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HMIPS
HM Inspectorate of Prisons for Scotland
INSPECTING AND MONITORING

NEWS RELEASE

HM Inspectorate of Prisons for Scotland publishes inspection report on HMP & YOI Polmont following Fatal Accident Inquiry determination

Date: 23 March 2026

HM Inspectorate of Prisons for Scotland (HMIPS), working jointly with Healthcare Improvement Scotland (HIS), has today published an inspection report on HMP & YOI Polmont. The inspection was commissioned by the Cabinet Secretary for Justice and Home Affairs following Sheriff Collins' Fatal Accident Inquiry (FAI) into the tragic deaths of Katie Allan and William Lindsay (or Brown) in 2018.

The inspection, carried out in August 2025, examined the progress made by the Scottish Prison Service (SPS) and NHS Forth Valley in implementing the FAI recommendations, with a particular focus on the safety of young men aged 18–23 held in Polmont.

Key Findings

Progress on FAI Recommendations
Inspectors found evidence that Polmont had taken action to implement the recommendations within its direct control and had engaged constructively with national SPS workstreams on issues requiring central action, such as piloting "signs of life" in-cell monitoring technology and reviewing ligature risks.

72-Hour "Talk to Me" (TTM) Admission Protocol
The introduction of a mandatory 72-hour suicide-prevention protocol for all new young male admissions was operating effectively. Staff collaboration between SPS and NHS teams was good. Case conferences were of a good standard, and young people generally understood the process. However, the volume of observations and case conferences placed significant pressure on both operational and healthcare staff.

Challenges in Mental Health and Healthcare Provision
The inspection highlighted notable pressures within healthcare services. A growing and increasingly complex prisoner population has stretched the Mental Health Team. Routine mental health assessment waiting times exceeded targets. Continuity of care was affected by the inability to consistently allocate named nurses. Despite these pressures, inspectors found a committed team delivering responsive support, and good governance arrangements underpinning clinical practice.

Time Out of Cell and Purposeful Activity
A major concern was the limited time out of cell for some young men in Monro Hall, and the restricted availability of meaningful activity compared with adult men and women held in the same establishment. Some activities were routinely cancelled due to staffing pressures. Opportunities for work, education, and recreation were constrained. The report concludes that the lack of purposeful activity represents a risk to health, motivation, and social development.

Safety, Bullying and Violence
Positively, staff awareness and application of the SPS anti-bullying strategy "Think Twice" was better than in other establishments recently subjected to a full inspection. Mediation

work by the Community Safety Team had helped reduce tensions. However, with all young men now accommodated in a single hall, relocation options for vulnerable individuals were limited.

Support for Families
The prison had a clear process for families to raise concerns through a 24/7 phone line, and these concerns were acted on appropriately. However, due to staffing pressures induction sessions for prisoners and their families had not been running. Some young men had trouble accessing visits, particularly at family-friendly times due to sharing visit slots with adult men. Bonding visits were valued but weekday morning scheduling made them inaccessible for school-age children.

Environmental and Infrastructure Issues
The report highlights a lack of a dedicated care suite for young people in acute distress, and inadequacies in safer cells. Inspectors noted that design features used in admission cells to reduce risk, such as magnet-held toilet doors, had not been replicated in safer cells.

Overall Conclusions
HMIPS concluded that Polmont staff are committed, skilled, and working hard to support young people at risk of self-harm. Many improvements have been made in response to the FAI, including better documentation, stronger governance, and enhanced multi-agency working.

However, significant systemic pressures, including limited purposeful activity, staffing shortages, and delays in receiving crucial background information from external agencies, continue to create risks. The report calls for urgent national and local action, particularly in relation to meaningful daily structure, increased healthcare team capacity, and the creation of safer, more therapeutic environments for vulnerable young people.

Quote
Sara Snell, HM Chief Inspector of Prisons for Scotland, said:
"While the prison has worked hard to implement the recommendations of the Fatal Accident Inquiry, and we saw dedicated staff delivering high-quality case conferences and working in collaboration, young men in Polmont continue to spend far too long locked in their cells with too few opportunities to develop skills, build confidence, and maintain positive mental health. Improving outcomes for these young men requires sustained, cross-agency commitment and the right resources in the right places."

Notes for editors
- The full report is available at: **www.prisonsinspectoratescotland.gov.uk**
- HMIPS is an independent scrutiny body with a statutory duty to inspect and monitor the treatment and conditions of people in Scotland's prisons.
- For further information please contact Kerry Love at Kerry.Love@gov.scot or on 07939 980452.

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