

SHERIFFDOM OF NORTH STRATHCLYDE AT PAISLEY

[2016] FAI 8

B30/15

Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

Inquiry into the circumstances of the death

of

MICHAEL PETER CAMERON, born 20 June 1984

Determination by

Sheriff Susan M Sinclair

Paisley

2015,

DETERMINATION

- (a) That Michael Peter Cameron died aged 21 years on 17 June 2006 at 0300 hours at Crosshouse Hospital, Kilmarnock following a murderous assault on him in Cell Ward 4 of the Health Care Centre of Her Majesty's Prison Kilmarnock on 16 June 2006 at 2331 hours.
- (b) The cause of Michael Peter Cameron's death was blunt force trauma of the head and neck sustained as the result of the murderous assault inflicted upon him by David Martin and Andrew Kiltie in Cell Ward 4 of the Health Care Centre of HMP Kilmarnock on 16 June 2006.
- (c) There were no reasonable precautions whereby the death and the murderous assault resulting in the death of Michael Peter Cameron might have been avoided.
- (d) That there were no defects in the system of work which contributed to the death.
- (e) There are no other facts relevant to the circumstances of the death.

NOTE

The Fatal Accident Inquiry took place in Paisley Sheriff Court over a number of days in April, May and June 2015. Submissions concluded on 17 June 2015 and I thereafter made Avizandum.

I extend sincere condolences to the family of the late Michael Peter Cameron. The fact that the Fatal Accident Inquiry took place some nine years after the passing of Mr Cameron must have been a matter of distress to the family and is regretted. The delay was due to a number of factors. Mr Cameron was murdered in June 2006. His assailants, David Martin and Andrew Kiltie, either pled guilty to the murder or were found to have participated in the assault which resulted in the murder in March 2008. In 2010 the Crown presented a Petition to Kilmarnock Sheriff Court seeking to hold a Fatal Accident Inquiry into the circumstances surrounding the death. The Health and Safety Executive then decided that it would be appropriate to consider whether or not a prosecution should be brought under the Health and Safety at Work etc. Act 1974. That investigation took some four years. In late 2014 the Crown presented a Petition to Paisley Sheriff Court seeking to hold the Fatal Accident Inquiry. In terms of normal court procedure and timetable this Inquiry was allocated a date in April 2015 and subsequent dates. It was initially considered that a period of six weeks would be required to hear evidence in this case.

At the Inquiry the Crown were represented by Mr Kelly, Procurator Fiscal Depute, SERCO, the operators of HM Prison Kilmarnock, were represented by Mr Gray, QC instructed by DLA Piper and the Scottish Prison Service were represented by Mr Dickson, Solicitor, Anderson Strathern. The family did not participate in the Fatal Accident Inquiry.

Evidence was given at the Inquiry by Andrew John Hill who is employed by SERCO as the Head of Performance and Compliance at HM Prison Kilmarnock (hereinafter referred to as "HMPK"); thereafter by Mr James Dougan who was, at the relevant

time, the Manager of the Health Care Centre within HMPK. After a break for the preparation of the Second Joint Minute, evidence was given by Professor Andrew Coyle, an eminent former Prison Governor who became an academic who had provided advice to the Government in relation to prison reform and management. Finally evidence was given on behalf of SERCO by Philip Wheatley who has had a career in the management of prisons culminating in him managing the entire prison establishments in England and Wales and who currently provides consultancy services to those who run private prison establishments within England and Wales.

Although this Inquiry was set down for six weeks, parties responsibly and carefully entered into two Joint Minutes of Agreement which resulted in little factual evidence being given. All necessary facts surrounding the circumstances of the death of Mr Cameron were agreed within these Joint Minutes. The Joint Minutes are lodged in process and are available. Transcripts of the evidence are available as are the Reports of the Expert Witnesses and the written submissions tendered on behalf of the Crown, SERCO and the Scottish Prison Service.

Accordingly, it is not necessary to make Findings in Fact in relation to this death. The facts surrounding the death are readily available in the aforementioned documentation. Nor is it necessary to summarise the evidence of the Expert Witnesses or the submissions of parties.

The circumstances surrounding the death of Michael Peter Cameron have been fully examined in the course of this Inquiry. The Inquiry was conducted under and in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("the Act"). Section 6(1) of the Act places upon the Sheriff the duty of making a determination setting out the circumstances of the death into which the Inquiry is being made insofar as they have been established to his satisfaction. Section 6(1) enumerates the circumstances as follows:-

- a. Where and when the death and any accident resulting in the death took place;
- b. The cause or causes of such death and any accident resulting in the death;
- c. The reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
- d. The defects, if any, in any system of working which contributed to the death or any accident resulting in the death;
- e. Any other facts which are relevant to the circumstances of the death.

