

SHERIFFDOM OF NORTH STRATHCLYDE AT PAISLEY

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

**DETERMINATION
BY
SHERIFF NEIL DOUGLAS**

**IN RESPECT OF
FATAL ACCIDENT INQUIRY**

INTO THE DEATH

OF

BRYAN ROSS

Paisley: 23rd February 2011

The sheriff having resumed consideration of the Fatal Accident Inquiry into the death of Bryan Ross, determines in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, “the Act” as follows:-

In terms of section 6 (1)(a)

That Bryan Ross who was born on 24th December 1995 died in bedroom six of the Safe Centre at Kibble Educational and Care Centre, Goudie Street Paisley sometime around midnight on 20th/21 July 2009 and was pronounced dead at 0210 hours on 21 July 2009.

In terms of section 6(1)(b)

The cause of death was hanging.

In terms of section 6(1)(c)

There were no reasonable precautions whereby the death might have been avoided.

In terms of section 6(1)(d)

There were no defects in any system of working which contributed to the death.

In terms of section 6(1)(e)

There are no other facts which are relevant to the circumstances of the death.

Short Summary

The formal determination of the Inquiry in terms of section 6 of the Sudden Deaths and Fatal Accidents Inquiry ((Scotland) Act 1976 is set out above.

At the time of his death, Bryan Ross, “B”, was resident in the Safe Centre (a secure unit) of Kibble Education and Care Centre, Goudie Street, Paisley under a warrant from a Children’s Hearing. He had been there from 27th March 2009 until his death on 20th/21st July 2009. Around midnight on 20th/21st July 2009 B hanged himself in his secure bedroom by means of a ligature formed from his dressing gown using the gap between the door and the door frame of the en suite facility as the ligature point. He was discovered at that time as a result of a routine check on him. It is likely that the action of hanging himself caused an immediate cardiac arrest and that death would have occurred almost immediately. For this reason any attempt by B to reverse his own actions would not have been possible. It was unlikely in the circumstances that an attempt to resuscitate him would have succeeded.

It has not been established why B acted in the way he did as there were no signs during his time at Kibble, including near the time of his death that he would consider acting in the way he did. Accordingly, it has not been established that B intended to kill himself. In

the past, B had shown impulsive and attention seeking behaviour including threats of self harm, but it has not been established, either, that B's action on the evening of 20th July 2009 was an act of impulsive or attention seeking behaviour or of deliberate self harm.

Various issues were raised at the Inquiry. In terms of the practices in place at Kibble, B should not have been left with his dressing gown in his bedroom overnight and its removal was overlooked. It could have been removed by Kibble staff. B had pyjamas and bedding within his room which could have been used to form a ligature had he wished.

B should have been checked that he had settled in his bedroom every fifteen minutes from bedtime until midnight, and that could have been done. The checking on that evening was of a lesser frequency. It would have been a matter of chance, had the fifteen minute regime been operated, that B's actions would have been discovered before they were. It would have been a matter of chance that the operation of the fifteen minute inspection would have prevented B's death.

B's self harm and threats of self harm, in the nature of impulsive and attention seeking behaviour, although historic in context, could and should have been communicated by B's social worker to the staff at Kibble. It would have been normal to have done so, on B's first arrival at Kibble. On that day, both B's social worker and his keyworker at Kibble were on leave and therefore not present and the matter was overlooked thereafter. On the evidence, knowledge of B's history would not have affected the regime applicable to him for night time monitoring on 20th July 2009. Along with the other young persons in Kibble, B was already closely monitored.

An item was found half concealed in B's pillow as a result of a routine inspection on 3rd May 2009 which was thought to be a model ligature. The find was assessed and steps were taken as a precaution to monitor B more closely as a result of the find. The manner of assessment of the find lacked structure but even if a decision had been taken for additional measures of supervision, it is likely such measures would have been removed

before 20th July 2009. That would have been so even if the staff at Kibble had been aware of B's previous history.

CPR had been stopped before the ambulance team arrived, contrary to Kibble policy, but had CPR continued it would have made no difference to the outcome.

There were systems in place at the time of B's death. The evidence disclosed individual failures to operate the systems but none of those failures might have prevented B's death or contributed to it. The absence of the existence of written systems would not have made a difference to the outcome.

Accordingly, it has not been established that any of the above mentioned issues met the criteria for findings as regards sections 6(1)(c)(d) or (e) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976.

The Care Commission carried out a thorough inspection of Kibble's operating procedures following the death of B. It gave directions and made recommendations relating to the operation of Kibble in light of circumstances of the death of B. Kibble has implemented these. These have improved the operating procedures at Kibble. The issue of effective communication between social workers and care establishments for young persons has been addressed nationally subsequent to July 2009 by the alteration of the requirements of the information to be provided, and the forms of written reporting have been altered by the introduction of a history of the young person known as a chronology.

The sheriff finds in fact:-

1. B was a thirteen year old boy at the time of his death. His date of birth was 24th December 1995. He had had a troubled upbringing. He had behavioural problems and he was vulnerable. He had been subject to the intervention of South Lanarkshire Council Social Work Department and subject to supervision requirements in terms of the Children (Scotland) Act 1995. These requirements

- had him reside, at times, with his grandparents, in Bardykes and Hillhouse homes and in the secure unit of Kenmure St Mary's home, a total of eight placements since being accommodated in November 2007.
2. As a result of a fire raising incident, a children's hearing granted a warrant that B reside again in a secure unit. As a result, on 27th March 2009 B was accommodated at Kibble Education and Care Centre, Safe Centre, at Goudie Street, Paisley ("Kibble"). He remained there continuously under continuation warrants from that date until his death on 20th /21st July 2009.
 3. The requirement to confine a young person such as B in a secure unit is of such significance that the requirement to confine must be reviewed by the Chief Social worker of the appropriate local authority having care of the young person every four weeks. B was therefore in a special category of young persons in the care of South Lanarkshire Council Social Work Department.
 4. Kibble Education and Care Centre is located in Goudie Street, Paisley and is administered by a voluntary Board of Trustees on behalf of the Elizabeth Kibble Trust. It has a campus comprising a number of buildings including the Kibble Safe Centre which is a secure unit. The Safe Centre is situated to the rear of the campus. The Safe Centre is purpose built secure accommodation opened in the year 2007.
 5. The Safe Centre at Kibble is subject to the statutory scrutiny of the Care Commission in terms of the Regulation of Care (Scotland) Act 2001. It also requires and has the approval of Scottish Ministers. The educational component of the school comes under the scrutiny of Her Majesty's Inspectors of Education and for registration purposes it is an independent school. It is inspected twice per year by the Care Commission. It has a good regulatory history, with no formal complaints or enforcement action but was subject to certain requirements and

recommendations of the Care Commission following the inspection carried out by the Care Commission and reported on 7th October 2009.

6. There are compendious guiding policies and standard operating procedures formulated in writing by the management of Kibble, and approved for the operation of Kibble. These included guidance in connection with recognising suicidal ideation and self harm. The staff were required to familiarise themselves with these and did so. Staff at Kibble also received training for the purpose of carrying out their functions at Kibble. In particular, they received training in Cardio Pulmonary Resuscitation (“CPR”) and attended regular refresher courses for that skill.
7. A series of documents were also maintained at Kibble in respect of each of the young persons in their care. These included an individual personal (Kibble) file for the young person. There was also kept a daily log for recording events. A communication book, (a comms Book) for recording events of the day so that those on shift and coming on the next shift would be aware of matters set out in the book.
8. There were also standard practices developed, to which the staff worked, but which were not written down. One such practice related to the night shift. It was to the effect that the young persons in the Safe Centre would be checked every fifteen minutes from being placed for the night in their bedrooms until midnight and hourly thereafter. If a young person was not asleep at midnight, observations were to be maintained at fifteen minute intervals until the young person was seen to be asleep. There was a log book for the night shift carer to record each time he carried out each check.
9. The Safe Centre contains three units and B resided in Barra unit. Barra has communal rooms and offices. The unit has access to secure shared facilities such as a gym, swimming pool, and outside recreational areas. There are six secure

bedrooms for single occupancy in Barra unit, and an observation secure bedroom. Each bedroom has a built in bed with normal bedding and an en suite facility containing toilet, wash basin and shower. In July 2009 and currently the access to each of the six bedrooms from the bedroom corridor was and is by a door which can be locked both electronically and by conventional key lock. There is outside each bedroom, built into the outside wall of the bedroom, a secure panel accessed from the corridor by staff using an electronic key. Part of the panel contains a six inch by three inch observation window which can be opened by the staff member to observe the occupant of the bedroom. This allows staff to monitor the occupant of the room. The panel also has controls for the supply to the room of water lighting and power. Any opening of a bedroom door and any opening of a monitoring window to any bedroom is electronically recorded. The fob to open the observation windows has a unique electronic number and that unique number is allocated to a carer on receipt of the fob. By that means the identity of the carer carrying out monitoring or accessing tasks can be readily identified. The observation secure bedroom was not and is not located within the bedroom corridor.

10. Prior to B's death, there was an internal door access between the en suite facility and the bedroom in each bedroom in Barra. That door could be locked back by staff into a frame set into the wall of the bedroom in an open position so that it became flush with the wall. There remained a small gap between the door and the door frame around the door when the door was locked against the wall. The door and its housing had been supplied as an entire unit from suppliers during the construction on the Safe Centre.
11. The corridor to the bedrooms is covered by an internal CCTV system.
12. The bedrooms were designed to contain anti suicide features including the elimination of ligature points. Prior to commissioning, the Safe Centre building had been inspected by representatives of the Care Commission and an architect

commissioned by the Scottish Government. Following on that inspection in 2007 the Safe Centre was approved for occupation as a secure unit for the accommodation of young persons. As subsequent events showed, the gap between the door and the door frame when the en suite door was locked in an open position, formed a possible ligature point.

