in light of the NOMS revised instruction.