It is important to appreciate the objectives and limitations of the Fatal Accident Inquiry. Evidence is given in public so that the knowledge of those responsible for investigation of the death is shared with the public and, in particular, with legitimately interested parties. The Inquiry, therefore, fulfils the important purpose of enlightening those with a legitimate interest in the death, for example, the relatives of the deceased, as to the cause of death. It should also serve the purpose of enlightening the public at large, which includes the relatives, as to whether any reasonable step could or should have been taken whereby the death might have been avoided. This means that there may be lessons to be learned from the facts that emerge at an Inquiry. If there are, the Sheriff may set out the circumstances in his determination under Section 6(1)(c), (d) or (e) mentioned above. The Sheriff is also empowered to make recommendations, for example, directing attention to ways whereby practices which might have contributed to the death can be improved. The Sheriff, therefore, has a very wide power to make determinations. Section 6(1)(e) of the Act is very wide and entitles the Court to comment upon and, if appropriate, make recommendations in relation to any matter which has been legitimately examined in the course of the Inquiry and the circumstance surrounding the death if it appears to be in the public interest to make such comment or recommendation.

It is, however, important to bear in mind the limitations of this form of Inquiry. The proceedings are summary in nature and take place in circumstances in which the interested party may have little idea of what the evidence is to be until it emerges. It

is, therefore, in most cases inevitable that an Inquiry limited in scope may not be able to answer all questions which have been raised during the course of the Inquiry.

It is also important to remember that a Fatal Accident Inquiry is an exercise in fact finding, not fault finding. It is not the function of the Court to make findings or express opinions on questions of fault or liability or attempt to apportion blame. The Inquiry is not designed for or suited to the determination of questions of fault or culpability which are more properly determined in the ordinary civil courts with a full system of written pleadings, full investigations and the discovery of evidence by opposing parties who have advance notice of each other's case by the time it comes to proof.

Although the Sheriff has very wide powers, these must be exercised, in my view, with caution bearing in mind the summary nature of the proceedings and the lack of formal pleadings. The Sheriff's determination in a Fatal Accident Inquiry may not be founded upon in any subsequent proceedings. Of course, interested parties have available to them the evidence led in the course of an Inquiry which may enable them to consider pursuing or defending an ordinary civil action in which issues may be explored more thoroughly.

Taking account of these considerations I am satisfied in the present case that the essential facts of where and when the death occurred and the cause of death have been established for the purposes of Section 6(1)(a) and (b) of the Act and I have so determined in my formal findings. I have made no formal determination in terms of Sections 6(1)(c), (d) or (e) of the Act.

This death resulted from a murderous assault committed upon Michael Peter Cameron by David Martin and Andrew Kiltie. The effects of this particular incident have had wide-ranging consequences on a number of people. First and foremost Mr Cameron's family suffered the loss of his life, their lives being altered for good. The families of Mr Kiltie and Mr Martin have suffered the loss of society of their sons

since Mr Martin is serving a sentence of life imprisonment and Mr Kiltie has been detained without limit of time in Carstairs. Mr Andrews, who was a prisoner aged 16 years and spending his first night in prison, will no doubt have been affected by witnessing this murder and being present in the same room when it was committed. Prison Custody Officer Brennan and Nurse Richardson who witnessed the murder have to live the rest of their lives with the knowledge that they were unable to do anything to prevent or stop it.

Statistics which have been provided and the Report of an inspection of HMPK in January 2005 by HM Inspector of Prisons who inspected HMPK between 25 to 29 October 2004 disclosed that there were no escapes leading up to the inspection, that the number of assaults had reduced significantly, significant steps had been taken by management, including an anti-bullying strategy, and prisoners and prison officers felt safe within Kilmarnock. It is against this background that events took place in June 2006.

It is, of course, self-evident that this murderous assault would not have happened had the three persons, Michael Cameron, David Martin and Andrew Kiltie not been within the same Cell Ward in the Health Care Centre of HMPK on that date and at that time. It is necessary to look at the decision making which led to them all being within in the Health Care Centre and sharing the one Cell Ward on the fateful evening.

I should record at the outset that Mr Andrews' presence in the Cell Ward had no bearing on the murderous assault. There is absolutely no evidence to suggest that he was involved in the start of it and he certainly took no part in the assault nor did he present any difficulties for staff when they entered the Cell Ward to deal with the aftermath of the assault. It is extremely unfortunate that a 16 year old on his first night in prison was witness to such an event. His presence on the Cell Ward and the systems which led to him being placed there are only relevant insofar as they deal

with the assessment by the Prison Custody Officers on the evening as to who should be sharing a Cell Ward with whom.