13. In July 2009 and subsequently, each occupant of the bedrooms in Barra had a cupboard outside his room in the nature of a locker, which contained his belongings including all his clothing including night wear. The locker was kept locked and access to it was controlled by staff members who opened and shut it as required, and access to the locker was always in the presence of a member of staff. Young persons occupying the rooms were allowed various personal and other items in their rooms, such as a television, books, papers, writing materials. Whether an occupant was allowed an item in a room depended on an individual assessment of the item requested and factors relating to that young person. That assessment took into account the risks attributable to the item in relation to the wellbeing of the individual young person at the time and any discipline issue. As an example a television for use in a room was sometimes removed from the room as a discipline sanction.
14. Dressing gowns and slippers are provided to the young persons by Kibble. As part of the operational procedures and risk assessments at Kibble, it was a requirement that dressing gowns and slippers were not allowed to remain in the bedrooms overnight to avoid a ligature risk. Staff had the responsibility to see to it each night that the young persons in Barra put their dressing gowns and slippers in their lockers outside their bedrooms before being locked in their rooms for the night.
15. The dressing gowns for the young persons were purchased from high street clothing stores. Of those that were in use by the young persons in Barra at around the time of B's death, some had conventional dressing gown cords or belts and

some had had the cords removed by staff at Kibble and short pieces of material sewn to the front edges of the dressing gowns, in the nature of fasteners or tabs, substituted for the cords or belts to obviate the need for dressing gown cords. This was to avoid the possibility that the cords might be used as ligatures.

16. The regime laid down at Kibble recognised that the occupants of the Safe Centre were young persons in care and that, within the requirement that they needed to be secure and kept safe, each should lead a life as normal as possible to allow them to develop physically and emotionally. The regime also recognised and took account of the fact that young persons in need of compulsory measures of care in a secure environment could be subject to behavioural and emotional disturbance; they could demonstrate feelings of low mood and depression and suicidal ideation; they could at times act and threaten to act in a manner that could be harmful to themselves and to others and they could behave in a manner that was attention seeking and impulsive. Accordingly, young persons in the Safe Centre were subject to ongoing close scrutiny and monitoring within the Safe Centre. Further, it was part of the regime that, where appropriate, heightened observations could be undertaken of any young person requiring additional scrutiny.

17. In relation to the issue of a propensity to self harm or to have suicidal ideation, there was a written policy as part of the Kibble documentation. It reads,

“3.10.1 Staff have a duty to protect young people as well as promote their safety and wellbeing. Within the Safe Centre, young people may pose a risk to themselves or others and therefore require varying levels of supervision. Further, the risks existing may necessitate various levels of observation. Staff will continually risk assess all situations and circumstances affecting individuals and respond with an appropriate intervention plan.

Young people may require observations if the risk assessment indicates that they

- Have a history of self harm &/or attempted suicide.
- [other categories are set out].....

When staff are required to undertake observations, they need to be aware of the young person's right to privacy yet achieve a balance between respecting this right and maintaining safety as well as meeting their emotional or primary care needs.

Furthermore, whilst conducting any observations, staff must be aware that their actions could further anger, frustrate or stimulate a young person in a negative manner.”

18. Self harm can be used by the young person as a coping mechanism for stress or anxiety; suicidal ideation relates to an intent to end life.
19. By reason of the already secure environment, it was relatively straightforward, when the need arose, to increase observations on any young person in the unit during the daily routine of the young persons in the unit. During the daily routine any increased observations could be done without undue attention being drawn to the increased scrutiny. As regards after bedtime observations, the opening and closing of the inspection window of bedrooms in Barra created a noise and a level of disturbance. Any use of the inspection window had the likely result that the occupant of the bedroom became aware that he was being observed. Accordingly, use for the observation window occurred only when necessary.
20. B was admitted to Kibble on 27th March 2009 for his protection and the protection of others, principally relating to a fire raising incident he had been involved in at a previous care home. B was allocated bedroom six in Barra unit, and occupied that bedroom throughout his stay at Kibble.

21. To know how best to meet the needs of and protect those residing in the Safe Centre, there is a need to assess new residents individually. It was normal practice for the staff member from Kibble receiving the young person to ask the person delivering the young person about the young person's history of suicidal ideation or self harm, if any. On arrival at Kibble the regime in place required that B have a key worker appointed to him who would have responsibility for B. His key worker was a Mr Walker. Neither Mr Meechan nor Mr Walker were available at the handover of B at Kibble, as each was on leave at the time. It was part of the induction programme for B that he be assessed. The assessment included an assessment of his mental health and emotional state. There was an initial planning meeting about B on 2nd April 2009 and a case conference on 24th April 2009 to consider that assessment and frame a care plan for B at Kibble.
22. In order to carry out these procedures, Kibble wished to obtain as much information about the background of B. The sources available were B himself, the social work department having care of B, and other sources capable of providing information on B's past such as previous care homes, the children's hearing documentation, medical records and assessments. Most of that information came from information provided initially by South Lanarkshire Council Social Work Department documentation supplemented by B's social worker, Mr Meechan. A South Lanarkshire Council Social Work Department social background report dated 28th January 2009 was given to the Kibble staff on B's arrival at Kibble. It ran to twenty three pages. The verbal briefing given to Mr. Walker by Mr Meechan was given on his return from leave in April 2009. Mr Meechan also gave Mr. Walker information about the names of persons in previous care homes who had dealings with B.
23. Mr. Walker and Mr Meechan met for the provision of that information on 17th April 2009. Mr Meechan also met with Ms McGeown, the trainee psychologist employed by Kibble on 24th April 2009 to provide her background information on B. Ms McGeown asked for information about B's previous psychological history

and Mr Meechan obtained for Ms McGeown two CAYP (NHS Lanarkshire Child and Families Clinics, C.A.Y.P.Team) Minutes of Consultation dated 1 July 2008 and 25th September 2008 written by the counselling psychologist of the CAYP team.

24. Prior to entering Kibble, B had been involved in certain incidents. The first was that, in about 2007, B had been noted by his teachers to bite his hand and was reported to have scratches and marks on his body. The second was that by 26th July 2008 he had been noted as having threatened to self harm. He had done so to care workers who challenged him when he was in the course of absconding from his then care home. That threat was that he would go to the motorway and walk in front of a car. The third was that by 17th August 2008, it was reported that on an outing to Millport he had walked in front of a motorcycle. The fourth was that by 17th November 2008, it was reported that he had deliberately shown a care worker in his then care home that he was putting a ligature round his neck.
25. Having been the social worker for B for two years, in late March 2009, Mr Meechan considered that the four incidents were not of current significance as regards self harm or suicide risk. On the first of the incidents he had seen B's arms on occasions and had not seen any evidence of harm. B was also known to have suffered physical injury from a family member at that time and Mr Meechan attributed any reported injury to B's person to that cause.
26. The second incident was a threat, but there had been no repetition of the threat known to him. Mr Meechan attributed the third incident to attention seeking. The information as regards the fourth incident was noted by the care worker who had observed it as attention seeking behaviour, and Mr Meechan accepted that opinion. Such threats by young persons in care are a feature of their attention seeking behaviour. Threats seeking to use a noose as described in the report are also sometimes a feature of attention seeking.

27. Mr Meechan was also aware at the time of B's admission to Kibble that B's uncle had committed suicide. He was not aware at the time whether B was aware of that fact. It would have been inappropriate for Mr Meechan to have raised the matter with B without knowing whether B knew. If B had not been aware of that fact, it would have been of little significance to any assessment of B as regards a propensity to self harm or suicidal ideation. He considered that it was not an issue he was bound to investigate.
28. Putting the incidents in the context of Mr Meechan's knowledge of B, Mr Meechan considered that the incidents were not current and should be treated as part of the history of B. Nonetheless, he thought that he had mentioned these matters to Mr. Walker and Ms McGeown, as part of the initial briefing of them.
29. The incidents were not referred to by Mr Meechan in the social background report of 28th January 2009. They were not mentioned by Mr Meechan to Mr. Walker or Ms McGeown at the briefing meetings; nor was the history of the uncle's suicide. Ms McGeown had contacted Ms. Stirling, the senior psychologist at Kenmuir St Marys where B had been in the secure unit, for information. Ms McGeown has no recollection of Ms. Stirling mentioning to her any incidents of self harm by B that she may have been aware of.
30. Had Ms McGeown known of these events, when a possible ligature was found in B's room on 3rd May 2009 she may have referred B to the CAMHS team; the local mental health team. Had she done so it is likely that the team would not have accepted the referral, as B would not have met the criteria for a referral. The criteria in 2009 were that there had to be present at the time of referral current mental health issues suggestive of self harm or suicidal ideation.
31. The review of B's care plan dated 2nd July 2009, signed by Mr Meechan, did not allude to issues of self harm or suicidal ideation, depression anxiety or stress.

32. B was challenging in his behaviour and confrontational with staff, from time to time, and the regime employed in the Safe Centre for all young persons was designed to reward good conduct and impose, if necessary, sanctions for bad behaviour, all consistent and proportionate with dealing with young persons of the age of B.
33. At Kibble B was the beneficiary of rewards and the recipient of sanctions throughout his stay. His behaviour was, in general, within the normal behaviour parameters of the other occupants, the only matter of difference being that B was about a year younger than the other occupants. B was at level 4 of the incentive scheme. Being on that level allowed him to have pens and pencils in his room overnight.
34. At Kibble B was guarded in the disclosure of information to those assessing him including Miss McGeown. There were periods when B would not engage at all with Kibble staff about himself or his feelings. When he was prepared to engage about himself at all, he would not be forthcoming about his past; he only spoke about the future. This slowed up a meaningful psychological assessment of B. Ms McGeown's assessment of B was not fully complete prior to B's death.
35. At Kibble it was part of the regime that the bedrooms of the young persons would be routinely searched, usually during the daytime when the occupants were not in their rooms. On 3rd May 2009, as a result of such a routine daytime room search by staff, there was discovered an item described by the finder as a ligature. It was a cord or torn material fashioned into a cord like item, similar to a dressing gown cord or belt, and was six inches long. It had a knotted loop at either end and the centre of the loop was a hole of about one inch in diameter. It was considered to be an unusual item. By reason of its dimensions it was unlikely to have been capable of going round the neck of B to form a ligature. When asked about the item, B was not prepared to be forthcoming about it, telling staff that it was

nothing to do with them. Ms McGeown advised staff to increase observations on B. She was not otherwise consulted by the staff as regards the find.

