HMIPS
HM INSPECTORATE OF
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INSPECTING AND MONITORING

Report on visit to HMP and YOI Polmont 4 - 6 August 2025

Inspection following the Fatal Accident Inquiry Determination in relation to the deaths of William Lindsay (or Brown) and Katie Allan

CONTENTS

Background

Overview by HM Chief Inspector of Prisons for Scotland

Inspection findings

Methodology and limitations

ANNEXES

Annex A Review of SPS Death in Prison Learning Audit and Reviews (DIPLARs) at HMP YOI Polmont

Annex B List of desired outcomes

Annex C List of abbreviations used in this report

1. Background

In accordance with Section 7(2)(d) of the Prisons (Scotland) Act 1989, on 24 March 2025, the Cabinet Secretary for Justice and Home Affairs instructed His Majesty's Chief Inspector of Prisons for Scotland (HMCIPS) "to investigate specific matters connected with prisons or prisoners which have been referred to the Chief Inspector by the Scottish Minister". Following the publication of Sheriff Collins' determination in relation to the Fatal Accident Inquiry (FAI) undertaken into the tragic deaths of Katie Allan and William Lindsay (or Brown) while in Scottish Prison Service (SPS) custody, this was to scrutinise the implementation of the recommendations made by the Sheriff.

The response to deaths in custody speaks directly to Scotland's human rights obligations, in particular the right to life provided for in Article 2 of the European Convention on Human Rights (ECHR). The State has the duty to protect the right to life of its citizens, including by taking reasonable steps to prevent someone's life from being avoidably put at risk. With people held in State custody this duty is heightened, due to their inherent vulnerability. When someone dies in custody, the State has a duty to provide an explanation of the cause of death. Where there is possible State responsibility for a death, there is a duty to carry out an effective investigation into the death, to establish if there was any State failure to safeguard the right to life and ensure accountability where State responsibility arises. Under Article 3 of the ECHR, the State has a duty to prevent torture, inhuman, or degrading treatment, and the obligation to undertake an effective investigation in any case where State responsibility may be engaged. This is the basis on which HMIPS and HIS have engaged in this work.

Our review of the work done by the SPS and the NHS to implement the FAI recommendations and keep young people in HMP& YOI Polmont safe from the risk of suicide focused exclusively on the young men held there between the age of 18 and 23. We did not inspect outcomes for women or adult males held at Polmont, but do reflect on this population occasionally in the report because services are provided across three populations.

Health care provision across the three prisons in Forth Valley is hosted by Falkirk Health and Social Care Partnership (HSCP), which holds the delegated responsibility for delivering and overseeing prison healthcare services on behalf of NHS Forth Valley. As the host partnership, Falkirk HSCP provides the governance framework, clinical oversight, and managerial arrangements for the healthcare teams operating across the sites. For clarity and consistency throughout the report, the healthcare provider is referred to collectively as NHS.

2. Overview by HM Chief Inspector of Prisons for Scotland

In August 2025, HMIPS and HIS carried out an inspection at HMP & YOI Polmont against a pilot methodology to assess how effectively young men at Polmont were being supported to live safely, with particular focus on the risk of suicide. We sought to address the outcome for prisoners whilst taking account of the work being done by the SPS to implement the FAI recommendations.

No additional support had been provided to the NHS to facilitate the introduction of the 72-hour Talk to Me (TTM) process for the young men between the ages of 18 and 21 years being admitted to Polmont. Despite this, the new approach was implemented effectively through good collaboration between healthcare staff and SPS staff. The calibre of the case conferences attended was as good as Healthcare Improvement Scotland (HIS) and HMIPS have seen. There was little push back in our discussions with young people experiencing the 72-hour procedure, but those who had been in multiple times and peer supporters, along with staff, wondered whether the priority ought more to be people arriving at prison for the first time or those presenting with concerns.

There had been a clear focus on the recommendations from the FAI, and the prison had implemented what was within its gift and engaged with the elements others were responsible for such as the introduction of in cell signs of life technology.

Due to changes in ways of working because of the FAI recommendations, along with the increasing complexity and risk within the prison population, the healthcare team had shifted capacity away from some person-centred activity. This meant tasks previously carried out by a named nurse, such as medication reviews, were no longer consistently allocated, leading to delays and reduced continuity of care. First Line Managers (FLMs) on the halls were having to let other work, such as accident reports, wait in order to focus on the case conferences (of which there were 11 on the busiest day). A full calculation of the differing staff skills and numbers, across all agencies, needed to deliver the work, both existing and newly arising from the FAI recommendations, as well as offering equity for the three differing populations being held at the prison, is urgently needed.

A concern was raised that young men were given a false impression of what the prison was like when on 72-hour observations, as the wrap around support consequent to being on the initial Talk to Me procedure, ended unless a young man was thought to be at risk subsequently. Support thereafter came from the wider Monro team. Healthcare staff completed a seven-day follow up for people who have been taken off the Talk to Me procedures and extended this to all people coming off the 72-hour process as well, to check whether they had any ongoing or emerging concerns.

We cannot understand why more collaborative effort is not made to bring young people straight to Polmont as soon as they are committed by the court, given the additionally vulnerable situation they are placed in arriving after healthcare staff shifts are finished; peer mentors were not available; and their first hours were spent on 15-minute observations.

There were ongoing challenges in obtaining timely information about a young person's history from community services and the courts. This has been a long-standing issue and had been identified as a contributing factor in previous deaths in custody. The continued delays in receiving essential background information presented a significant and potentially harmful risk.

The major concern from this inspection was the amount of time the young people spent locked up in their cells, or on the halls, and the lack of positive activities and outside interests available to them. Good work had been done to reduce the numbers of enemies, restricting what a young man was deemed as safe to do and mediation work was being undertaken by the Community Safety Team. This shift in focus from separating enemies to mediating and negotiating communal life was an important first step in making more opportunities available to the prisoners, in Monro Hall.

Improving outcomes for the young men held at Polmont is not just about making things available. It is about having staff skilled and engaged, with an understanding of how to work with and motivate young men, and the endless patience to work with them to gain their trust and willing participation. There were excellent examples of staff with these skills, both in the SPS team and external agencies, and these are the behaviours to build on.