The Health Care Centre at HMPK was constructed when the prison was constructed and was required in terms of the Contract between the Secretary of State for Scotland and Kilmarnock Prison Services Ltd dated 10th November 1997 (hereinafter referred to as “the Contract”). The prison is operated on behalf of Kilmarnock Prison Services Ltd by SERCO. The Contract set out the requirements for what it should contain. It required to have in patient facilities for 16 prisoners. *Inter alia* the Health Care Centre was designed with four three-bedded wards, two two-bedded wards and two single cells. It was constructed in a manner common to other prisons of its age. It was to provide a Health Care Service to prisoners meeting the requirements of the Prison Rules, all mandatory UK Regulations and the standards of the National Health Service. Shortly after this incident the provision of in patient facilities for prisoners was stopped and any prisoner requiring in patient treatment was transferred to a local NHS Hospital. This continues to the present day.

HMPK was constructed and operates as a local prison. In terms of the Contract it requires to house prisoners sent to it on a daily basis by the local Courts. In 2006 it had facilities for 596 prisoners. The mix included those on remand, those convicted and awaiting sentence and those serving short sentences of under four years. It also included those under the age of 21 years. It had no separate or specific facilities for Young Offenders (those under the age of 21 years). HMYOI Polmont is a specialist facility for Young Offenders. In June 2006 the number of Young Offenders housed in HMPK was around 130, having just dropped from a maximum the previous month of 140. That totals around one quarter of the total prisoner population. In terms of the Prisons and Young Offenders Institution (Scotland) Rules 2006 those aged under 21 years had to be housed and kept separate from those aged over 21 years so far as was reasonably practicable.

On 16 June 2006 Cell Ward 4 in the Health Care Centre housed one over 21 (the deceased), one aged 16 (Stephen Andrews), and the assailants, David Martin aged 19 and Andrew Kiltie aged 18.

The Inquiry was able to determine that on the night of 16 June 2006 one four-bedded Cell Ward, number 4, was occupied by Mr Cameron, Mr Martin, Mr Kiltie and Mr Andrews. There was a further four-bedded ward and three of the persons within that four-bedded ward were persons who were to be kept separate from Mr Kiltie. Nothing is known about any other occupant of that four-bedded ward or the occupants of the third four-bedded ward. Nothing is known of who was occupying the two single cells and of the two two-man cells it is only known that one of those was occupied by a prisoner who was being kept there on his own because he had murdered his cellmate in Dumfries Prison. It is known that of the sixteen available beds, fifteen were occupied.

Had Young Offenders not been housed in HMPK or had they had separate facilities for housing them, this murder would not have happened. The numbers of Young Offenders sent to HMPK has reduced since this event and in 2014 the number of persons under 21 years old housed there has consistently been in single figures.

The next area for investigation was whether or not the Health Care Centre was being used for the purpose envisaged in the Contract.

The Contract provided that in-patient facilities for up to 16 prisoners in the Health Care Centre should be provided. They were to be segregated to ensure separation of different classes of prisoner. The Doctor, Dr Kopal, sent only a handful of prisoners to it in all the time it accepted in patient prisoners. The vast majority of prisoners housed there were vulnerable or had mental health difficulties. Whilst this may not have adhered to the strict wording of the Contract provisions, HM Inspectorate of Prisons in 2005 commended the use by HMPK of the Health Care Centre. At paragraph 6.5 of their Report they state “the healthcare beds seem to be used largely

for prisoners who are vulnerable for some reason — those with learning difficulties, problems of chronic self harming behaviour — and on those occasions when children under the age of 16 have to be held in prison until alternative accommodation is secured, which may be for periods of up to six weeks. This use of the healthcare facilities themselves is to be commended insofar as these vulnerable prisoners are identified and offered additional support.”

In January 2006 a number of concerns were raised by the Scottish Prison Service Controllers about the operation of the Health Care Centre in HMPK. The Controllers did not necessarily think that prisoners were inappropriately housed in the Health Care Centre but were concerned that there seemed to be a lack of a Care Plan to justify them being there. There were a number of other concerns such as the prisoners not getting their medication on time, prisoners being prescribed the wrong medication, prisoners not being able to see a doctor or other health care professional when they wanted to, and on one occasion a prisoner returned to the Health Care Centre from hospital without the Health Care Centre being aware of the treatment he required. A Health Care Audit was planned for October 2006 and this was brought forward to August 2006. The decision to bring the Audit forward was taken in March 2006 before the event with which this Inquiry is concerned. A Notice of Non Compliance was issued on 25 April 2006 by the Controllers to SERCO (SPS Production 15, Page 121). The details of the non-compliance related largely to outpatient treatments.

Staffing levels in the Health Care Centre were considerably higher than staffing levels on the wings, particularly in the evening where the maximum of sixteen prisoners would be supervised by one Prison Custody Officer and one nurse. The level of staffing on halls was substantially lower given that prisoners are locked in their cells overnight.