36. As a result of the find, Mr Naylor who made the find, reported the matter to the duty manager Mr Naismith. Mr Naismith ascertained from Mr Naylor that the item could not be used as an instrument of self harm. He enquired of another member of staff about B and ascertained that B had no history of self harm or suicidal ideation, but that he had shown attention seeking behaviour on occasions. He concluded that the find did not suggest a serious intent to self harm. Nonetheless he considered that it was necessary to err of the side of caution and gave instructions to staff on shift that they had to keep a close eye on B. Mr Naismith considered that there should be kept fifteen minute observations on B thereafter including fifteen minute night observations until further review. He did not write down that instruction. B was subject to close scrutiny throughout that day. The discovery of the item was also noted by Mr Naylor in the Comms book and in his notes in B's personal file. The Comms book is used for passing on information to other members of staff and other shifts. Ms McGeown was informed as was Mr Meechan.

37. No increased observations were maintained on B during the nightshift of third to fourth May 2009 and no further observations of a heightened nature were thereafter put in place.

38. On 19th July 2009, in the evening, B had a confrontation with a member of staff when he threw a bottle of water at him. In consequence of the incident and its aftermath, B required to be dealt with by a restraint procedure when placed in his bedroom. That procedure involved him being physically restrained so that he was not in control of his person during the restraint procedure. The procedure was a part of the regime and only used where necessary. It was unusual for B to be the subject of a restraint procedure. The incident was resolved that evening with B suffering the sanction of the removal of his television from his room.

39. The following day, 20th July 2009 proceeded without incident until after B had showered between 8 p.m. and 8.30 p.m.. B went into the kitchen but refused to accept responsibility for a minor issue relating to the use of the kitchen. When challenged by Mr Morton, the care worker on duty, B continued with his approach to the matter, and was directed by Mr. Morton to his bedroom for a period of reflection. B accepted that he would be confined in his room for a period of reflection. From that time until 9.30 p.m. B remained in bedroom six. Mr Morton and, on one occasion, Mr Scott (who had come on duty at about 9.10p.m. as night shift carer) entered and spoke to B in his bedroom.
40. By 9.30p.m. B accepted a sanction for his conduct from Mr Morton, being the removal of his television from his room for the night. He was then locked into his room for the night.
41. B had been wearing his dressing gown after his shower, as the young persons were not allowed in the communal areas in pyjamas without wearing dressing gowns.
42. As B was being locked in for the night at 9.30pm., he asked for and was given paper, pencils, and magazines from the cupboard outside his room. B was locked into his room for the night with his dressing gown.
43. The practice for night shift observations by Kibble staff in Barra of the young persons in their bedrooms was that the person in the observation room was to be checked every fifteen minutes throughout the night and the occupants of the six bedrooms were to be checked every fifteen minutes up to midnight and thereafter every fifteen minutes until the occupant was asleep and hourly thereafter. This practice was formulated in 2007 by Kibble management as a practical rule, a default position, to meet the requirement of the Care Commission that observations were to be kept and be appropriate to the individual needs of the

- young person from the individual risk assessments. The practice as decided on was told verbally by Mr Harte to his managers in 2007, who were to disseminate among the staff. In 2009 the practice was still based on the 2007 verbal instruction. Part of the regime was that the night carer on duty had to complete a log of the observations made as regards the bedrooms contemporaneously.
44. The person on nightshift on 20th/21st July 2009 was a Mr. Scott. The night shift started at 10 p.m.. Mr. Scott was the sole carer on night shift for the six occupants of the secure bedrooms in Barra. He also had responsibility for a young person in an observation room outwith the bedroom corridor. Mr Scott was unaware of the find on 3rd May 2009.
45. Mr Scott manually recorded in the nightshift log for observations of the bedrooms that observations had been taken every fifteen minutes from 9.30 p.m. until midnight. The electronic record as regards access to room six that evening showed that Mr. Scott had been in room six at 21.32 hours and that he had opened the observation window at 21.57 hours, 22.46 hours, 23.14 hours and at 00.02 hours, notwithstanding that he had completed the nightshift observations book as having carried out observations every fifteen minutes.
46. Ms McGrory, the night shift manager of the Safe Centre, had been issued with a electronic pager known as a Blik and a CB radio receiver. Just before midnight she had entered the office in Barra to make a cup of tea and had placed the radio, which was normally clipped onto her trouser belt, on a table.
47. At 00.02 hours Mr. Scott checked B, and on closer inspection he saw that B was seated with his back to the en suite door and hanging from the door by what was found to be B's dressing gown formed into a ligature.
48. Mr Scott entered room six, removed the ligature from around B's neck. He activated his personal pager (Blik) which summoned Ms. McGrory, the night duty

- manager, and he started immediate cardiopulmonary resuscitation procedures (CPR).
49. When summoned by Mr. Scott, Ms. McGrory did not take her radio with her and Mr Blaikie, the staff member in charge of the operations room, had to send her another radio by means of another worker, Ms Emma Faulds who took the radio to Ms McGrory for her use.
50. Ms. McGrory entered room six some fifty seconds after being summoned by Mr Scott by means of the Blik. When Ms Mc Grory entered, she asked Mr. Scott when he had last checked B. He replied that he had done so fifteen minutes before.
51. Ms McGrory contacted the operations room to summon the emergency services. Mr Blaikie, from his operations room, summoned the ambulance service, directed another night duty manager, Mr Pullar to wait at the entrance of the Safe Centre to admit the ambulance team and asked another person to go to the main building to contact and direct the ambulance team to the Safe Centre.
52. The ambulance service were contacted and directed to Kibble. By reference to the Ambulance Service electronic system, the service was contacted at 00.12hours on 21st July 2009. An ambulance and a paramedic team were dispatched to Kibble at 00.13 hours and arrived on scene at Kibble at 00.17 hours. The ambulance summoned to Kibble arrived at the front of the main school building. There was no one present at the gate of the Kibble campus, nor at the main building, to direct them to the Safe Centre. The ambulance team had not received directions as to the location of the Safe Centre.
53. Mr Fallow, a paramedic, immediately made the ambulance known by activating the ambulance lights. A member of Kibble staff appeared and directed them appropriately to the Safe Centre.

54. The lapse of time from arrival on scene by the ambulance team to gaining entry to the Safe Centre, which would have been avoided had there been a member of staff waiting for the ambulance at the entrance to Kibble or at the main building, was of the order of two minutes.
55. While she and Mr Scott were waiting for the ambulance team, Ms. McGrory thought she heard movement outside and thought that it was the arrival of the ambulance team. She told Mr. Scott that the ambulance crew had arrived and that he should let them deal with resuscitation. Mr. Scott stopped CPR at that point.
56. The ambulance team on scene did not, in fact, arrive in room six at that point, and CPR was resumed by them about five to six minutes after Mr Scott had stopped. B was examined by a paramedic at around 00.20 hours (ambulance recording time).
57. The ambulance team, including a Mr Farrow, engaged in resuscitation procedures thereafter but ceased further procedure on B about 00.42 hours and the ambulance team left.
58. The period during which CPR was not being administered prior to the arrival of the paramedics would have been reduced to about four minutes had the ambulance team been able to attend at the Safe Centre immediately.
59. The timings shown on the electronic record for access to the bedrooms, the timings shown on the electronic record on the CCTV recording, and the timings on the electronic record of the ambulance service were not synchronised. Each bore to show a different time from the other two for the events that were occurring. Each record was likely to be accurate to show lapse of time.

60. A post mortem examination of B was carried out by Dr. Julia Bell, pathologist, on 24th July 2009 and her report was dated 19th August 2009.
61. Her examination disclosed that B had died as a result of hanging. From her observations of B she concluded the physical action of dropping/hanging was likely to have caused an immediate reflex cardiac arrest, with the result that B would have lost consciousness immediately and would have been dead very shortly thereafter.
62. Persons suffering a reflex cardiac arrest in these circumstances are very unlikely to be capable of being revived, however soon after resuscitation is attempted. Further, permanent irreversible brain damage would have commenced about four minutes after the loss of consciousness and death.
63. B was last seen alive at 23.14 hours on 20th July 2009 and when seen at 00.02 hours on 21st July 2009, had no vital signs when found, nor were any vital signs observed throughout the CPR. When Ms. Mc Grory entered room six at 00.07 hours on 21st July 2009,(CCTV time) she noted B's dressing gown hanging from a pencil jammed into the top of the door recess. Ms. Mc Grory did not notice anything of the nature of a dressing gown cord lying in the room. She noted that B's body was discoloured, that he had urinated. On her subsequent return to the room she noted that B's lips were pale gray blue, that his toe nails and finger nails were clear white. She thought that B had been dead for some time.
64. B died sometime between 23.14 on 20th July 2009 and 00.02 hours on 21st July 2009 as a result of reflex cardiac arrest following on him hanging himself. He hanged himself by means of him forming a ligature with his dressing gown, securing it by jamming pencil and paper to a ligature point available at the upper corner of the locked-open door of the en suite to his bedroom and dropping.

65. Prior to July 2009, B had been receiving medical treatment from his general medical practitioner for the condition, athlete's foot. This meant that any time that B wished to go swimming he had to wear a swimming sock as a preventative measure. This was annoying to B. Shortly before his death, B had again visited his G.P. who had confirmed that B was now clear of the condition and could return to swimming without the sock. At around that time B had also spoken to Ms McGeown about his forthcoming move to the open estate and asked her advice about which unit he should ask to be moved to. B was aware that, although the children's hearing to deal with this move could not take place as scheduled (it being inquorate), that his carers were to recommend to the hearing such a move and that the delay of the hearing would not delay his anticipated move out of the Safe Centre.
66. At around the time of his death B was not showing signs of depression, suicidal ideation, self harm or threats of self harm. He showed no change of behaviour as regards education. His appetite was good. His health was good. He was looking to the future. He was interacting with others in the same way as he had done before and he was beginning to develop a more trusting relationship with the staff at Kibble. In the past, when at Kibble, B had expressed the view that he was not sympathetic to people who had suicidal ideation.
67. B's death by hanging on 20th/21st July 2009 came as a shock to staff at Kibble. They did not consider that B was a suicide risk nor was he thought likely to self harm. His death at his own hand was entirely unforeseen by the staff at Kibble.
68. At a national level, the regular review of the format and content of social work information recorded for young persons, has, subsequent to July 2009, required that a summary of the issues about the young person be maintained as a specific chronology of the young person. This is intended to have all the necessary summary of information available for use in a better form.

69. The Care Commission carried out an investigation into the death of B at Kibble and produced a report.

70. Following that investigation they made the following requirements which Kibble accepted:-

(a) The Board of Kibble must ensure that all staff are clear about their responsibilities with regard to first aid and cardiopulmonary resuscitation to ensure the safety of service users.