Sara Snell
HM Chief Inspector of Prisons for Scotland

3. Outcomes and commentary

Expected Outcome 1: Prisoners live in a safe and secure environment which actively reduces the risk of self-harm and suicide.

Inspection findings

The immediate physical and mental health needs of young men were assessed on arrival at Polmont by members of the Mental Health Team using a standardised screening tool. Screening information was clearly recorded in the electronic patient record system.

The ongoing national issue of late arrivals into prisons continued to present challenges. Anyone admitted into a prison should receive a health screening on admission which must be carried out by a registered health professional. This is to ensure that the immediate health needs of individuals are identified and addressed. While person-centred screening was available during working hours, young men admitted after core working hours - because of late court sittings or delays in transportation - did not receive the same standard of assessment on admission. In one example of late arrivals at the prison, two young men were admitted after 23:00 on consecutive nights.

A robust system was in place to ensure that all late arrivals received a full health screening the following day. However, the risk remained that SPS staff did not have access to up-to-date healthcare information during the initial period of custody when individuals arrived after healthcare staff had finished for the day. This limited their ability to recognise clinical deterioration or urgent health needs until the full health screen had been completed.

Validated tools were available to support drug and alcohol withdrawal assessments as part of the screening process. Nursing staff were able to explain the steps they would take if someone was considered unfit to be in custody, and written guidance was available to support decision-making in these situations.

Most young men, apart from those on enhanced and national top end regimes on Monro Hall, Flat 2, did not have sufficient time out of their cells for recreational and social activities to promote good mental health, and were disadvantaged in comparison with the adult men and women held in Polmont, who had significantly more social and recreation time. Those who received the minimum time out of cell had only one hour in the fresh air and 45 minutes social time out of their cells per day. The early morning offer of fresh air at 07.30 was not taken up during our visit and the 10.00 session was generally not popular either. The young men found both times too early. The spaces in which fresh air were taken were small and unattractive. Even the normal human activity of eating together was unavailable. Hall staff attributed this to the complex separation needs of young men, due to conflicts and potential for violence. It is essential young men in Monro Hall have more purpose to their day with activities and events to support their mental health and ensure equality with the other prisoner groups.

Operational staff had limited specific training to identify and refer people with mental-health concerns. SPS staff received mandatory training in the TTM suicide-prevention strategy, which included recognising early signs of distress and taking immediate safeguarding action. This provided a baseline level of awareness but did not replace the need for further training.

While 49 such staff had completed Mental Health First Aid (MHFA) training between January 2024 and January 2025, the programme was suspended due to contractual issues and had not reached everyone. Plans were in place to resume training in September 2025. Additional training in trauma-informed practice and effective engagement, particularly for those working directly with young men, would strengthen their ability to recognise distress, respond safely, and make timely referrals to healthcare, chaplaincy, and other internal supports.

Emergency first-aid capabilities were well established. All SPS staff received mandatory first-aid training, and refresher compliance stood at 78%. Several staff had also completed advanced first-aid training. The SPS require at least one member of staff with this level of training to be available in the prison at all times; the evidence from our visit indicated that this standard was not consistently met during the night shift.

Prison staff were clear in their responsibilities to preserve life. Operational staff worked closely with the healthcare team during daytime hours, promptly alerting them to any medical concerns and supporting access to clinical assessment when required. During the night shift, a clear medical emergency response procedure was in place: officers initiated the appropriate emergency response; provided basic first-aid measures within their competency; and contacted the NHS out-of-hours healthcare service. An established process was in place for ambulance attendance when required. This arrangement ensured clinical decision-making and treatment were available even when on-site healthcare staff were not present.

Each residential level was equipped with fully stocked first-aid kits, defibrillators, and emergency response bags. Following a Death in Prison Learning, Audit and Review (DIPLAR) recommendation, anti-ligature cutters had been added to response kits. Given the requirement for a specialist first-aid trained member of staff to be on duty at all times, the prison should consider making advanced first-aid training mandatory for key roles or improving incentives for voluntary uptake.

Near miss incidents, where the actions of SPS and NHS staff helped prevent a suicide, were investigated through a structured, multi-agency process. Lessons learned were reviewed at the monthly Performance Assurance Meeting. The prison had a dedicated learning log managed by the Suicide Prevention Lead. Recent guidance had enhanced procedures for identifying ligature risks. Whilst Polmont were recording data on harm and death, it was sent to SPS HQ and reviewed centrally and not used locally. Regular analysis of data, taking account of patterns and trends, would better inform operational decision-making and preventative strategies at a local level.

The NHS followed its clinical governance processes for Learning from Adverse Events Reviews and Significant Adverse Event Reviews, ensuring that incidents

were thoroughly reviewed and lessons were embedded into practice. In cases of deaths in custody, the DIPLAR process was used to explore contributing factors and promote learning and prevention. This process was observed to be well embedded, with healthcare staff reporting they felt actively involved and included throughout. This collaborative approach supported a more integrated and reflective culture, strengthening the quality and safety of care delivered within the prison setting.

Recommendations from FAIs were prioritised, implemented, and regularly reviewed. They were monitored via a central SharePoint system accessible to senior managers and reviewed during routine performance meetings. At the time of the visit, the prison management team had completed the FAI recommendations for which it was solely responsible and were working with the SPS dedicated taskforce to complete those for which joint SPS responsibility had been identified.

The FAI recommended the removal of ligature anchor points in standard prison cells where practicable. Some specific hazards, like bunk beds and doorstops had been addressed, but the planned Anti-Ligature Toolkit to assess all Scottish prison cells had yet to be implemented. No cell was fully ligature-free or suicide-proof hence the importance of the prison prioritising protective factors for the young men in their care.

In response to the recommendation that the SPS should review and revise its policy regarding permitting young prisoners to routinely have possession of items which are readily capable of being used as ligatures without ingenuity or adaptation, SPS staff reported that personal possessions were removed only in exceptional, documented circumstances following a multi-disciplinary review. There was little evidence of a rationale being given for any such removal, contrary to the existing TTM guidance. Staff allowed additional personal items when they provided a young person with support, comfort or assisted their mental health, subject to appropriate FLM. The SPS had established a short-life working group to review all items young men are routinely permitted to have in their possession. This included a review of those items that young prisoners were permitted to purchase within and outwith the prison, items that families and friends were permitted to send in, and any personal items or clothing that prisoners have in their possession when they are admitted to custody.