There was also a contingency plan in place so that if the Prison Custody Officer required to enter a Cell Ward housing more than one prisoner, assistance would be

sought from other Prison Custody Officers on duty in the prison. From the time when the alarm was raised at the start of the incident until Prison Custody Officers were able to enter Cell Ward 4, approximately two minutes and twenty four seconds elapsed. This is a more than satisfactory response time in prison to deal with an incident. There are no issues with the level of staffing available on the night. Professor Coyle in his evidence suggested that if prisoners were to be held in four bed wards, six Prison Custody Officers would require to be on duty to deal with any issues such as this that might have arisen. Mr Wheatley on the other hand considered that the response time to this incident was well within what would be expected in any prison establishment in England and Wales.

I preferred the evidence of Mr Wheatley in relation to this to the evidence of Professor Coyle. I consider that Professor Coyle was dealing with the matter with the wisdom of hindsight and furthermore failed to take into account the higher level of staffing available within the Health Care Centre than on the wings in the prison. There was a contingency plan to respond to an alarm call within a very short time.

It is also worthy of note that Cell Ward 4 which housed Messrs Cameron, Kiltie and Martin was consistently covered by Closed Circuit Television ("CCTV"). The CCTV did not, for reasons of personal privacy, cover the toilet area where the initial part of this assault started. That, however, was not relevant given that the bulk of the assault and the part of the assault which resulted in the death took place within the ward area and was recorded on CCTV, albeit that the CCTV was not actually being watched until Prison Custody Officer Brennan pressed his personal alarm for assistance. Furthermore, the entire assault within the ward was witnessed by both Prison Custody Officer Brennan and Nurse Richardson who were consistently demanding that Messrs Martin and Kiltie stand back from Mr Cameron. They were unable to personally enter the Cell Ward until reinforcements arrived since that would have compromised their health and safety and might have resulted in the prisoners breaking out of the Cell Ward. There can be absolutely no criticism of

either Prison Custody Officer Brennan or Nurse Richardson for their actions on that evening. They did everything that could possibly safely be done.

I, therefore, consider that there was nothing in relation to the staffing levels in, or the operation of, the Health Care Centre which contributed to the murderous assault leading to the death of Mr Cameron.

At the time of the death of Mr Cameron prisoners were admitted to the Health Care Centre if they were at risk of or had attempted to self-harm or take their own lives. Whether or not to locate a prisoner in the Health Care Centre was determined through the HRAT (High Risk Assessment Team) process. When a prisoner was received into reception a risk assessment would take place to determine whether or not the HRAT process should be opened. If a prisoner was to be located to a shared cell, a Cell Sharing Risk Assessment (hereinafter referred to as "CSRA") should have been completed. If the prisoner was to be located within the Health Care Centre or moved within the Health Care Centre, further Locating or Relocating in Health Care forms should have been completed. Despite the evidence of frequent moves within the Health Care Centre for both Messrs Martin and Kiltie only two such forms exist, one for Mr Kiltie dated 8th June 2006 and one for Mr Martin dated 2nd May 2006. They record that Mr Kiltie can be difficult to manage when agitated. The Risk to Others section is not completed. Mr Martin's form notes that he has assaulted staff and other prisoners. He is described as Low Risk and suitable for any location. He required to be kept separate from two named prisoners. Three named prisoners in Cell Ward 3 required to be kept separate from Mr Kiltie.

Once it had been determined that a prisoner required to be housed within the Health Care Centre responsibility for allocating or re-allocating a prisoner a cell within the Health Care Centre lay with the Segregation Managers. In making such assessments they would have checked the Prison Computer System (hereinafter referred to as "PR2") and discussed the move with the Prison Custody Officers within the Health Care Centre.

David Martin had been subject to 15 HRATs over the period between 2004 and March 2006 which was the date of the one nearest in time to the murder. At that time he was remanded to HMPK on a charge of murder. He was placed on an HRAT whilst within the segregation unit on 22 March 2006. He was found to have tied his bed sheet into a noose and stated that he would find something to hang himself with. He was placed on a Level 2 watch which was increased to a Level 1 watch and then reduced to a Level 2 watch. The process started on 22 March and closed on 13 April 2006. He was housed within the Health Care Centre throughout the duration of this HRAT process and was assessed as being at a high risk of suicide. During the period of this HRAT he was noted as urinating in his cell, lunging at a prison officer, displaying slightly aggressive behaviour, irate, striking his head against the window, self-harming by cutting his arm and his behaviour prevented medical treatment being administered. He stated he would break a prison officer's nose, he was ready to blow, he may hang himself, he punched a window, he was hearing voices, he was banging a cell door and becoming angry and he was involved in a fight with another prisoner. He stated he needed to be on the highest level of watch to protect others from him. He needed to be restrained, was cheeky and demanding of staff. On 7 March 2006 he stated he required a Level 1 watch to prevent him from killing someone. The psychology department assessed this homicidal ideation as being directed at prison staff as opposed to other prisoners. On 29 March 2006 a letter was sent to Dr Kopal, the prison doctor from consultant psychiatrist J Flowerdew stating that it would be wise to watch him quite carefully in Health Care and that he may have Post-Traumatic Stress Disorder. Once this HRAT was closed he remained in the Health Care Centre. His behaviour settled down and he was appointed passman. This is a post given to trusted prisoners.