(b) Managers of the Safe Centre need to ensure that they have all available information about the health needs of young persons provided at the point of admission.

(c) Staff need to know, understand and follow the procedures for checking young persons during the night.

(d) Staff must accurately record when they are doing checks on young persons during the night. This recording should be accountable and correspond to the electronic system.

(e) Communication amongst staff must improve. Staff should be fully aware of the protocol for the level of observations and should also be fully aware of what to do when an item of concern is found. This should be lead by the management team.

The Care Commission also made the following recommendations as regards Kibble (or other care establishments) which Kibble accepted:-

(a) All services, on or linked to the campus, should have a procedure in place to ensure that emergency services can quickly find the relevant building.

(b) All secure services should make links with health Board LAAC nursing colleagues to ensure that medical information about young person admitted to secure care is made available to the service as quickly as possible.

(c) Potentially dangerous or significant items discovered in secure services should be removed to a safe place and kept for further reference and a record kept. When staff are unsure what such an item might be, it should be photographed and emailed to other secure services to check if they recognise it and for their information.

(d) Policies about the removal of items (including clothing) from young people's rooms at night should be understood by staff and carefully followed.

(e) Suggestions from the consultant architect regarding possible modifications to the en suite doors should be considered by the service and other stake holders.

(f) Quality assurance measures need to be put in place for senior managers to check and monitor practice e.g. observation recordings. These need to be more formal and accountable.

66. The management of Kibble implemented the Care Commission requirements and recommendations. In addressing the matter of the ligature point created by door to the en suite in a locked back position, Kibble decided to remove the door altogether. By doing so the occupant of the room still retains privacy from the viewing window. The management formulated and implemented a written policy for night shift observations of fifteen minute observations to midnight whether the young person was asleep or not and hourly thereafter provided that by midnight the young person was asleep. The manual recording of nightshift observations was done away with and the electronic information is relied upon. That electronic recording is itself monitored at regular intervals by management on a random selection for inspection. Procedures as to how to deal with unusual finds like ligatures have also been put in place.

Note:

On the application of the procurator fiscal for a Fatal Accident Inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 in the public interest, I heard evidence from Monday 1st to Friday 5th November 2010 and submissions on Tuesday 9th November 2010. Those represented at the Inquiry were Mr Logan, procurator fiscal depute representing the procurator fiscal, Mr Watson, solicitor advocate, representing Kibble Educational and Care Centre and Mr Wade, solicitor advocate representing South Lanarkshire Council. I heard submissions from Messrs Logan, Watson and Wade.

The following witnesses were called by the procurator fiscal and gave evidence:

Gerard Harte: Executive Director, Kibble

Patrick Meechan South Lanarkshire social worker

Donald Walker care worker Kibble

Denise Carroll, Nurse, Kibble

Avril Mc Geown, Trainee Psychologist, Kibble

Andrew Naylor, Care Worker, Kibble

David Naismith, Care Worker, Kibble

Alan Scott, Care Worker, Kibble

Bryan Livingston, Development Manager for Children's Services Regulation, Care Commission

Elizabeth Mc Grory, Care Manager, Kibble

Robert Blaikie, Care Manager, Kibble

Emma Faulds, Care Manager, Kibble

Gary Norton, Care Worker, Kibble

Robert Fallow, Paramedic, Scottish Ambulance Service

Julia Bell, MB ChB FRCPATH DipFMS DipMJ(Path), Pathologist

No witnesses were called by any other party.

The submissions for the Crown

Mr Logan, procurator fiscal depute, made the following submissions;-

As regards section 6(1)(a) and (b) his submissions are as reflected in the determination.

As regards section 6(1)(c)

On the test of precautions which might have prevented the death he submitted that

(1) the staff members placing B in his room on 20th July 2009 could have ensured that B's dressing gown was removed and placed in a locked cupboard; and

(2) A member of staff responsible for observations could have carried out observations every fifteen minutes up to midnight and thereafter every hour.

As regards section 6(1)(d) as to defects in any system of working that contributed to the death, he submitted that Kibble had a defect of working in not having in place a written policy, clear to all members of staff, as to how frequently observations should be carried out on the young persons during the night. Further, they did not have in place a system for checking to ensure that the observations were being carried out at the appropriate times. Such a system of checking would be a reminder to staff to ensure that the system was being carried out. He submitted that the monitoring frequency of once per week, put in place after B's death was sufficient.

As regards section 6(1)(e) he made no submissions on the basis that, on the evidence, there had been no causal connection between the matters which might be raised and the death.

Submissions for Kibble

There were submissions on what the Inquiry should find proved in evidence and submissions about who should be believed and accepted.

As regards section 6(1)(a) and (b) Mr Watson adopted the submissions of the procurator fiscal subject to this, that he submitted that the immediate cause of death was reflex cardiac arrest.

As regards section 6(1)(c)

He submitted by reference to authority that any precaution required to be a real and lively possibility (Carmichael: Sudden Deaths and Fatal Accident Inquiries (3rd Edition) 5-75).

He submitted that none of the precautions submitted by the procurator fiscal would fall into that category. The Inquiry should be slow to hold that removal of B's dressing gown was a reasonable precaution. If it was a reasonable precaution, it did not contribute to the death of B. The Care Commission had said that B, "was determined to kill himself and he could potentially have done so using his pyjamas if his dressing gown had not been available." Accordingly, removal of the dressing gown was not a reasonable precaution that might have avoided death.

On the matter of the night observations by the staff, he submitted that what was advanced by the procurator fiscal was not a reasonable precaution. There had been no expert evidence. The evidence from Mr Livingstone for the Care Commission was that there required to be a policy regarding observations but the Commission did not require a stated frequency. The policy had to be tailored to the individual needs of the young persons in the care of Kibble. He had no criticism of the 15 minute policy but what Mr Scott had carried out that night was a system adapted to the needs of the B which was what the Care Commission required.

He indicated that the procurator fiscal had rightly not made submissions on the matter of transfer of information since the evidence showed that the existence of additional information would not have altered the regime for B on 20th July. Likewise, the removal of a ligature point created by the door was not a reasonable precaution whereby the death might have been avoided. Finally, any issue of Mr Scott stopping CPR was not a reasonable precaution, for the evidence supported the proposition that B could not have been revived.

His submissions as regards section 6(1)(d)

He submitted that, “if the sheriff detects a defect in a system it must be one which contributed to the death”: Carmichael (cit supra);11-06

There had been no expert evidence about the appropriateness of systems. He submitted that, in any event, the Inquiry had to differentiate between system and the carrying out of the system by the staff. Mr Morton knew that the dressing gown ought not to have been in the room (system), but he had not seen to it that it was removed (execution of system).

Mr Scott knew that the system was to carry out 15 minute checks until the young person was asleep and he carried that out. Had there been a written system it would have been to that effect in any event.

As regards CPR, Mr. Scott had known of the system that until the emergency services arrived CPR was to be continued, but for the reasons he gave he had not followed out. In each case a system had been in place which, for the reasons given, had not been carried out. In any event none of these had contributed to the death.

As regards section 6(1)(e)

He submitted that none of (i) the events of 3rd May 2009; (ii) the level of observations of 20th July 2009, (iii) the location of the dressing gown on that date or (iv) the provision of CPR, were circumstances of the death. No finding should be made under this sub paragraph.

Submissions for South Lanarkshire Council Social Work Department

Mr Wade submitted that apart from the formal findings there should be no further findings under section 6(1)(c)(d)or (e).

It was clear from the evidence that South Lanarkshire Council Social Work Department were in the second rank of involvement and he invited the Inquiry not to make any comments of a critical nature. No one had foreseen B’s death and all had been shocked by it.

He challenged whether, on the evidence, it had been shown that B had intended to take his own life. It was notable that the Crown had not asked the Inquiry to make such a determination. An adult might be presumed to have meant what he did, but the picture was less clear in a disturbed adolescent. There had been no expert evidence. The pointers in the evidence, to a layman, were to the contrary. B's enquiries about moving to the open estate and his prospective resumption of swimming were aspects of looking to the future and at odds with suicidal ideation. The mechanism of his death by reflex cardiac arrest had resulted in instant unconsciousness depriving B of the opportunity to attempt to reverse the process. On the whole evidence, the Inquiry would not be able to conclude, on a balance of probabilities, that B intended to take his own life.

The evidence of the ligature issue on 3rd May 2009 supported the proposition that the police statement was wrong and that the length of the dressing gown cord was 1 ½ feet to 2 feet and that it had been a dressing gown cord. He submitted that the finding of the dressing gown cord in the circumstances in which it had been found would not have changed the regime for B at Kibble by 20th July.

As regards the issue of the ligature on 20th July, the Inquiry had not heard evidence from the police, or of their investigation or views following the investigation. Mr. Wade reviewed the evidence about the ligature and submitted that the ligature used by B had been a dressing gown cord and not the dressing gown. The cord described by Mr Scott in evidence he submitted, had been pretty much like that found on 3rd May.

It was clear from the evidence that Mr Meechan was highly committed to the care of B.

If there was an implied criticism of Mr Meechan about the absence of transfer of information that was a discrete issue.

On the matter of the self harm incidents, he referred me to the social work records and to the family history. He submitted that Mr Meechan had been correct and that B had not been suffering from mental health issues or suicidal ideation and references in the social

work report of 2nd May 2007 to depression had been wrong. That could be seen from the fact that the two CAYP (sometimes referred to as Cape) reports made no reference to mental health or suicidal ideation issues.

There had been two references to depression in reports by Ms McGeown following screening (the emotional wellbeing screening of 30th March 2009). Her evidence was that B was less depressed than normal and did not refer to B being depressed in her subsequent report. The evidence showed that B had no suicidal ideation, quite the reverse. B denied self harm or suicidal ideation. He analysed her assessments in relation to B's upbringing. He referred to the evidence from Ms McGeown that suicidal ideation was dynamic and that the CAMHS team would not have accepted B because B showed no dynamic features; current evidence of mental health problems. That evidence, he submitted, put the evidence of Mr Meechan in context.

As regards Ms McGeown's evidence that she might have investigated the incidents of self harm had she known of them, the evidence was that it was unlikely that such investigations would have made progress due to changes of personnel. Her discussion of B with Ms Stirling the principal psychologist at Kenmure St Marys had not elicited the information about the ligature as a self harm threat, nor the motor cycle incident. Clearly in providing information Ms Stirling had filtered the information that was relevant to B for Ms McGeown and had chosen not to mention it. In any event, it would have made no difference to the regime for B.