Following a review of the recommendation that the SPS should undertake or commission a research project in relation to the availability and cost of alternative bedding materials for use in cells by young prisoners in Polmont, it had been determined that no available materials could be manufactured or adapted for use as bedding that is both rip-proof and incapable of being used as a ligature. The SPS project team created to deliver the FAI recommendations reported they had gathered sufficient evidence that there is no intermediate bedding option on the market that is rip resistant and does not compromise comfort and rest.

In response to the FAI recommendation that the SPS should actively pilot and review use of in cell “signs of life” suicide prevention/monitoring technology in Polmont, three companies were trialling “signs of life” detection technologies, each based on either movement or heart rate monitoring. Selected cells on floors two and four of Monro Hall, two cells within the SRU, along with several cells at HMP & YOI Stirling were to be equipped for the pilot beginning in early August 2025. Progress had been

positive, and a supplier selection was anticipated by the end of 2025. SPS HQ will determine any future roll out of signs of life technology in light of the pilots.

Expected Outcome 2: Prisoners at risk of self-harm or suicide receive individualised care from a multidisciplinary team and have unhindered access to help, including from their families.

Inspection findings

Healthcare services and the Mental Health Team in particular, played a key role in supporting young people at risk and responding to the increasing complexity of need within the establishment.

The Mental Health Team had undergone a significant shift in service delivery in response to the increasing complexity and acuity of the prison population, particularly following the arrival of convicted adult males and the rising number of women held in the establishment.

The implementation of the FAI-recommended 72-hour TTM protocol for young men entering Polmont added further pressure on the team's capacity. In addition, the Management of Offenders at Risk Due to Any Substance (MORS) policy, designed to identify and support individuals at heightened risk due to substance use, contributed to increased demand on healthcare resources. The growing number of individuals placed on MORS required additional assessment, documentation, and coordination, further stretching clinical time and reducing capacity. Collectively, these pressures created significant challenges in delivering timely, coordinated, and person-centred care within an already complex environment.

To support the delivery of safe and consistent care, mental health nurses completed a Mental Health Assessment Competency Framework within six months of commencing post. This provided assurance that healthcare staff were equipped with the necessary skills in communication, assessment, and treatment planning.

The automatic placement of all individuals onto TTM for 72 hours had, in some cases, led to the process being viewed by both healthcare and SPS staff more as a procedural requirement rather than a dynamic, decision-making tool for assessing individual risk.

Service-wide improvements had enhanced the quality and consistency of care. Structured documentation and standardised templates supported more reliable clinical record keeping. Targeted training in trauma-informed care, adolescent mental health, and suicide prevention helped ensure that healthcare staff were equipped to meet the complex needs of the population. Governance was strengthened through regular multidisciplinary reviews and clearer escalation pathways, with senior healthcare leadership providing strategic oversight to sustain improvements.

To manage population pressures and meet the demands of the 72-hour protocol, the healthcare team adopted a highly responsive approach to service delivery. While this supported timely intervention and effective risk management, it reduced opportunities for staff to engage in reflective practice or plan longer-term interventions. As a result, the team was not always able to allocate a consistent named nurse or key worker to individuals requiring ongoing support. For example, patients needing regular medication reviews were often seen by different nurses

depending on shift patterns, affecting continuity of care and limiting opportunities for holistic, person-centred support.

Urgent referrals continued to be prioritised; however, the increasing workload for mental health nurses contributed to delays in routine assessments. At the time of the inspection, 104 individuals were on the mental health waiting list, with an average wait of 12 days, exceeding the service's seven-day target. Nonetheless, the team's commitment to responsiveness and risk prioritisation remained evident despite these significant operational pressures.

The healthcare team had made efforts to engage meaningfully with young people at various points. This included one-to-one assessments before case conferences and follow-up reviews, seven days after removal from TTM monitoring. A patient engagement co-ordinator facilitated focus groups, drop-in clinics, and individual sessions, gathering feedback that informed care planning and prompted timely action.

Young people placed on TTM were reviewed at every case conference, where suicide and self-harm risks were assessed to inform ongoing risk management, and a mental health nurse attended daily to ensure documentation was updated and care remained coordinated. These processes were supported by person-centred practice and effective collaboration between SPS and healthcare staff. The full TTM process was observed, including case conferences, documentation, clinical note-keeping, and communication between teams. The approach was well structured, consistently applied, and worked effectively. Staff demonstrated a clear understanding of their roles and responsibilities, supporting timely, person-centred risk management and care planning.

A review of live and closed TTM files evidenced a variety of strategies to reduce risk and support the individual. In most cases, particularly those on the new 72-hour admission process, young men were placed on various levels of supervision from 15 to 60 minutes. Most were placed in a normal cell with all items in use and afforded recreation, access to fresh air and were able to pick up their own meals.

To support implementation of the 72-hour protocol further, the healthcare team also held weekly TTM rapid rundown meetings. These were conducted separately from clinical team meetings and were designed to supplement them by enabling focused, structured discussions on patient progress, care planning, and interprofessional communication. This structured and multi-layered approach to case discussion was positive, reflecting a well-organised and proactive model of care that supported timely decision-making and enhanced continuity across services.

Closure and transitional plans were completed for every case conference, with most of the follow-up work being completed by the Mental Health Team and documented in the electronic patient care record. Most of the plans involved access to healthcare services such as mental health or substance use services.

FLMs were the case managers for those on TTM. A bid for a dedicated officer for the admission area had been successful, one member of staff for each shift, including nightshift, but they had not taken up post at the point of the inspection. The staff

members selected to carry out this role were however already dedicated to working in reception when on duty. SPS staff within the admission area were knowledgeable of the TTM process, had a good understanding of those they looked after and showed a caring approach.

A comprehensive admission process carried out by the dedicated officer in the hall generated information that was helpful in developing a picture of each young man admitted to the prison. This information was cascaded to various internal and external partners. There were ongoing challenges in obtaining timely information about a young person's history from community services and the courts. This was a long-standing issue identified as a contributing factor in deaths in custody. The continued delays in receiving essential background information presented a significant and potentially harmful risk. Where concerns were highlighted, the officer referred the person to support services such as substance use services or social work. On admission, a young person was allowed one number to be added to their telephone list at reception. However, often there was no answer from the number and there was no way of contacting anyone else unless they had access to a hall phone. Prison staff being able to add additional telephone numbers when this happened, or a wider range of numbers being added on admission would resolve this.