Prior to the murder Andrew Kiltie was subject to six HRAT procedures between December 2005 and May 2006 on various spells of incarceration in HMPK. The last HRAT opened on 13 May 2006 and closed on 12 June 2006. He stated that he was going to cut his throat, slash a member of staff, tie his strip condition clothing round

his neck, smash his head against the wall and bite himself. He was subject to a Level 1 watch then reduced to Level 2 and subsequently to Level 3. He was assessed as being of a high risk of self-harm and suicide. He self-harmed, attempted to withhold his medication, was difficult to manage when agitated, was not happy sharing his cell with anyone other than his cousin, he reported feeling angry and frustrated and said he was constantly being threatened in H and G wings by other prisoners. He stated that he was coping well in the Health Care Centre. On 12 June 2006 he threatened to stab his lawyer and when searched broken pieces of plastic were found on his person. He was originally located in a single cell but told staff he wished to move on to a ward and moved to Cell Ward 4 on 2 June 2006. He was relocated within different areas in the Health Care Centre on four occasions and was relocated to Cell Ward 4 on 12 June 2006.

Michael Cameron was subject to the HRAT procedure twice; once when he was on remand in June 2005 and on 13 June 2006 when he was remanded again to HMPK. He had attempted suicide the previous night and stated that the first chance he got he would do it properly. He was placed on a watch on the HRAT procedure, placing him on Level 2 ward watch conditions within the Health Care Centre. He was subject to that watch level when he was murdered. No self-harm or suicidal incidents took place during the process and no behaviours of concern were noted by prison staff or the multi-disciplinary case conferences. At the start of the watch he was placed in a single cell. On 15 June 2006 he advised a psychologist that he would prefer to share a cell to relieve his boredom and distract him from self-harm. On the same date a multi-disciplinary case conference decided that he could be placed in a ward under Level 2 watch conditions and he was placed within Cell Ward 4 that day.

I am satisfied that the persons within Cell Ward 4 of the Health Care Centre were properly there on the evening in question. They all met the criteria for detention and observation in the Health Care Centre due to mental health problems and risk of self harm. Mr Andrews was vulnerable and considered a risk of self harming because of his age and it being his first night in custody. The next question to consider is

whether or not they ought to have been allocated to share the same Cell Ward at that time.

Once prisoners are located to the Health Care Centre a risk assessment required to be completed by the supervisor. David Martin was moved to a single cell on 12 May 2006. Crown Production 21 is a Health Care Relocation Form for him completed on 2 May 2006 by the Segregation Supervisor which moved him from a four bed ward to a two bed ward. That form was only partially completed. On 12 May 2006 he moved from a single cell to Cell Ward 4. Ward 4 was at that time empty and David Martin would have been the only occupant. The Segregation Officer believes he did complete the necessary form but no such form is within the prison records.

In relation to Andrew Kiltie's stay and moves within the Health Care Centre, there is a relocation form for him completed on 8 June 2006 but it does not state where he was to be located within the Health Care Centre and it is not fully completed. There are no other forms in his prison records.

Michael Cameron's prison records do not contain any Health Care Location or Relocation forms and it is not known whether or not they were ever completed.

For completeness Steven Andrews was received into HMPK on 16 June 2006 and there is a Cell Sharing Risk Assessment completed for him. It is noted that he has concerns about sharing a cell. The section of this form which was due to have been filled in by the Residential First Line Manager is incomplete. Given his age and it being his first time in prison he was placed into the Health Care Centre. No location to Health Care form was contained within his prison records. There was only one available bed in the Health Care Centre when Steven Andrews was admitted that being the one in Cell Ward 4.

CSRA were introduced in England and Wales in 2002 following the murder by his cellmate of Sahid Mubarek in HMYOI Feltham on 21 March 2000. He had been

required to share a cell with a person who the prison authority should have known to be a racist with a history of violence. That incident resulted in a major review of risk assessments for prisoners sharing cells in all UK jurisdictions. The incident was the subject of a Judicial Inquiry led by Mr Justice Keith. His Report was published on 29 June 2006. He made a number of recommendations including recommendations about risk assessments for prisoners sharing cells. The CSRA in use in England and Wales at the time of Mr Justice Keith's Inquiry balanced the need to share a cell in order to reduce the risk of suicide with a need for a prisoner to be on his own so as to reduce the risk the prisoner posed to others.