As regards the family history, there was no evidence that the assessment had been wrong or that Mr Meechan had been aware that B had been aware of the family history of suicide.

The car incident when he was at Bardykes dated from about 26th July 2008. The Millport cycle incident was to be found in a report of 17th October 2008. The ligature issue was mentioned in the same report. There had been, he said, an abundance of evidence that

threats by young persons of the age of B were not uncommon and the issue threats of using a noose was fairly common among young persons in care.

There had been neither expert evidence about any psychological aspects of the circumstances nor from any expert in the provision of care for young persons.

In any event, the evidence was clear that, by the time of his admission to Kibble, all the self harm incidents were stale and only of historic interest. In particular, there had been the evidence of Ms McGeown that there had been no evidence of serious intent by B, and no dynamic risk.

Even if there had been disclosure of information by Mr Meechan to Ms McGeown, there was no causal connection to B's death. Even if it could have made a difference, the evidence was that a greater monitoring regime was not available and that the arrangements in place had not been implemented.

As part of recent social work development, there was now kept by social workers an individual chronology for each young person in care, but it was not foreseeable that one was required at the time. At the time of B's admission to Kibble, the social worker struck a balance as to what was relevant, thereby avoiding the recipient of the information being overwhelmed by information of doubtful relevance.

Mr Meechan had not featured the self harm incidents because they had not been relevant and the relevance of them would have been diminished by the passage of time. At most, the provision of information would have made a short term difference because Kibble staff would not and did not consider B as a suicide risk at the time of his death and they may have been right.

On the matter of the ligature point, the fact that Kibble had eradicated it by removing the door, could not infer that they should have noticed the matter earlier and removed it.

As regards the ambulance service familiarisation issue, the Fire service had a statutory duty as regards knowledge of buildings that that ambulance service did not have.

Findings and reasons for the determination

For the most part the evidence led by the Crown about the events of B's life and the circumstances of his death were not substantially challenged.

Kibble

The buildings of the Kibble Safe Centre at Goudie Street Paisley are described above.

Kibble and the operating procedures and the staff.

Kibble has a comprehensive written set of policies applicable to the operation of the Safe Centre. It also had a comprehensive written set of standard operating procedures applicable the Safe Centre. These were referred to in passing in evidence.

Mr Harte, the centre's executive director, explained that these policies and procedures were supplemented with practices developed over time. The evidence raised the possibility that, at the time of B's death there were different views among the staff as to what those practices were and how aspects of the Safe Centre were to be operated.

A particular example was that Mr Harte was of the view, in his examination in chief, that implementation of the original Care Commission requirements for normal night time observations required a night shift monitoring system of checking each occupant every fifteen minutes until midnight and hourly thereafter provided that the occupant of the room had been asleep by midnight. In cross examination he accepted that the frequency of observation was fifteen minutes until the young person was seen to be asleep and hourly thereafter. Mr Scott maintained that the method of proceeding depended on a risk assessment of each occupant and that there was no definitive fifteen minute procedure in place. Mr Harte said that the practice then in place was a practical application of the requirement of the Care Commission that each young person be assessed and a care plan put in place which included night time observations appropriate to the risk assessment.

Such evidence as there was from other staff members of Kibble was supportive of Mr. Harte's understanding as set out in his examination in chief. There was no written operating procedure setting out the detailed aspect of matters.

B's life prior to entering Kibble

B had been under the supervision of South Lanarkshire Council Social Work Department for some time and had been accommodated in open care homes at Bardykes and Hillhouse homes in Lanarkshire and in secure accommodation at Kenmure St Marys care home by direction of the Children's Hearing system.

B had been moved back from Kenmure St Marys to Hillhouse but as a result of a fire raising incident the Children's Hearing considered that for his protection and for the protection of others B required to be accommodated in secure accommodation. It was considered that Kibble Safe Centre represented a more suitable secure environment for B.

The intention of South Lanarkshire Council Social Work Department was that if B could achieve stabilised behaviour, it would be appropriate to move him back to an open care home.

B and social work intervention

Mr Meechan, an experienced social worker, was allocated to B as his social worker in 2007. He familiarised himself with B's life history from records and from information supplied by the social worker who previously worked with B's family. Thereafter, he was involved with B's welfare. B was under supervision as it was considered that he was in need of compulsory measures of care. He was living in family but as a result of an incident he moved to live with his grandmother from November 2007 until 18th December 2007. At that time he was then moved to a foster placement until April 2008 when he was moved to the children's unit at Bardykes care home. He remained there until August 2008 when he was moved to Hillhouse care home. He was there until October 2008 and was moved to Kenmure St Marys secure unit at that time. He was then moved within that establishment to an open unit before, in February 2009, he was moved

back to Hillhouse. In February 2009 there was a fire raising incident and on 27th March 2009 he was placed at Kibble Safe Centre.

The circumstances of B were regularly reviewed by South Lanarkshire Council Social Work Department and by a Children's Hearing. Mr Meechan was involved in preparing reports for and participating in these reviews. When in a secure unit, South Lanarkshire Council Social Work Department required that the circumstances of B be reviewed by the Director of Social Work every four weeks. At those meetings there was an ongoing assessment of B including psychological input. There was also face to face contact with the staff in the care homes in which B was accommodated.

B going to Kibble

Following on the order of the Children's Hearing, B was taken to Kibble on 27th March 2009. Mr Meechan was off work at the time B was taken to Kibble. Mr Meechan returned to work on 15th April 2009. Mr Meechan met with Mr. Walker, B's key worker on 17th April 2009. There was a requirement that Kibble hold a case conference applicable to B within three weeks of his arrival. Such a case conference was held on 24th April 2009. Mr Meechan attended the case conference about B on 24th April 2009 and provided information about B to the conference. He also met separately with Ms McGeown, Kibble's trainee psychologist to pass on information at that time.

Kibble were given the twenty three page Social Background Report of 28th January 2009 relating to B either on his arrival at Kibble or at the latest when Mr. Walker met Mr Meechan on 17th April 2009. Mr Meechan also undertook to Ms McGeown that he would try to obtain two CAYP reports on B and he did this.

Did Mr Meechan pass on information about B's self harm incidents?

On the evidence, Ms McGeown wanted as much information as possible about B. The evidence was that South Lanarkshire Council Social Work Department had five files of accumulated reports and information about B. It was not suggested in evidence that Mr. Meechan should have provided all the files to Kibble. For Mr Meechan, therefore, it was

a matter of judgement for him to decide what should be conveyed to Mr Walker and Ms McGeown.

It was the position of Mr Meechan that he did not consider that B's personal harming of his body to be accurate on the basis of his observation of B and of the subsequent conviction of another for assaulting B. I accept that evidence as being correct and reliable. In any event the evidence was that the matter had arisen in 2007 and following his reception into care there had been no evidence of that form of self harm thereafter.

As regards the matter of the car and motor cycle, I accept Mr Meechan's evidence that these were acts of impulsive behaviour seen against a background of B's other conduct. I accept that Mr Meechan considered them, and from his experience of B, that he was entitled to see them as such. I also agree that, as presented to him, the matter of the ligature in Hillhouse was attention seeking conduct and his assessment of that was reasonable. I accept therefore that in the exercise of his professional judgement that it was reasonable for him not to see the four incidents, insofar as factually based as other than the impulsive acts of someone attention seeking and that B's other conduct supported such a position.

The information that B's uncle had committed suicide, while known to Mr Meechan, did not carry with it whether B had been aware of the fact. It was reasonable in such circumstances that he did not raise the issue with B in circumstances where there was no evidence of suicidal ideation manifest.

While the Care Commission report makes reference to B's mother reporting that B was aware of his uncle's suicide, how and when that information became available is not set out in the report. There was no clear evidence as to when Mr Meechan became aware of the fact that B's uncle committed suicide. There was no evidence that the information apparently provided by B's mother was accurate. I accept that Mr Meechan did not know whether B knew of the circumstances of his uncle's death. The issue of whether he

should have followed it up was not explored in evidence, and I am unable therefore to form a view on the matter.

The information that B had put a ligature round his neck as an attention seeking gesture was set out in the report where it appears. Mr Meechan, in exercise of his discretion as an experienced social worker, was entitled to evaluate that report and accept it for what it was worth and place it in context.

Mr Meechan thought that he had mentioned all these matters to Mr Walker and Ms McGeown, but each said he or she had no recollection of being told. Having seen and heard them, I consider it likely that they would have remembered Mr Meechan telling them and would have noted it down. The information was not written down in the records of Kibble and it should have been had it been mentioned. Mr. Meechan was a caring and committed social worker to B. Mr Meechan was less certain of his recollection about passing on the information than the other two. On the whole evidence, I consider that Mr Meechan probably did not tell Mr Walker or Ms McGeown of these incidents in the manner Mr Meechan spoke of.

Details about suicidal ideation and self harm were issues to be raised at the time of the young person's arrival at Kibble. As it happened, both Mr Walker and Mr Meechan were on leave at the time of B's arrival at Kibble, and the matter was not thereafter addressed by either.

B at Kibble

Only general evidence was led at the Inquiry about B's day to day living in Kibble up to the third of May, or indeed from then until 19/20/21 July 2009.

The find of the third of May 2009

On 3rd May 2009, as a result of a routine daytime inspection an item was found half in and half out of B's pillow.

Mr Wade asked me to hold that the item found was not six inches long but was a dressing gown cord of 1 ½ to 2 feet long. He submitted that the recording in the police statement that the item was 1 ½ to 2 inches was wrong and that the item was a dressing gown cord of about 2 feet. Mr Watson submitted that the item had not been hidden.

Of the people who gave evidence only Mr. Naylor had seen the item. He had found it hanging half in and half out of the pillowcase. In cross examination he accepted that it was not completely disguised and that possibly it had not been hidden away and that B may not have bothered if it had been found.