The FLM responsible for TTM cases had responsibility for checking that all documentation was completed before completing their shift. A weekend review of live TTM case files was part of an assurance process undertaken by the Duty Manager. Oversight of the TTM process was the responsibility of a Unit Manager. The SPS requires 25% of closed files to be reviewed and the Unit Manager reviewed all closed files. Even with two stages of assurance, mistakes such as signatures and/or dates missing, were still being identified at the closed file review stage. The Unit Manager contacted the appropriate person to take action to ensure files were accurate before agreeing finally to close them.

Peer mentors were in place within the prison and had received training relevant to their supportive role. Peer mentoring provided young people with informal guidance from fellow prisoners, helping them navigate their first days in custody and understand key aspects of prison life. Mentors met young people in the first-night area, usually on the evening of admission, but followed up the next morning if they were late night arrivals. They offered information on visits, canteen, regime, education, and work parties, and gave practical advice on avoiding common difficulties such as borrowing or debt.

The training provided to peer mentors did not extend to the level of specialist emotional-support skills offered through the Listener service. Peer mentors were not Samaritans-trained. The Listener service was not available to young men in Monro, as a result of a policy decision by SPS Headquarters. This is in contrast to the position in the community where young people can volunteer to provide this service. Given the complexity of the population in Polmont, there was a need to consider whether peer support training is sufficiently aligned to the risks and vulnerabilities of the young people they support. While peer mentors were well-motivated and willing to assist, the absence of 24-hour peer support or a Listener service limited the availability of peer-based emotional support for those in crisis.

The prison did not have a care suite, which HMIPS considers essential for supporting young people in acute distress. In the absence of such provision, young people were placed in safer cells when required. However, these cells contained several ligature points and therefore could not be relied upon to prevent self-harm. The overall environment did not meet the standard of a supportive crisis space. Young people reported mixed experiences of safer cells; some found them unhelpful and isolating, while others felt they provided the environment they needed at the time. The lack of a dedicated care suite limits the prison's ability to provide a calming, supervised environment where protective factors, such as peer or staff presence and access to communication with friends and family, can be used proactively to reduce distress.

The cells used by young men arriving for their first 72 hours at the prison had soft, magnet-held toilet doors. It is difficult to understand why similar adjustments had not been made to the safer cells where people had been identified more clearly at risk of harm.

By the time of our inspection, in the 176 instances where a young person had been assessed under the new 72-hour process, 120 (68%) were removed at the end of 72 hours. No young men had been placed under constant observation under the new process. Supervision levels varied on a case-by-case basis. When an assessment of risk was made, the observation times varied from between 15 to 60 minutes.

Young people told us they understood the new 72-hour TTM protocol, although many reported they would have preferred not to be subject to it. They expressed differing views about the relevance of being placed on it. Some felt that monitoring was unnecessary when they were not in crisis, while others believed they would have been placed on TTM regardless of the new process. Staff highlighted that workloads had increased significantly due to the volume of observations and case conferences, although they also emphasised that the structured approach reduced the likelihood of missing anyone in crisis during the initial admission period.

Several young men described frequent overnight observations as intrusive or sleep-disrupting, particularly when the spy-hole cover was lifted. Some staff acknowledged that the process could feel overly cautious and had attempted to minimise disruption by keeping the spy-hole open, although this was not consistent practice. Some young men commented that the term "Talk to Me" felt misleading, as they did not always experience meaningful engagement during observations.

The environment also influenced the experience of monitoring. One safer cell was equipped with smart-glass technology, which removed the need for physical spy-hole checks and reduced disturbance. Staff viewed this positively, and extending smart-glass to all safer cells would support more proportionate and less disruptive observations during periods of heightened risk.

TTM closed files evidenced plans being made for those being released within six weeks of being removed from TTM. Healthcare staff demonstrated clear and effective discharge planning processes, which focused on continuity of care. These systems ensured that young people received appropriate follow-up and referrals upon release, supporting a safe transition back into the community and helping to

maintain engagement with health services beyond custody. There were instances where people under the 72-hour process returned to court and were released. We found two young men who had been held overnight in prison custody on 14 May 2025 and 19 June 2025. While a plan was put in place so that one of these young people could access community support including substance use services, mental health services and his GP, we have to question the appropriateness of custody in these instances. William Lindsay (or Brown) was the subject of an Alternative to Custody report submitted by Social Work to the Sheriff on 4 October 2018. Social Work were unable immediately to secure appropriate accommodation for him and he was remanded to custody at Polmont, where he died three days later. The fact of William's death should be a constant warning only to deprive people of their liberty where this is necessary to ensure public safety.

Expected Outcome 3: Prisoners feel and are safe from victimisation, violence and other antisocial behaviour

Inspection findings

As a result of training carried out in the spring, there was a greater awareness amongst staff in Monro Hall of the SPS Anti-bullying Strategy - Think Twice, than HMIPS had seen in any other prison. In line with recommendation 10 of the FAI Determination, staff confirmed that any intelligence-based information suggesting that a young person had been or was being bullied was promptly shared with the FLM in the residential hall in which the young person resided. This was underpinned by a Standard Operating Procedure (SOP). The records we looked at showed that the SOP had been followed. This recommendation had also resulted in a review of the SPS Think Twice Strategy, which was underway. A short-life working group had been established, and research had been undertaken with staff and prisoners to understand the limitations of the existing strategy and support the drafting of a new one. The second phase was to consult Governors in Charge and NHS colleagues on how the new draft strategy will work within the operational context. A series of short films highlighting the experience of bullying and those being bullied were planned to set the scene for piloting the new strategy in 2026 and then evaluating it.

SPS staff talked confidently about how they identified those at risk of being bullied and what action they took to defuse tensions. If necessary, and where possible, they said they tried to relocate perpetrators of bullying rather than the victims. The young men felt that staff were approachable and would intervene if problematic behaviour was brought to their attention. However, the fact that all young men were now located in one hall limited relocation options, and when consideration of known enemies was taken into account this sometimes resulted in the victim being moved rather than the perpetrator. The prison's Community Safety Team [1] had been deployed in Monro Hall to help with de-escalation and mediation. Personal officers in residential areas had yet to be trained to take on these roles with confidence themselves. More formal training in Restorative Justice [2] based approaches is needed.