In May 2005 CSRAs were introduced in Scotland. The process involved an initial assessment in the reception area, input from Health Care staff and a final decision from the Residential First Line Manager.

When a prisoner arrived in Reception the Reception Officer had to complete an Act2Care Interview (in Kilmarnock known as "HRAT"). This was intended to identify if the prisoner presented with any risk of attempted suicide or self-harm. This risk had to be considered and balanced against the risk of harm to others if the prisoner required to share a cell. The Assessment form had four simple questions concerning the prisoner's past charges, whether those charges created a need for protection or segregation, any concerns the prisoner had about cell sharing and any other concerns about racial, religious, cultural and/or ethnic issues which could have an adverse impact on the prisoner's wellbeing. Thereafter, the Residential First Line Manager had to consider any intelligence or other evidence that would prevent a prisoner sharing a cell. This written assessment which involved filling in a simple form did not look at the dynamics of two or more prisoners sharing a cell or ward; it only produced an assessment of the generic suitability of a prisoner to share a cell. Thereafter, when locating a prisoner to a cell, Prison Custody Officers would be expected to carry out a dynamic risk assessment of the compatibility of the prisoners who were about to share. The written process ensured that any information held in

any Scottish Prison Service records was taken into account when the suitability of prisoners to share a cell was assessed.

Although there was provision for entering the results on the prisoner computer database, PR2, this was not central to the decision making, although PR2 provided information such as intelligence to inform the Residential First Line Manager's decision. The default position was that prisoners would be expected to share a cell unless a risk factor was present. The system was in place and operating at HMPK in 2006 prior to the death of Michael Cameron. Accordingly, there ought to have been an individual CSRA for Michael Cameron, Steven Andrews, Andrew Kiltie and David Martin. The ones produced in the Inquiry were those for Michael Cameron and Steven Andrews and neither of them was fully completed.

The system has been upgraded since 2006. The use of PR2 has been improved and offence aggravation codes were introduced to provide information that certain prisoners might produce more danger to others on the grounds of racial, sectarian or homophobic intolerance. In 2008 a revised CSRA system was introduced. The CSRA was moved to the computer based PR2 system and integrated with the risks and conditions section. The responsibility for conducting and recording the CSRA was transferred to the Residential Officers responsible for locating the prisoner. The system was set up so that a prisoner could not be allocated a cell on the PR2 recording system without having had a CSRA completed first. They were supplied even in establishments where there was no cell sharing. The PR2 system generates a CSRA automatically when a PR2 cell allocation is about to be made. The Residential Officer has to record whether it is the prisoner's first night in custody and whether the Act2Care (or HRAT) assessment indicates that cell sharing is a risk.

Act2Care/HRAT is structured to identify whether a prisoner is at risk of attempting suicide or self-harm and is carried out whenever a prisoner is admitted or returned to an establishment and must include a nurse and doctor's assessment for all new admissions. The Residential Officer has to assess whether the prisoner has been charged with an offence requiring protection (generally a sex offence or offence of

violence against a child) and whether the prisoner has concerns about cell sharing. The Residential Officer requires to check the linked prisoner section of the PR2 to identify potential enemies and the risks and conditions for the presence of racist, sectarian or homophobic markers or any history of bullying or being bullied and any history of violence against a cell mate. The presence of an adverse factor does not preclude cell sharing but justification must be provided in the authorising notes box. CSRA also looks at smoking preferences.

Further improvements are planned in the CSRA. There is to be a move from providing a generic assessment of suitability to share a cell to a process which looks at the relationship between the individuals who will be sharing a cell. It will be electronically documented and easy to use. The revised process is designed to provide a robust and fully documented CSRA process which will enable Residential Officers to make decisions on cell sharing on the basis of all relevant information available but is dependent upon risk information being properly entered on the PR2 computer system.

David Martin has a history of having been abused by a family member as a child. The fact that David Martin had been the victim of sexual abuse was not recorded in any of the HRAT assessments because the psychologists who were dealing with him were not aware of it. Had they been so they would have recorded it during the HRAT assessments for its relevance to be considered in respect of interactions with other prisoners accused of or convicted of committing a sexual offence. Both Segregation Supervisors were unaware that David Martin was a victim of sexual abuse and both of them considered that if they had known that, they would have considered it inappropriate for Mr Martin to share a cell with someone who was accused of or convicted of a sexual crime because it would either place him at risk of further abuse or place the other prisoner at risk from him. The PR2 system did not flag this information up in respect of David Martin.