Mr. Naylor's evidence about the dimensions of the item was far from certain. His evidence initially was that it was about six inches long and made of torn cloth such as bedding or from a pillow case but that he had called it a dressing gown cord. He was 99% sure that it was a dressing gown cord with loops at either end that were about the size of a 50 pence piece. In cross examination for Kibble he reiterated the same evidence about its dimensions. He conceded that he had written in the log of that day that it was a six inch belt. He accepted that for it to be called a ligature that it would have to be long enough to go round a neck and that the item found was not long enough to go round a young persons neck. He changed his position in cross examination when his police statement was put to him. In that statement he had said that at first he had thought the item unusual and thought that B was intending to harm himself by putting it around his neck. He was asked if he had told the police that it was 1 ½ to 2 inches long which was in the statement. He said that if they had noted that then that was an error; it might have been of that width but not length.

Mr Harte, who had not seen the item, questioned whether it had been a ligature at all, as it had been described to him as being eight inches long with loops at either end so small that no head could be put though them. His impression had been that it had been more of a model of a ligature, if anything, rather than a ligature itself.

Whatever its description, Mr Naylor was sufficiently concerned about the find that he notified various parties of the find and advised that a very close eye be kept on B as a possible suicide risk. I accept that Mr. Naylor thought the object had been the subject of an attempted concealment; that it was a possible ligature of some sort, which on reflection he now recognised was incapable of going round a neck, that it was about six inches long and like a dressing gown cord. B had been asked about it but refused to be forthcoming about it.

The precautions taken following the discovery of the ligature

Mr Naylor consulted his manager on duty, Mr Naismith. Mr Naismith ascertained from Mr Naylor that the item looked like a model of a ligature. In particular, Mr Naylor confirmed to Mr Naismith that in his view the ligature could not be used as an instrument of self harm and there was no history of self harm or suicidal ideation known to him about B. Mr. Naismith asked another member of staff who knew B about B. The member of staff said B could be attention seeking and had done small things to attention seek before. Mr Naismith advised that fifteen minute watches be kept on B when not otherwise under observation in communal areas. He advised that a close eye be kept on B and this was done throughout the day on 20th May 2009. Mr Naismith was of the view at the time that 15 minute observations should be made thereafter, including bedroom observations. No such fifteen minute instruction was recorded in writing at the time. B was not the subject of fifteen minute observations on the evening of 3rd May 2009 or thereafter. The default regime prevailed on the evening of 3rd May 2009 and thereafter as regards B.

Dressing gowns and dressing gown cords

The dressing gowns for the young persons were bought in high street stores as required. In general terms therefore they would have cords/belts to secure them shut. Mr Harte thought that, after purchase, all the dressing gowns had been adapted by removal of the cords/belts and by the sewing on of short ends of cloth to the front edge of the gown to allow for fastening. Doing so avoided the necessity for long dressing gown cords/belts and avoided the possible use of a cord as a ligature. Evidence from other staff members

was that in July 2009 of the dressing gowns worn by the young persons some had cords and some had the short ends. Overall, I consider it more probable that there was a mixture of short end dressing gowns and corded/belted dressing gowns.

What was the monitoring regime in place for the bedrooms

Mr Harte gave evidence that the routine for monitoring young persons in their rooms after they had been shut in for the night was a verbal one.

The requirements of the Care Commission in 2007 had been that it was for Kibble to devise and maintain a regime taking account of the individual risk assessments applicable to the young persons in their care. In order to meet the requirements of the Care Commission and in assessing a framework to meet the requirement, at that time, management had looked to apply a general rule. Management looked at various time intervals and had decided that a fifteen minute interval between inspections of bedrooms through the portal was appropriate. Mr Harte explained that that information had been given to managers and the information had cascaded down to staff.

In examination for Kibble Mr. Harte accepted that the regime was fifteen minutes until the young person was asleep and hourly thereafter.

Ms McGrory gave evidence from her experience both as a night carer and night manager that the regime that was expected of a night shift carer was inspection every fifteen minutes until midnight and hourly thereafter (for young persons not on heightened watch). She was not challenged about this.

Mr. Scott said that in July 2009, there was no regime laid down. The frequency of monitoring depended on the individual risk assessment of each young person. He said that best practice was that the frequency of inspections should be fifteen minutes until the young person was asleep and hourly thereafter. He maintained that best practice had to yield to the events of any particular shift to meet the individual needs of the young persons in the care of Kibble.

The electronic monitoring information I saw in evidence related to 3rd May and 20th July 2009. Mr Scott was not on duty on 3rd May 2009. There was no supporting documentation for Mr Scott's statement and I have difficulty with Mr Scott's evidence as noted below. That said, I accept that it is always possible that a verbal instruction can be misinterpreted. I accept also that a regime of fifteen minutes until the young person is asleep and hourly thereafter may meet the Care Commission requirement on an individual risk assessment, where there is no reason to believe that the young person is at risk.

The evidence of Ms McGrory as night shift carer and manager over a number of years carries weight. Her evidence was clear and definite and it was not challenged. I accept her evidence and hold that it was the responsibility of the night carers to do fifteen minute observations to midnight, whether the young person was asleep or not.

The evidence was that following B's death a written instruction of what was described as "rigid" fifteen minute observations is now in place.

It was also part of the regime that there were log sheets to record the night observations of the bedrooms. These were to be filled in contemporaneously by the night carer on duty. The need to do so has been dispensed with post October 2009.

What happened on the night of 19th July 2009

I heard evidence from Mr Scott and Mr Morton about the 19th of July 2009. B had been challenging in his behaviour and had thrown a bottle of water at Mr. Morton. Matters had escalated to the point where B had been the subject of a restraint procedure and putting him in his room. It was said that B had then been spoken to and had eventually accepted responsibility for his misconduct, and agreed to the sanction of removal of his television. The incident is recorded contemporaneously in the log of Kibble and I accept that such an incident happened.

Ms. McGrory gave evidence that B was not a young person whose conduct normally led to restraint procedures. There was no evidence to suggest other than that the matter was resolved that evening.

What happened from the row on 20th July until B was found at 00.02 hours on 21st July 2009

I heard evidence from Mr. Morton the back shift care assistant in Barra and from Mr. Scott the night shift care worker.

As regards Mr Morton, he explained the events of the evening whereby B had been ordered to his room for sounding off in the kitchen and not accepting responsibility. He explained that B had then been spoken to in his room.

B had been wearing a dressing gown in the kitchen because he would not have been allowed out of his room without wearing it. Following the incident in the kitchen, B was in his room from then, continuously, until he was locked in the room for the night. The electronic record showed that Mr. Morton entered B's room several times until he went off shift and that Mr. Scott had also entered the room prior to Mr. Morton leaving for the night. I was advised that matters had been resolved between B and Mr Morton before he went off shift. It was Mr Morton who locked B in for the night and B was locked in with his dressing gown.

It is a rule that no young person has his dressing gown in his room at night. To explain the position Mr Morton maintained that the responsibility for putting the dressing gown in the locker outside that room was that of B. His evidence came across as if he bore no responsibility to see that it was done. A matter of note is that B had behaved badly on two consecutive nights and on the second night, notwithstanding that all was said to have been resolved, B was left with his dressing gown when he should not have been. The explanation of Mr Morton about whose responsibility for seeing to it that the dressing gown was put in the locker; he saying that it was up to B to do so, not that it was his responsibility to see that it was done, was not convincing. His evidence overall left me

with an uncertainty as to whether matters were as settled with B as Mr Morton maintained. If all was well then why was the matter of the dressing gown overlooked?

On the whole evidence, I am unable to find it established that when Mr Morton left B, the issues had been resolved and that B was settled and ready to be locked in his bedroom for the night. There is no contrary evidence. What Mr Morton says in evidence may be so, but the weight of his evidence is not sufficient to persuade me that it has been established.

As regards Mr Scott's evidence of what happened on the night shift, the difficulty I have is that his manual records are at variance with the computer print out of the monitoring of the bedrooms. He sought to suggest that his manual recording in the log book related to a new young person in the observation room. I did not find that explanation convincing. Ms McGrory gave clear evidence, not cross examined, that when she entered room six for the first time and in a state of shock she had asked Mr Scott when he had last checked B. According to her, Mr Scott had replied, fifteen minutes ago. Clearly, that was not correct. This was not put to Mr Scott who gave evidence first. Ms McGrory also gave evidence that Mr. Scott said that when seen earlier B had been reading, not that he had been sleeping, but that he had been reading. Ms McGrory later in her evidence said she was not sure whether Mr Scott had told her about B reading at the time of entering the room or later.

As noted, Mr Scott's evidence was that the regime to be followed was that observations were not to be specifically and mechanically fifteen minutes, but were to be tailored to meet the requirements of the occupant of the room. His position was that B had been reading at 21.57 hours, had been apparently sleeping at 22.46 hours, and again apparently sleeping at 23.14 hours. In that event, it is unexplained why he would feel the need to tell Ms McGrory inaccurately that the observation was last done fifteen minutes before, when according to his evidence there was no need for him to do fifteen minute checks because B was asleep. In these circumstances, I did not find his evidence satisfactory on this point and I am not prepared to find what he said as established.

It follows that it is not established what state of mind B was in after his altercation with the staff member, nor is it established that B was in any particular state of wakefulness or sleep up to midnight. By force of circumstance it must be the case that between 23.14 hours and 00.02 hours B was awake at some point.

As this was an issue at the Inquiry, it might have assisted had the CCTV evidence of the checking of B by Mr. Scott that evening from bedtime, covering the period of the electronic record, if available, had been produced. It may have shown the opening of the inspection windows and the manner in which it was done.

What happened following the discovery of B hanging at 00.02 hours on 21st July 2009

The inspection by Mr Scott of room six at 00.02 hours on 21st July 2009 was the subject of evidence including the CCTV camera recording. The CCTV recorded time shown on the screen does not coincide exactly with that of the electronic door opening information, the CCTV camera showing the door opening as 00.05 hours when the electronic information had it at 00.01.30hours. The timings mentioned below are the timings taken from the CCTV recording. The CCTV does not show what was going on in the room but it shows the arrival of Mr. Scott, of him entering room six and the night manager Ms McGrory and her comings and goings, the arrival of Ms Emma Faulds and the arrival of the ambulance team. I accept the evidence of Mr Scott that on inspection at 00.02hours he accessed room six and that he found B seated with a ligature round his neck, that he pulled off the ligature, that he found B to have no vital signs, and that he administered CPR continuously until advised to stop by Ms McGrory about 00.13hours. There was then a gap of time before the ambulance team entered the corridor and room six at 00.19 hours. I accept the evidence of Mr Fallow, the paramedic of the team, that resuscitation was attempted until 00.42 hours (ambulance service time recording) when it was stopped and that there had been no evidence of life in B from his arrival. Further, I accept the evidence of Ms Mc Grory, who was not an expert, that there were signs which suggested to her that B had been dead for a while.