There was clear evidence of incidents of violence being investigated, and data on violence and bullying being regularly reviewed by the Tactical Tasking Group with practical action taken in response. Major efforts had been made to review the list of known enemies which had reduced from 800 to approximately 400 across the prison. Although a Violence Reduction Strategy had been developed it had not been updated since 2022. Reinvigorating it should support a stronger, more strategic multi-agency approach to violence reduction across the prison.

The Inclusion Team provided excellent support for those at risk of isolation to encourage them to re-engage. They encouraged participation and integration through a tailored support package, including personal tuition at the gym and escorting people individually to try out opportunities in the Learning Centre and work sheds, as well as therapeutic activities such as Paws for Progress dog handling

[1] work to bridge the gap between police and young people and focus on reducing reoffending
[2] Restorative justice is a voluntary, victim-focused approach to crime and conflict that brings together those harmed with those responsible to repair harm and prevent reoffending

sessions. Similarly, residential staff welcomed the presence of the new Kinetic Youth Team organising fun activities at recreation times during weekdays and at the weekends as another way of supporting the mental wellbeing of the young men and reaching out to those at risk of isolation. The Kinetic Youth Team ran a domestic violence themed programme that encouraged reflection on behaviours and attitudes that might have a wider value in reducing tensions between those living in Monro Hall. The Community Safety Team used to run a Positive Choices behavioural training programme covering various elements that might contribute to anti-social behaviour. Due to being reassigned to the mediation role within Monro Hall they had not run the course for young men since August 2024.

A major concern was the lack of access to purposeful activity. Superficially there appeared to be a reasonable range of activities for the young men in Polmont, but some of these activities were not available at the time of our inspection and others only provided opportunities for a small number of young men, or others, like life skills classes, were only initiated near to liberation. For example, the only work opportunity available to young men on Monro Level 1 was the VT joiners and that was regularly cancelled due to staff sickness and the need to redeploy staff. Many of the young men and residential staff expressed deep frustration at the much more limited range of opportunities available to the young men now that the prison also housed women and adult men.

While recognising the need to make effective use of capacity at Polmont to manage the population pressures across the adult male estate, the opportunities for purposeful activity for the young men were unacceptably poor. On one morning of our inspection only 22% of young men were engaged in activities outside their residential area, excluding gym. That day the prison provided only 150 hours of time out of cell in activities outside the accommodation block to those housed on Monro. Work, education and other activities outside the accommodation blocks provide mental stimulation and a sense of purpose and normalisation, as well as supporting rehabilitation. On the wing young people were reliably offered recreation and time in the fresh air and those with passman duties were at least out of their cell.

The Learning Centre assured us that all young men could access some form of learning within two weeks of admission, but some young men expressed frustration at waiting five months to access education. This may have been awaiting the course of their choice rather than access to learning but demonstrated the need for improved communication between residential staff, the Learning Centre, and the young men to ensure they understand and are encouraged to take alternative options while awaiting their preferred course.

Expected Outcome 4: Prisoner's families and friends are encouraged to interact with the prison, know how to raise concerns and contribute to their care

Inspection findings

The prison had established a clear and accessible process for family members and friends to raise concerns about prisoners' mental health and wellbeing, via a dedicated 24/7 concern 'phone line, prominently displayed on the prison's website. The 'Family and Friends' section of the website provided detailed guidance including what callers could expect when they call, what information to leave, and what actions staff would take. Calls were promptly actioned by Emergency Control Room (ECR) staff who informed residential FLMs, who acted quickly to assess and support prisoners, including consideration of placing them on TTM or referring them to mental health services. FLMs updated the caller with the outcome of the discussion. Further information about the concern line was available in the establishment, with leaflets in the visitors waiting room and the CrossReach visitor induction pack. Operational guidance was available, and all relevant staff understood what was required of them.

There was some evidence of staff encouraging prisoners to involve their family and friends in their care. Personal Officers reported that they encouraged prisoners to maintain contact with families and invite them to Integrated Case Management (ICM) meetings. Family and friends' attendance at ICMs had increased somewhat between 2021 and 2024. From a total of 183 case conferences held for the whole prison population during this period, the number of accepted invitations had increased from 27 to 49 but there is no data to say what proportion of these attendances were for young men. Further work was required to increase attendance. In all TTM cases reviewed, the opportunity for prisoner's families to attend was recorded as declined. One young person stated that he did not remember being asked if he wished a family member to be present and thought that his chosen family member would have attended had they been asked.

Prisoner induction was not running at the time of the visit. When operational, induction had included the opportunity to invite friends and family into the prison to begin involving them in their family member's care at an early stage. Restarting these family induction sessions will offer the prison the opportunity to talk families through how to raise any concerns they may have and how best to support their family member.

CrossReach, an independent service supporting prisoner families and friends during visits, helped build positive relationships. They shared feedback from quarterly visitor forums with the prison at quarterly stakeholder meetings. They had examples of inconsistent treatment of visitors which they felt they had raised at these meetings, but which had not sufficiently been responded to, including the turning away of a family who had travelled from Inverness because an error had been made in the booking. Decisions such as this were being made by staff at the front of house when they should be escalated immediately.

Promoting the visitor support services during prisoner and family inductions when they resume will also increase awareness of sources of support. We were told by young men and staff that families were invited to attend performing arts events, which supported family contact, but we were not able to confirm this with the lead person as they were on leave during the inspection. Wider chaplaincy engagement with families could be enhanced at key events throughout the year, although collaborative efforts existed with families at Christmas and supporting of bereaved families.

Next of kin details were collected at admission and recorded, but some prisoners had not provided this information, and no formal follow-up took place. There was no process to review the information held or to update next of kin information at the prisoners' request.

Nationally, there was no formal process for gathering information from families to assist in the assessment of the young person's risk and care on admission. An SOP was in place to manage suicide risk concerns raised by external parties about individuals admitted from court. Immediate risks, typically identified by the courts, were reported via a designated email and shared with key healthcare and mental health staff. A duty mental health nurse would review the alert, check the young person's records, take appropriate action, and communicate the outcome. This process ensured timely responses to urgent concerns.