There was a good deal of examination and cross-examination of Professor Coyle and Mr Wheatley, the two experts who gave evidence, about the Cell Sharing Risk Assessments and Messrs Martin and Kiltie's previous behaviour in prison. It also explored whether or not had the Prison Custody Officers known that Mr Martin had been a victim of sexual abuse would he have been allocated to share with an alleged sex offender. Professor Coyle's opinion was that victims of sexual abuse must be kept separate from sex offenders and that all sex offenders must be kept separate from other prisoners, except those also accused of sex offences. Mr Wheatley's evidence was that in some prisons in England and Wales there was no policy of segregating sex offenders because segregating and giving them protection could place them at risk or result in them being marked men.

Professor Coyle was very critical of the fact that Messrs Kiltie, Martin and Cameron were allocated to share a Cell Ward. He was, however, unwilling to second guess operational decisions.

By contrast Mr Wheatley told the Inquiry he had carried out an assessment based on the information available prior to the murder about the three men concerned and thought that asking them to share a cell was appropriate. Although Prison Rules say, where reasonably practicable, adult prisoners should be kept separate from young offenders, three out of the four were young offenders, that is Messrs Kiltie, Martin and Andrews. Mr Cameron was only just 21. Therefore, in terms of age they were housed appropriately. Generally speaking young prisoners are to be kept away from adult prisoners so that adult prisoners do not cross-contaminate young prisoners.

He did not think there was anything inappropriate in a sex offender being housed within the Health Care Centre with other prisoners not accused of sexual offences. He did not consider that there was anything inappropriate in housing an alleged sex offender with somebody who had been a victim of sexual abuse. Mr Wheatley's position was that a large percentage of the prison population were persons unfortunate enough to have been subject to sexual abuse as youngsters and,

furthermore, that those accused of sex offences would not necessarily be a risk to people who had previously been subject to such abuse. Persons subject to such abuse are not necessarily or likely to be violent towards persons accused of being sex offenders. Professor Coyle on the other hand thought it was wholly inappropriate for a sex offender to be housed with other prisoners, for a victim of sexual abuse to be housed with a man accused of a sexual offence and for a 21 year old to be housed with young prisoners.

I preferred the views of Professor Wheatley in relation to this particular point since he was willing to look at the facts and circumstances available at the time and apply his mind to the judgement and the decisions of the Prison Custody Officers in relation to housing these three prisoners. Professor Coyle was certainly very eminent but was unwilling to second guess operational decisions made at the time.

Professor Wheatley was particularly complimentary about the levels of supervision within the Health Care Centre and said it was the best that he had ever seen in a prison. The Cell Ward was constantly monitored by CCTV, effectively one wall of the Cell Ward was windows so that anybody passing in the corridor would have a view into the Cell Ward. The Health Care Centre was staffed at night when this incident took place by a Prison Custody Officer and a nurse and two of the four people within this Cell Ward were subject to a watch, one every fifteen minutes and the other every thirty minutes. Examination of the records shows that by and large these watches took place as prescribed. Mr Wheatley, therefore, thought that there was a high degree of supervision within this Cell Ward which should have provided an element of safety.

Mr Wheatley described this murder as unique and almost impossible to predict because it took place in the full view of CCTV and in the full view of the Prison Custody Officer and nurse, both of whom were instructing the prisoners to desist. Mr Wheatley said that in his experience if prisoners were going to commit crimes, the presence of CCTV and/or a Prison Custody Officer would act as a significant

deterrent, that is because by and large people do not commit crimes in situations where they think it is likely that they will be caught and held to account for their actions.

Mr Wheatley's view, in contrast to Professor Coyle's, was that this murder was not one which could have been predicted on the basis of the information available to the prison staff prior to the murder. He had examined the previous behaviour of all three in custody. Both experts agreed that recent behaviour in custody was the best indicator of current behaviour in the prison setting and having done that, Mr Wheatley said in his view there was nothing in the previous behaviour of any three of these prisoners which would have suggested such a violent, murderous assault would take place.

By contrast, Professor Coyle was of the view that placing David Martin and Andrew Kiltie together was a grave error. He said this because each of them was documented as being unstable and difficult and David Martin's behaviour could change at very short notice. Prison staff should have anticipated that this type of assault would happen if these three men David Martin, Andrew Kiltie and Michael Cameron, were housed together.

I preferred the view of Mr Wheatley because he looked at the information available to the Prison Custody Officers at the time, the occupants of the Health Care Centre that evening and the Director's Rules. He also looked at the alternatives and the reasons why the three were in the Health Care Centre in the first instance. His view was that the other housing options would have been less satisfactory and more likely to have resulted in a death due to suicide. Had that happened the alternative housing decisions would have been totally unsupportable and the prison and its staff would have been justifiably criticised for taking those decisions. Suicide is a far higher risk in prison than murder. Death by suicide is a far higher risk within the prison setting than in the general population at large. Murder in prison is statistically lower than in the free population. Therefore taking decisions to try and minimise the risk of death

by suicide, given what was known about the mental health of the three prisoners was reasonable in all the circumstances. I preferred his view that this death was not foreseeable and that sufficient precautions were in place which should have prevented it.