What was the ligature used by B

I was asked to hold that the ligature used by B was a dressing gown cord. There was conflicting evidence about that. On balance, I consider that on the evidence it was the dressing gown itself that was used as the means of hanging. I did not hear from the police officers at the scene. It would have been helpful to have heard that evidence. I did not see the dressing gown and neither cord nor belt was produced. As noted, there was conflicting evidence about whether dressing gowns used by the young person had cords or short fasteners. The preponderance of the evidence supported the existence of full dressing gown cords or belts having been attached to at least some of the dressing gowns at the time of B's death. No one could remember if B's dressing gown had a cord. The photographs do not appear to show a cord. The fact that B in those photographs is not wearing his dressing gown but that it is in close proximity to his body may be an indicator. The evidence of the pathologist, if anything, tends to point away from the more defined mark that a cord might make in that the evidence of the ligature mark was suggestive of a wider piece of material. I consider that the word "cord" is unlikely to be used to describe a fastener in the form of a wider belt of the same material as the dressing gown, but that, too, is speculative.

The ambulance service

The evidence was that the ambulance containing the paramedic, Mr. Fallow arrived at Kibble in four minutes from the call being made from Kibble. There was a delay in getting to the Safe Centre because there was no one available to direct them to the Safe Centre. The delay was swiftly overcome by Mr Fallow's prompt and effective action, and on arrival at the Safe Centre Mr Pullar was waiting to unlock the door and let them in. When Mr Fallow entered room six he found Mr. Scott. Mr Scott was not administering CPR at that time. Mr Fallow found no signs of life in B. He carried out standard procedures including CPR and the administering of medication. At no time did he detect any signs of life and he stopped any further treatment at 00.42 hours.

As it was likely that B was already dead some time before 00.02 hours it is unlikely that, had they arrived any earlier, their earlier arrival would have made any difference.

There was some evidence from Mr Harte that the fire service had inspected the Kibble campus and retained a plan of the campus. Mr Wade suggested that the fire service had a statutory responsibility as regards the premises which the ambulance service did not. I heard no evidence about this. It appeared that Mr Fallow had been to Kibble before. There was evidence that the operator for the emergency services had to check if Kibble was the same as Kibble School suggesting that the information held was not up to date. The confirmation was instantaneous and the ambulance was on scene in four minutes. It was not suggested that there was any issue of delay in getting to Kibble, and I can see none. On the evidence, I consider that the performance of the ambulance service on that evening was entirely satisfactory.

It was suggested that the ambulance service should have a map of the campus for ambulances arriving at Kibble, but this was not explored. Another way of dealing with the matter is for Kibble to ensure that when an ambulance is called that a member of staff goes to the gate or other strategic place to give the ambulance directions. Mr Blaikie gave evidence that he had organised this, but, on the evidence, no one went. I accept that Mr. Blaikie attempted to do this. It seems to me that organising that that be done, should be one of the responsibilities of the operations room operator. There was some discussion in submission about whether there should be a requirement to nominate a staff member of Kibble or an office holder for that job. Mr Watson suggested that I should not be prescriptive about the matter. I can see that without nominating someone ahead of time, the same issue could arise again. Accordingly, I see the current arrangements as a weak link. However, I accept that I heard insufficient about the permutations of running Kibble to be prescriptive about the matter.

Post mortem findings

Dr Bell gave evidence that I entirely accept. She said that B had died as a result of hanging; that from the absence of congestion in his face it was likely that the action of

hanging had caused an immediate reflex cardiac arrest in B. The result of that would be that B would have lost consciousness immediately and would have been dead almost immediately thereafter. Her evidence was that it is very unlikely that someone suffering reflex cardiac arrest by hanging could be revived. She also gave evidence that permanent brain damage would start occurring about four minutes after death. She indicated that she had no experience of the length of time after death that a person might be revived as that was a matter more within the experience of a paramedic. Mr Fallow, who gave evidence earlier than Dr Bell, was not asked about this.

The Care Commission report

I heard evidence from Mr Livingstone who had carried out the inspection for the Care Commission following the death. I accept his evidence. I accept that the directions and recommendations outlined in that report were appropriate to the circumstances found following the death of B. Mr. Harte gave evidence that these had been implemented and I accept that to be so. There was no contrary evidence. The ligature point created by the locked back door was dealt with by the removal of the door altogether. Mr. Harte indicated that the removal of the door still allowed the occupant of the bedroom privacy from the inspection door.

Suicide, self harm and keeping safe

Miss McGeown pointed out that there was a difference between self harm and suicidal ideation, the former being a coping mechanism for stress and the latter being an intent to end life. All the indicators were that B was not thought to be a suicide risk by any of those who dealt with him. That view applied generally throughout his stay at Kibble.

Mr Wade in his submission suggested that it would be speculation to hold that B intended to commit suicide. He raised the issue because the Care Commission report stated that B had been determined to commit suicide. Mr Wade pointed out that it may be reasonable to infer that an adult of full age may have intended the consequence of his actions but that could not be said with as much certainty with a thirteen year old boy.

There is no doubt on the evidence that the behaviour of B was deliberate and not accidental in the sense that there was a ligature knotted and around his neck and that he had secured it to a ligature point. The issue raised is whether B was intending to kill himself rather than taking an impulsive and perhaps attention seeking action without having the necessary knowledge to understand that his action could be irreversible.

All the parties represented at the Inquiry were clear that I should not look at the voluminous records lodged by the Crown except those that had been spoken to by witnesses. I accept that. In the absence of evidence about B's day to day discipline over the period of his stay, I cannot form a view about whether, for instance, B's behaviour on 19th/20th July 2009 was an indicator of a looming emotional crisis for B, or whether it was part of his general pattern of behaviour. I accept that I heard from Mr Morton and Mr Scott about B's behaviour, but I have reservations about their evidence generally.

On the evidence, there were no signs to indicate that B was contemplating suicide on 20th July 2009. There was no evidence that he was depressed. He had been eating well; he had been to the doctor to get the all clear from Athletes Foot condition, so that he could swim without wearing a sock, he had sought out Ms McGeown to ask her about the best part of the open unit to go to in anticipation of being given mobility and a transfer to the open estate. I accept that B was aware that a move was likely to happen soon, notwithstanding that the children's hearing could not take place and therefore to approve it. B was looking forward, which was an indicator against suicidal ideation. Ms McGeown was shocked by news of it and had not thought it likely. I consider that her evidence is evidence of weight as she was the person who was monitoring B's emotional wellbeing and I consider that she was a credible and reliable witness on this point.

Nonetheless, for some reason, on the night of 20th/21st July 2009 B decided to act in the way he did.

Was there a consequence of Mr Meechan not telling Mr. Walker and Ms McGeown about the incidents?

Put shortly, the answer is yes in that the Kibble staff were not aware of the prior history of B as regards the incidents.

The issue still arises whether Mr Meechan got it wrong on this occasion and that the matters should have been further investigated and given a greater priority. On the evidence I heard I accept that Mr Meechan exercised his discretion appropriately in placing these matters in the category of events in the life of B rather than as issues of immediate concern.

As Mr Meechan thought he had mentioned it, it has to be assumed that it was a matter he should have raised. Further, having regard to the mention made by Kibble, as set out in the policies, of receiving information about self harm and suicidal ideation, it is unfortunate that the issue was not specifically raised by Mr. Walker and Ms McGeown.

Ms McGeown maintained in evidence that she would have followed them up to put them in context, and check them from original sources. I accept that she may well have done so, but there may be some question as to how far she would have been able to carry forward those investigations and the extent of any additional benefit she would have achieved. She did speak to Miss Stirling the psychologist at an earlier care home and she, Miss Stirling, had not mentioned the ligature incident although, from the report, she was privy to the information at the time. Miss Stirling was not called to give evidence. The thrust of the evidence was that B was a boy of thirteen who had many other issues and showed impulsive and attention seeking behaviour.

The evidence from Ms McGeown was that had she known of the earlier incidents and once the ligature had been found on 3rd May, she would probably have referred to matter to CAMHS, the child psychology team. This is stated as a probability only. Ms McGeown gave evidence that suicidal issues are dynamic in the sense of being in the present. She was reasonably certain that had she done so at that time, CAMHS would have been unlikely to have accepted the referral as not coming within their remit as B was not manifesting current signs of mental illness or a need for mental welfare input.

None of the threats by B had been carried out; there was no evidence that B put himself in harm's way by standing in front of motor vehicles other than the motor cycle (and the circumstances of that incident were not explored in evidence). B's ligature incident at Hillhouse had been treated as attention seeking behaviour. As time passed, the significance therefore of the incidents had appeared to have diminish to historic and therefore of less relevance to the issue of self harm and suicide. The ligature of 3rd May 2009, while an unusual event, was not obviously connected to other then current behaviour. For that reason, CAMHS would more likely have simply referred the matter back to Ms McGeown with the suggestion that there be appropriate monitoring.

I deal with the separate issue of the find of 3rd May as affecting heightened measures of observation below. However, I accept, on the information Kibble had at the time about B, that by 20th July 2009 there would have been no additional monitoring of B.

Would that have been the case if they had known about the incidents, and separately should there have been extra measures?

On the evidence, the procedures in place at Kibble in 2009 to handle an incident like the find of 3rd May lacked structure. Because of that, in my view the matter of the ligature find on 3rd May 2009 was not fully or formally assessed. In a structured formal assessment it may have been the case that the person carrying out the assessment would have raised the issue of self harm and suicidal ideation and of ligatures in past history specifically. In that event Mr Meechan may have been asked specific questions about self harm and suicidal ideation and ligatures. Had he been asked specifically it is likely that he would have mentioned the history. There would have been several possible elements to such an assessment; self harm, suicidal ideation, a possible interest in, a fascination for, an obsession with ligatures, a propensity to (a) threaten self harm without following through, (b) to wind up the carers, (c) impulsive behaviour, (d) attention seeking behaviour. In the event, Mr Meechan, Mr Walker and Ms McGeown each knew of the ligature find yet, on the evidence, did not think to pursue the matter. On being told Mr. Meechan did not mention the earlier incident nor did Ms McGeown or anyone else at

Kibble make any enquiry about B's previous history of self harm, suicidal ideation or with ligatures.