While the SOP supported prompt action on immediate risks, delays in receiving broader background information from courts and external services continued to affect the timeliness and accuracy of assessments. This risked the identification of healthcare needs and appropriate interventions. There was ongoing engagement with the SPS, NHS, and external services to improve communication, alongside national efforts to strengthen systems and ensure timely access to essential information. Despite these efforts, challenges remained.

Children's rights to maintain contact with parents in custody were recognised, with multiple visit options including face-to-face, virtual, bonding visits, and access during closed visits. However, all visits had to be booked seven days in advance, and the young and adult men attended the same visit session, dependent on whether they were a mainstream or protection prisoner. Young men struggled to get visits, particularly for evening and weekend sessions, which were most suitable for school age children. The adult men were reportedly more organised in booking visits and staff in their halls were quicker to action requests. This was also the case for virtual visits. As a result, it was reported that some young men had stopped trying to book visits altogether.

The prison offered bonding visits every weekday morning for 90 minutes. Weekend sessions were only 45 minutes long, with only six slots available over the two days. Bonding visits provided a more relaxed environment where parents and their children could move around the visit room and there were more toys available. These visits were limited to three prisoners per session and one session per prisoner per week. However, the weekday morning timing was unsuitable for school-age children, and there were reports of children being taken out of school to attend them. While weekday sessions were full during school holidays, they were often underused

during term time. Family Contact Officers expressed a desire to expand family events and introduce evening bonding visits but were restricted by limited access to the visit room. Prisoners on closed visits were still allowed bonding visits with their children, ensuring that positive parental contact continued. Young men spoken to were positive about bonding visits, praising staff and the child-friendly environment. One young man described how his neuro-different sibling struggled during regular visits, so bonding visits had been arranged to support contact. Another prisoner was also using bonding visits to maintain relationships with siblings. There was no specific provision for smaller, quieter visit sessions for neuro-different children or family members outside bonding visits.

Visit restrictions were applied fairly and not used as punishment. Regular reviews took place, and the outcome was clearly communicated to prisoners and visitors.

4. Methodology and limitations

To enable HMIPS to capture evidence consistently about what is being done in Scottish prisons to prevent deaths in custody and what action is taken from learning when deaths do occur, we piloted at Polmont a methodology to allow us to gather and compare quantitative and qualitative data. We have initially looked only at death by suicide because the Fatal Accident Inquiry (FAI) into William Lindsay (or Brown) and Katie Allan's deaths in 2018 was the starting point, and the three subsequent deaths 2021, 2023 and 2024 also appear to have been completed suicides.

The high number of prisoners being placed on observations under the MORS policy at Polmont, because of concerns that they had taken illicit substances (15 the weekend before we inspected, 20 the weekend after) means we must focus on this issue when resources allow.

The overarching outcome we looked for was whether prisoners are living in an environment which reduces the risk of harm. This includes harm to self, such as through suicide, and harm from others such as bullying, intimidation and violence. We wanted to assure ourselves that those at risk of harm from themselves or others are identified and given appropriate care and support, and that those in situations of vulnerability who are at risk are identified, protected from harm and neglect, and receive effective care and support.

The method we used for this piece of work was to pilot a bespoke inspection Standard, drawing on our current inspection methodology, in which we looked for six outcomes. The first two were inspected by HIS and their findings are incorporated into the last four outcomes findings:

- Prisoners' immediate health and wellbeing needs are assessed on admission
- Those at risk of self-harm or suicide are supported
- Prisoners live in a safe and secure environment which actively reduces the risk of self-harm and suicide
- Prisoners at risk of self-harm or suicide receive individualised care from a multidisciplinary team and have unhindered access to help, including from their families
- Prisoners feel and are safe from victimisation, violence and other antisocial behaviour
- Prisoner's families and friends are encouraged to interact with the prison, know how to raise concerns and contribute to their care

HMIPS and HIS also looked at the extent to which the FAI recommendations had been met.

Limitations

There were some limitations to our inspection methodology.

Due to initial time constraints and resourcing restrictions, we were unable to conduct a literature review in advance of drawing up the pilot inspection Standard, to research risk and protective factors regarding deaths in custody. The indicators we

looked for were therefore based on pragmatic and operational experience of what a supportive environment might look like, combined with the FAI recommendations, rather than being firmly grounded on evidence of what this should comprise. That is a gap we are seeking to redress as we develop this work.

Similarly, this method did not include a comprehensive analysis of all data relevant to deaths in custody. Based on the literature review, we intend to ground data requests in the evidence about risk and protective factors. In the meantime, we took the data readily available to us from the SPS.

Our pre-inspection survey is usually managed by the HMIPS senior researcher and conducted by HMIPS staff, whereby we select participants using a random sample which provides a representative sample of the whole population of the prison. We did not conduct a pre-inspection survey for this inspection, meaning that the views of the young men were partially represented and depended on who we spoke with. Engagement with us was, of course, voluntary and one young man who came in under the new admissions process on the middle day of the inspection was not prepared to talk with us.

We piloted a methodology to gather evidence and understand families' experiences of raising concerns about their family members and the follow up they received. We put up posters in the visit's areas explaining our aim and had one of our team stationed there to explain what we were doing and encourage those who had raised a concern to contact us independently and privately outside the prison. Three people initially contacted us, but none led to additional evidence we could use. As learning from this pilot, we will explore other options to hear from this essential group.

Annex A

SPS Death in Prison Learning Audit and Reviews (DIPLARs) at HMP YOI Polmont

Ideally the pilot standards would have incorporated the recommendations from DIPLARs, but instead we approached this retrospectively. After we left the prison, we reviewed DIPLAR reports from Polmont spanning the past eight years, relating to the deaths of William Lindsay (or Brown) and Katie Allan in 2018 and the three subsequent deaths in 2021, 2023 and 2024. This revealed that, while our three-day inspection had gathered evidence either completely or partially for some DIPLAR recommendations, some had not been covered at all.

When considered collectively, four recurring high-level themes were consistently identified across all DIPLAR reports:

- SPS and NHS staff training
- Inter-agency communication
- Documentation standards
- Governance and operational consistency

Family engagement and emergency response and safety protocols were themes noted in some, but not all, of the DIPLAR reports.