Accordingly, although it is patently obvious that the form filling in this case had not been properly carried out, I am not minded to state that a reasonable precaution would have been to correctly complete all of the forms. It does not seem to me likely that this murder would have been prevented if the forms had been completely accurately filled in. There was no evidence that further information was available which would have led to a different decision being taken in relation to housing the three prisoners together. I considered it is more likely that there would have been a coherent and cohesive paper trail which would have led to the exactly the same result. However, it goes without saying that systems are in place for a purpose and that the requisite forms should have been correctly completed and properly filed.

Although Mr Wheatley accepted that convicted and untried prisoners should be kept separate as should adult and non-adult prisoners, it does not appear to me that given the ages of the persons involved and the short time they shared, that it is likely that it could have been anticipated that their sharing would have resulted in a murderous assault. Furthermore this murder happened on their second night of sharing the Cell Ward. The Observation Notes do not indicate any concerns, building tensions or worries. They suggest that all three prisoners are getting on well throughout their time together until this unexpected and unprovoked assault. There is no discernible reason for this attack to have taken place.

I accept the Procurator Fiscal's analysis of the eight strands of failure from the Prison Rules, the Contract and the paperwork all being uncompleted or breached to a degree. However there was no evidence to suggest that sex offenders would not be placed in the Health Care Centre if it was considered that they needed to be there. Michael Cameron was subject to HRAT at the time having just tried to commit

suicide. The uncompleted risk assessment forms, lack of location in healthcare forms and non accessing of information within PR2 all show that the paperwork was not properly completed at the time. However no evidence exists to show that had they been a different decision would have been made about housing any of the prisoners in that Cell Ward on that night. The allegation about bullying in relation to David Martin dated back to 2004. Both Professor Coyle and Mr Wheatley accepted that recent behaviour was the best indicator of future behaviour and behaviour in November 2004 would not be considered recent. The evidence of the Segregation Manager who would have been concerned about David Martin sharing a cell is in my view tainted by hindsight. He should have known at the time that David Martin was sharing a cell. I suspect his concern arose after the murder rather than before it. I accept that the sharing arrangements on the night of the murder were in breach of the Prison Rules in that the deceased was over 21 years old and the others under 21 years old. I accept that there was time to review these. I also accept the evidence of Mr Wheatley that he looked at the alternatives and that the solution in place was the best available on that night balancing all factors in each prisoner's case. He took account of the Contract which required the separation of prisoners of different classes.

Accordingly, I am not minded to make any determination that there were reasonable precautions that might have avoided the assault which resulted in the death.

Both the Procurator Fiscal Depute for the Crown and Mr Dickson for the Scottish Prison Service submitted that I should make a recommendation that if information was given at case conferences to clinicians which might have a bearing on prisoner safety or cell sharing, the information should be included within the PR2 system. I am not minded to make this recommendation because I consider that it is important that clinicians should retain the power to decide what can or cannot be disclosed by them given their requirement to respect patient confidentiality. However, if they have information which they consider could be safely shared then, in my view, they ought to be reminded that such information can and should be entered into the

prison computer system PR2. However, I am anxious that clinicians should not feel under pressure or obliged to disclose information which they would be uncomfortable in disclosing because of patient confidentiality. Furthermore it is in the best interests of prisoners to feel free to discuss all issues concerning their health and wellbeing with Health Care professionals. If they think that there is a risk that sensitive information will be shared more widely it might inhibit their freedom to have frank discussions which may adversely affect their wellbeing or the wellbeing of fellow prisoners. Lack of frank discussion may result in information being undisclosed which should be disclosed to Health Care professionals.

I am conscious that the relatives of Michael Cameron may feel puzzled as to why there are no recommendations which can be made to prevent such a dreadful incident happening in the future. There were certainly failings on the part of the Prison Custody Officers in relation to accurate form filling and strict adherence to the Prison Rules about segregation of prisoners. Many of the changes which would have formed recommendations have been made already such as improvements to the CSRA and the PR2 system. Very few Young Offenders are now housed in HMPK. All these changes should help to prevent a further incident of this type. However the violence offered against Michael Cameron was unexpected and in my view unforeseeable. I am unable to make any recommendations for change to practices which might have prevented this tragedy.

I am obliged to the Procurator Fiscal Depute, Mr Gray and Mr Dickson for their careful and responsible handling of this case and for the detailed, helpful and thorough submissions and substantial agreement of evidence in this case.