With hindsight therefore it can be seen that a protocol for the dealing with unusual finds with a formal assessment procedure would have been better to deal with the find of 3rd May 2009. It is speculation to say what such an assessment would have found or put in place. There is always a balance to be struck in determining what should be done in such an assessment. Had such a procedure been in place and had the previous history been known about, it may have resulted in a longer period of observations at that time.

However, it would be speculation to hold that B would and should have been subject to special measures of monitoring by 20th July 2009. If anything, the evidence tends to a conclusion that any such additional measures would not have been in place by 20th July 2009. As already noted, young persons in the Safe Centre were already the subject of close monitoring and a balance had to be struck based on continuous assessment by staff of the young person, and B showed no signs of self harm or suicidal ideation.

The consequences of B's actions on 20/21 July

The pathologist indicated that the lack of congestion in B's face was suggestive of B suffering from an immediate reflex cardiac arrest as he hanged himself. I accept that evidence. In those circumstances B would have had no time to reverse his actions. He would have become unconscious immediately and death would have followed almost immediately thereafter. Such a set of circumstances would therefore leave open the possibility that while B's actions were deliberate, his intention was not to take his own life.

Mr Wade submitted that the Inquiry did not hear any expert evidence about suicide or self harm. There was evidence in the standard operating procedures setting out what the indicators of suicidal ideation were and these were similar to signs of depression. There was evidence from Ms McGeown that B was depressed on admission to Kibble by reason of his circumstances and the lack of control over his own life, but that such a state would

be usual for a person in B's position. As I understood her, B was less depressed than might have been expected of him. Certainly, her later reports did not refer to B being depressed. On the evidence none of the signs of depression were present in B at any time that he was in Kibble. By reference to the Care Commission report Mr. Wade highlighted that the wording, "It would seem that [B] was determined to kill himself" was not borne out by the facts.

If B did not intend to commit suicide then one of the alternatives was that he was using the mechanism of hanging to draw attention to himself without being aware or having the knowledge that the matter could go too far or be irreversible, or being reckless as to the consequences. Such behaviour could fall into the category of self harm. Mr Wade also submitted that there was no evidence to support such a proposition either.

With hindsight it can be seen that a combination of confrontational encounters with the staff on two consecutive evenings might set the scene for the preparation of an act, if not suicide, then of reckless conduct. Again, with hindsight, there had been examples of conduct which could be of the same nature, in the threat of stepping in front of a car and actually stepping in front of a motorcycle. There had also been the threat of the use of a ligature in an earlier home for show and the finding of a ligature or model of a ligature on 3rd May. When all these pieces of information are put together there could be a pattern.

As I understood Mr Meehan, B was in Kibble because his behaviour, in particular an incident involving fire raising, created a danger to himself and others. By reason of his behaviour he was not keeping himself safe because of his wilful or reckless conduct. As regards self harm, the behaviour may have been the same and the result may have been the same but the intention may have been different. While I had some evidence from Ms McGeown about the difference between suicidal ideation and self harm, the difference, if any, between self harm and keeping oneself safe from attention seeking or reckless conduct was not explored.

Mr Wade submitted that to say that B died as a result of him not keeping himself safe would be as speculative as a finding of intention to commit suicide, standing the absence of evidence. I agree that, on the evidence, each is speculative.

Viewing the evidence of B's life at Kibble as a whole, such as it was, I accept that evidence of suicidal ideation has not been established. The deliberate use of a ligature on the one hand, but his likely immediate unconsciousness and death on the other, leave it an open question as to what B's intentions were that night. I accept therefore that it has not been established that B intended to take his own life as opposed to taking an action that did not keep him safe and from which he was unable to withdraw.

Accepting the evidence that, historically, B had shown acts of impulsive and attention seeking behaviour resulting in him not keeping himself safe, it has not been established how that history was connected to the circumstances of his B's death. It has not been established whether the likelihood of such behaviour would have been random or pre determined. It has not been established how the previous incidents could have been put in context to allow the staff to be informed of a likelihood of repetition. It is difficult to set out, therefore, even with hindsight, what additional measures would have been appropriate or necessary.

If keeping B safe was to be treated as avoidance of self harm, it might be expected that Kibble staff should be aware that B might be capable of random acts of impulsive and attention seeking behaviour which might result in him not keeping himself safe. By being in the Safe Unit B was already closely monitored. It has not been established that the incidents of 19th and 20th July were notably different from his earlier behaviour at Kibble, or that the incidents increased the risk of an act of impulsive or attention seeking conduct.

The requested determinations

I take the procurator fiscal's submissions to the Inquiry in turn.

Under section 6(1)(c) The procurator fiscal submitted

(1) the staff members placing B in his room on 20th July 2009 could have ensured that B's dressing gown was removed and placed in a locked cupboard;

I accept that Mr Morton could and should have seen to it that B's dressing gown was locked in the cupboard before securing B in his bedroom for the night. It is axiomatic that had the dressing gown not been in the room it could not have been used as a ligature, as it was.

However, it was clear that B had pyjamas and bedding which could have been used as ligature material as a means to hang himself. On the evidence it is impossible to know whether, if there had been no dressing gown, there would have been no death. Standing that there were other materials readily available, such as pyjamas and bedding from which a ligature could have been formed and standing that it was not suggested that B should have been deprived of nightwear and bedding, it is speculation to say that he would not have proceeded to act in the way he did, had the dressing gown been absent. Accordingly, it would be speculation to say that the removal of the dressing gown might have prevented B's death and in such circumstances it would be inappropriate to make such a determination.

(2) A member of staff responsible for observations could have carried out observations every fifteen minutes up to midnight and thereafter every hour.

On the evidence I accept that Mr. Scott could and should have carried out fifteen minute observations until midnight. He did not do so.

However, even if there had there been a fifteen minute inspection on the night of 20th July 2009, it is speculative to suggest that it would have affected the outcome. I heard no evidence about how long it would have taken to set up the ligature. What was done did not appear to be elaborate or time consuming, but that itself is a speculation. The evidence was that B would have been dead in a very short space of time on using the ligature. Accordingly, it appears that it would have been entirely by chance that the

fifteen minute observations would have affected the outcome. In such circumstances it would be inappropriate to make such a determination.

As regards section 6(1)(d) as to defects in any system of working that contributed to the death, the procurator fiscal submitted that Kibble had a defect of working in not having in place a written policy, clear to all members of staff, as to how frequently observations should be carried out on the young persons during the night.

Further, they did not have in place a system for checking to ensure that the observations were being carried out at the appropriate times. Such a system of checking would be a reminder to staff to ensure that the system was being carried out. He submitted that the monitoring frequency of once per week, put in place after B's death was sufficient.

I accept that there was no written system for night shift observations. I accept that as the system in place was a verbal system it was open to possible misinterpretation. I accept that it would have been better to have been in writing, as it now is and that could and should have been done. I also accept that the system of observations could and should have been monitored.

However, as I accept that there was a fifteen minute regime instructed to be in place, the fact that it was not followed on the night shift of 20th July 2009, was not a defect in a system. I consider that, on balance the system was reasonably clear to staff members. In any event the absence of a written system had no bearing on the outcome of the events of that night. I draw the inference from the evidence that the fact that Mr Scott did not follow the system in place was not due to the system being misunderstood. Accordingly, it would be inappropriate to make the determination set out by the procurator fiscal.

Mr. Scott's position was that he had not done regular fifteen minute checks for some time and he had no need to do so as regards B. If that was so, had there been a system of monitoring the electronic information, that situation would have come to light. I have set

out above why I am not in a position to hold it established Mr Scott had been using a different monitoring regime.

However, had a monitoring regime been in place and had it had the result that Mr Scott was monitoring every fifteen minutes up to midnight, for the reasons set out above, the absence of such a system could not be said to have contributed to the death of B. That is because it is speculation to suggest that the fifteen minute inspections would have made any difference. In such circumstances, the absence of monitoring the observation system cannot be said to have contributed to the death of B.

In submission, there was touched on a proposition that if the inspections had been less frequent and known to be so by the occupants in the rooms, that knowledge could have been used for B's preparations. The matter was not pursued, there was no evidence to support what was in effect a speculation and it was not the basis of the procurator fiscal's submission.

As regards section 6(1)(e) the procurator fiscal made no submissions on the basis that, on the evidence, there had been no causal connection between the matters which might be raised and the death. I agree.

The procurator fiscal did not raise the issue of the ligature point in submissions. I agree that it is not an issue. Of course, had there been no ligature point at the locked door, that point could not have been used as a ligature point. Had no other ligature point been identified by B then he would not have had the means to proceed in the way he did. The locked door as a ligature point had not been identified as a danger. The fact that the door has now been removed altogether does not mean that it should not have been there from the start. The need to give the young persons in the Safe Centre privacy and whether the issue of the gap in the door should have been addressed was not really explored. All that can be said is that it was not considered an issue at the time and there is no evidence to suggest that it should have been seen earlier.

The procurator fiscal made no submissions as regards the nature of communication between South Lanarkshire Council Social Work Department and Kibble. In particular the matter of self harm and suicidal ideation was not the subject of submission. The procurator fiscal did not suggest that there had been a defect in the system as regards the assessment of B at stages in Kibble. Had there been a formalised policy for assessing B as regards the ligature find and increasing and reducing observations, properly implemented, I am of the view on the evidence of B's subsequent behaviour it has not been established that Kibble would or should have changed the level of observations by 20th July 2009. On the findings set out above, I consider that it would be speculative to suggest that the absence of the information about the incidents and the family history had a part to play in the death of B. As already said, the young persons including B were the subject of round the clock daily ongoing scrutiny and assessment by trained carers who were trained to observe patterns of behaviour.

The procurator fiscal made no submissions as regards other circumstances. I accept that the other issues did not have a part to play in the death of B.

Neither Mr Watson or Mr Wade asked me to make additional findings under the various headings.

Mr. Livingstone said in evidence that at a national level, the ongoing review of communication issues had resulted in a variation of the form of paperwork in social work reports in the area of young persons such as B. As a result of that change there is now a chronology of the young person set up and maintained. While the matter was not gone into in detail, as I understand it, the chronology is a summary record of the relevant issues of the young person.

As a result of the Care Commission report, Kibble has an improved operating procedure, and in light of the changes already made by Kibble I have no other matters to raise.