The persistent recurrence of four primary themes throughout the eight-year period we looked at indicated that action taken in response to previous DIPLAR recommendations had not addressed the issue.

The following compares findings from the visit by HMIPS to HMP and YOI Polmont 4 to 6 August 2025 with the findings of the five DIPLAR reports:

SPS and NHS Staff Training

DIPLARS identified that mental health and disability awareness training for SPS officers was to be scoped to upskill staff in managing young people. Training support was also required for NHS staff in relation to documenting formal or informal discussions and clinical notes.

The inspection found that SPS staff had limited specific training to identify and refer people with mental-health concerns. SPS staff received mandatory training in the TTM suicide-prevention strategy, which included recognising early signs of distress and taking immediate safeguarding action. This provided a baseline level of awareness but did not replace the need for further training. Targeted training in trauma-informed care, adolescent mental health, and suicide prevention was provided to NHS staff. NHS staff are trained and assessed in clinical documentation through their professional qualification and the regulatory requirements of The Nursing & Midwifery Council (NMC). In addition to this, localised documentation training was also delivered by the Professional Lead Nurse to strengthen staff confidence and consistency in record-keeping. Record-keeping was further monitored through managerial clinical supervision, which included periodic auditing

of documentation. The notes reviewed during the inspection, such as TTM entries and wider clinical records, were consistently well-structured, accurate, and appropriately applied in practice.

Inter-agency Communication

The DIPLARs highlighted the need for clearer, more coordinated information-sharing processes following a death in custody, including uncertainty around who should be notified of a death and at what stage. Communication gaps were identified within the TTM process, particularly the absence of external prison-based and Criminal Justice Social Work from case conferences. External agencies involved in DIPLAR meetings should be provided with a copy of the DIPLAR policy to ensure clarity of purpose and to reduce the risk of conflict or distress. The findings also identified the need for NHS staff to obtain information from external agencies as early as possible, supported by the establishment of a clear NHS email point of contact. NHS staff should be included in future debrief sessions, and improved information-sharing is required between agencies regarding deaths in custody and escalations in MORS, specifically between prison-based and Criminal Justice Social Work teams. Internally, clearer communication is needed to ensure hall boards are accurate and aligned with roll checks.

The inspection found an SPS SOP was in place to manage suicide risk concerns raised by external parties about individuals admitted from court. Immediate risks, typically identified by the courts, were reported via a designated email and shared with key health and mental health care staff. However, while the SOP supported prompt action on immediate risks, delays in receiving broader background information from courts and external services continued to affect the timeliness and accuracy of assessments. There was ongoing engagement with the SPS, NHS, and external services to improve communication, alongside national plans to strengthen systems and ensure timely access to essential information. Despite these efforts, challenges remained.

Documentation Standards

The DIPLARs identified concerns about the recording of MORS checks being grouped together rather than documented as individual instances, and the need to review NHS documentation practices, including the use of retrospective case note entries, with training provided where necessary. It was noted that a concern email received from a Criminal Justice Social Worker had not been recorded, highlighting gaps around the need to record and action email-based concerns. The use of consent forms was identified to ensure that all information received is properly documented and that staff undertaking assessments have access to accurate and complete information. Improvements were required in the accuracy and completeness of record keeping, including signatures and dates. In addition, detailed records of decision making at case conferences should be recorded and all staff should complete the TTM refresher training.

The inspection found that NHS improvements had provided structured documentation and standardised templates enhancing clinical record keeping and governance through regular multidisciplinary reviews and clearer escalation

pathways, with senior healthcare leadership providing strategic oversight to sustain improvements. An FLM responsible for TTM cases checked that all documentation was completed before finishing duty. A weekend review of live TTM case files was part of an assurance process undertaken by the Duty Manager. Oversight of the TTM process was the responsibility of a Unit Manager. Although the standard recognised by the SPS is to review 25% of closed files, the Unit Manager reviewed all closed files. Despite this, gaps in basic paperwork such as signatures and dates continued.

Governance and Operational Consistency

DIPLARs identified the need for clear guidance on notifying relevant staff of a death in custody when individuals are absent due to sickness, as well as the importance of completing a full cell search when a young person or female was placed on MORS to remove any illicit substances. Concerns were also raised about the extended period a cell remained out of use following an incident, as this can act as a distressing reminder for other young people. The findings further highlighted the need to maintain TTM status for young people entering custody for the first time when full background information is not yet available, until normal presentation and risk factors are clearly understood. Improved compliance with the Governors and Managers Action relating to telephone concerns and the TTM process was also identified, including the completion of concern forms, timely feedback to the referring agency, and clear communication to all FLMs to reinforce these requirements. Court reports and relevant documentation should be transported with young people when they are remanded to support informed decision-making on arrival. DIPLARs also identified the need for NHS staff to undertake robust initial assessments using a standardised template with clearly defined risk assessment fields, with completion monitored through audit and supervision. In addition, attendance by social work staff at TTM case conferences for all looked-after children in custody should be ensured, alongside strengthened links between social work, mental health, and residential staff.

The inspection found that the 72-hour TTM process for young people at Polmont had worked well with good collaboration between NHS and SPS staff. The prison had established a process for agencies, family members and friends to raise concerns about prisoners' mental health and wellbeing, via a dedicated 24/7 concern phone line, prominently displayed on the prison's website. Calls were actioned by Emergency Control Room (ECR) staff who informed residential FLMs, who assessed and supported prisoners, including consideration of placing them on TTM or referring them to mental health services. FLMs updated the caller with the outcome of the action. Immediate risks, typically identified by the courts, were reported via a designated e-mail and shared with key healthcare and mental health staff. A duty mental health nurse would review the alert, check the young person's records, take appropriate action, and communicate the outcome. Structured documentation and standardised NHS templates had enhanced clinical record keeping. Governance had been enhanced through regular multidisciplinary reviews and clearer escalation pathways, with senior healthcare leadership providing strategic oversight to sustain improvements.

Family Engagement

DIPLARs identified that initial contact with a family following a death in custody should be limited to approximately three attempts, with voicemails left where appropriate to allow the family to return the call. It was also identified that communication and support processes for families and visitors required strengthening, including reiterating the use of concern forms to staff at Polmont, ensuring these forms are readily available in the visits room, and displaying clear notices in the visits area to inform visitors who they should approach if they have concerns about their family member or friend.

The inspection found evidence of staff encouraging prisoners to involve their family and friends in their care and information for a concern telephone line was available in the establishment, with leaflets in the visitors waiting room and the CrossReach visitor induction pack. Any calls were actioned by the ECR staff who informed residential FLMs, who acted to assess and support prisoners, including consideration of placing them on TTM or referring them to mental health services. FLMs were required to update the caller with the outcome of the discussion. A clear and accessible process for family members and friends to raise concerns about prisoners' mental health and wellbeing, via a dedicated 24/7 concern 'phone line, was prominently displayed on the prison's website.

Emergency Response and Safety Protocols

DIPLARS identified several operational and procedural issues in relation to deaths by hanging and wider risk management practices. The Code Blue process was to ensure that the first person on scene should take the weight of the body and request a crash pack, inconsistencies were noted in the use of ligature cutters, highlighting the need to review crash pack contents and ensure the correct equipment is available and used. Risks associated with ligature points within cells were identified alongside the need for continued national work to reduce these points. Additional concerns included the need to consider cell checks to ensure illicit substances are not accessible when a young person is placed on MORS, and the importance of SPS HQ progressing a wider review of MORS. Local practices at Polmont, such as night shift welfare checks, required reviewing to determine their appropriateness and necessity. Finally, gaps were identified in the TTM process on admission, including the need to initiate MORS when individuals appear under the influence and to ensure relevant information from the Procurator Fiscal is fully captured within the initiation documentation.

The inspection found evidence that prison staff were clear in their responsibilities to preserve life. Each residential level was equipped with emergency response bags and anti-ligature cutters had been added to them. No cell was fully ligature-free or suicide-proof but some specific ligature points such as bunk beds and doorstops, had been addressed and the planned Anti-Ligature Toolkit to assess all Scottish prison cells was yet to be implemented. There was no evidence gathered during the inspection about MORS practices or procedures in respect of admissions or cell checks.

Annex B

List of desired outcomes

Expected outcome	Desired outcome
1. Prisoners live in a safe and secure environment which actively reduces the risk of self-harm and suicide	• **Young men in Monro Hall experience equitable time out of cell**, comparable to other prisoner groups, with meaningful activities available, resulting in higher uptake and contributing to improved wellbeing and reduced isolation. **Fresh air sessions are scheduled at times that maximise participation.** • **Young men are able to engage in safe, structured social interaction**, reducing isolation and promoting positive peer relationships. Including **Communal dining opportunities**, fostering social connection, normalised routines, and improved mental health outcomes. • **All frontline staff demonstrate foundational competence in mental health awareness**, with Mental Health First Aid training embedded and consistently delivered. **Staff working with vulnerable and young prisoners consistently apply trauma-informed approaches**, leading to safer, more supportive, and responsive care. • **A trained specialist first aider is available on every night shift**, ensuring timely and effective emergency response. **Key roles consistently hold specialist first aid qualifications**, either through mandatory requirements or strong incentives, strengthening overall safety standards. • **Local leadership has timely access to accurate harm and death-related data**, enabling proactive decision-making, targeted interventions, and improved preventative strategies.
2. Prisoners at risk of self-harm or suicide receive individualised care from a multidisciplinary team and have unhindered access to help, including from their families	• **Observation of prisoners in safer cells is conducted in a way that minimises distress and disruption**, through the use of smart glass doors that support safety while reducing anxiety associated with spy-hole checks. • **Young men experiencing acute crisis have access to a dedicated care suite**, providing a safe, therapeutic, and supportive environment that better meets their immediate mental health and wellbeing needs. • **Prisoners are able to maintain timely contact with approved family and support networks**, with authorised staff empowered to add phone

	numbers on arrival, reducing unnecessary delays and supporting wellbeing and stability. • **Delays in completing routine mental health assessments are addressed** through building NHS capacity consistently to meet timelines.
3. Prisoners feel and are safe from victimisation, violence and other antisocial behaviour	• **Violence across the establishment continues to reduce**, supported by an effectively implemented violence reduction strategy that is responsive to emerging trends and risks. **Incidents of bullying and violence are resolved constructively and sustainably**, with formal restorative justice programmes embedded and staff trained to facilitate meaningful resolution and accountability. • **Young men experience consistent, joined-up support between Residential and Learning Centre staff**, resulting in maximised engagement, improved attendance, and better educational outcomes. • **Young men on Monro have access to a wide range of meaningful work and purposeful activities**, strengthening motivation, improving mental wellbeing, and contributing to reductions in drug use and violence.
4. Prisoner's families and friends are encouraged to interact with the prison, know how to raise concerns and contribute to their care.	• **NHS partners follow a consistent and clearly defined process for raising concerns**, resulting in accurate documentation, timely responses, and improved accountability. • **Families are engaged early in the custody journey through reinstated induction sessions**, increasing awareness of available supports and strengthening family involvement from the outset. • **Chaplaincy services play an active role in supporting families**, contributing to stronger, more resilient support networks for young men in custody. • **No prisoner remains without identified next of kin due to process gaps**, with clear follow-up procedures in place when details are not provided at admission. **Next of kin information is accurate and regularly reviewed throughout custody**, ensuring reliable communication channels in both routine and emergency situations. • **All young men have equitable access to visits**, supported by an improved booking system that prioritises fairness and access to child-friendly times. **Bonding visits are accessible to families**

	with school-age children, including the availability of weekday evening sessions. **Visit opportunities are inclusive and responsive to diverse needs**, with tailored or quieter sessions available to support neuro-different children and families.

Annex C

List of abbreviations

DIPLAR	Death in Prison Learning Audit and Review
ECHR	European Convention on Human Rights
ECR	Electronic Control Room
FAI	Fatal Accident Inquiry
FLM	First Line Managers
HIS	Healthcare Improvement Scotland
HMCIPS	HM Chief Inspector of Prisons for Scotland
HMIPS	HM Inspectorate of Prisons for Scotland
ICM	Integrated Case Management
MORS	Management of Offenders at Risk Due to Any Substance
SOP	Standard Operating Procedure
SPS	Scottish Prison Service
TTM	Talk to Me – SPS Suicide Prevention Strategy