010

cc Questions
MEA

SECRETARY OF STATE FOR SCOTLAND

SCOTTISH OFFICE
WHITEHALL, LONDON S.W.1

Tim Flesher Esq
Private Secretary
10 Downing Street
LONDON

MEA

23 July 1985

I have suggested to the LPS that they might suggest two is too long for a day with 3 statements

Dear Tim

CHISWICK REPORT

I attach a draft of the statement which my Secretary of State intends making tomorrow afternoon about the report of the Working Group on Suicide Precautions at Glenochil Young Offenders Institution and Detention Centre and would be grateful for your clearance.

I am sending copies of this letter to David Morris (Lord Privy Seal's office), Murdo Maclean (Chief Whip's Office), Richard Hatfield (Cabinet Office), Joan McNaughton (Lord President's Office), Hugh Taylor (Home Office), David Beamsih (Lord Chief Whips Office) and Bernard Ingham.

Yours

Andy Rinning

ANDY RINNING
Private Secretary

B.R.

STATEMENT BY THE SECRETARY OF STATE FOR SCOTLAND

WEDNESDAY 24 JULY 1985
HOUSE OF COMMONS

CHISWICK REPORT

WITH PERMISSION, MR SPEAKER, I SHOULD LIKE TO MAKE A STATEMENT ON THE REPORT OF THE WORKING GROUP ON SUICIDE PRECAUTIONS AT GLENOCHIL YOUNG OFFENDERS INSTITUTION AND DETENTION CENTRE WHICH IS PUBLISHED TODAY.

COPIES HAVE BEEN PLACED IN THE VOTE OFFICE AND IN THE LIBRARIES OF BOTH HOUSES. I HAVE ALSO LAID COPIES OF THE DETERMINATIONS OF THE SHERIFF PRINCIPAL IN THE CASES OF ANGUS BOYD AND DEREK HARRIS.

IN NOVEMBER 1984, FOLLOWING A RECOMMENDATION BY THE SHERIFF PRINCIPAL, AFTER A FATAL ACCIDENT INQUIRY, I SET UP AN INDEPENDENT WORKING GROUP UNDER THE CHAIRMANSHIP OF DR DEREK CHISWICK, CONSULTANT PSYCHIATRIST AT THE ROYAL EDINBURGH HOSPITAL, WITH THE FOLLOWING REMIT:-

> "TO REVIEW THE PRECAUTIONARY PROCEDURES ADOPTED AT GLENOCHIL YOUNG OFFENDERS INSTITUTION AND GLENOCHIL DETENTION CENTRE TO IDENTIFY AND SUPERVISE INMATES WHO MIGHT BE REGARDED AS SUICIDE RISKS; AND TO MAKE RECOMMENDATIONS."

I ASKED DR CHISWICK AND HIS COLLEAGUES TO EXPEDITE THE REPORT AND I AM MOST GRATEFUL TO THEM FOR COMPLETING THEIR WORK BY THE END OF JUNE.

THIS IS AN IMPORTANT REPORT ON A SUBJECT WHICH HAS GENERATED A GOOD DEAL OF UNDERSTANDABLE PUBLIC CONCERN. IT MAKES A CONSIDERABLE NUMBER OF RECOMMENDATIONS, THE MAJORITY OF WHICH

I AM READY TO ACCEPT, ALTHOUGH SOME WILL REQUIRE MORE DETAILED EXAMINATION. THERE ARE HOWEVER A NUMBER OF RECOMMENDATIONS WHICH I CANNOT ACCEPT. AS I CANNOT IN THE TIME AVAILABLE TODAY GIVE A DETAILED RESPONSE TO ALL THE RECOMMENDATIONS, I HAVE LAID WITH THE REPORT A PAPER WHICH SETS OUT MY INITIAL RESPONSE TO IT.

I WOULD REMIND THE HOUSE THAT PROCEDURES TO IDENTIFY AND CARE FOR VULNERABLE AND INADEQUATE OFFENDERS, WHO MAY HAVE GENUINELY SUICIDAL TENDENCIES, MUST BE A VITALLY IMPORTANT FEATURE OF ANY PENAL INSTITUTION. NEVERTHELESS THESE ARE A TINY MINORITY OF THE INMATES. WE MUST NOT LOSE SIGHT OF THE FACT THAT THE PRIMARY PURPOSE OF CUSTODY IS THE DEPRIVATION OF LIBERTY AS A PUNISHMENT. THE INMATES AT GLENOCHIL ARE THERE BECAUSE THEY HAVE OFFENDED AGAINST SOCIETY AND REQUIRE CUSTODIAL SENTENCES AND REHABILITATION. THEY INCLUDE MANY HARD AND BRUTAL OFFENDERS. ABOUT HALF OF THOSE IN THE YOUNG OFFENDERS INSTITUTION ARE SERVING SENTENCES OF BETWEEN 3 YEARS AND LIFE FOR PARTICULARLY SERIOUS OFFENCES. THE AUTHORITIES AT GLENOCHIL HAVE TO MANAGE THEIR CUSTODY AS WELL AS THAT OF A COMPARATIVELY SMALL NUMBER OF VULNERABLE YOUTHS.

I NOW WISH TO REFER TO SOME OF THE DETAILED POINTS MADE IN THE REPORT. THE REPORT'S BROAD CONCLUSIONS ARE - I AM PLEASED TO NOTE - IN ACCORD WITH THE RECENT FINDING BY THE SHERIFF PRINCIPAL, WHO CONDUCTED THE FATAL ACCIDENT INQUIRY INTO THE DEATH IN APRIL OF DEREK HARRIS, THAT THERE IS NO EVIDENCE THAT THE REGIMES OPERATED AT GLENOCHIL OR THE ACTIONS OF STAFF WERE RESPONSIBLE FOR ANY OF THE 7 DEATHS WHICH HAVE TAKEN PLACE SINCE 1981: ONLY 3 OF THE 7 DEATHS WERE DETERMINED AS DELIBERATE SUICIDES. IN SUBMITTING THE REPORT DR CHISWICK STATES THAT THE WORKING GROUP HAD BEEN IMPRESSED BY THE DEDICATION OF THE GOVERNOR AND HIS STAFF AND THAT THE RECOMMENDATIONS MADE IN THE REPORT IMPLY NO CRITICISM OF THE STAFF AT GLENOCHIL.

THE WORKING GROUP ACKNOWLEDGE THAT, NO MATTER WHAT STEPS MAY BE TAKEN TO PREVENT SUICIDES, THERE IS NO GUARANTEE THAT THESE MEASURES WILL BE SUCCESSFUL. THEY CONSIDER THAT THE AIM SHOULD BE TO ACHIEVE A PROPER BALANCE BETWEEN PROCEDURES THAT REDUCE RISK TO A MINIMUM AND YET ARE COMPATIBLE WITH AN ACCEPTABLE WAY OF LIFE IN A PENAL ESTABLISHMENT.

THE REPORT SAYS THAT, IN RELATION TO THE YOUNG OFFENDERS INSTITUTION, WHERE ALL BUT 2 OF THE DEATHS HAVE OCCURRED, THE MAJORITY OF INMATES SERVE THEIR SENTENCES IN A PURPOSEFUL MANNER AND THAT THE PROBLEMS ARE ATTRIBUTABLE LARGELY TO A FEW INMATES WHO BEHAVE AGGRESSIVELY TOWARDS THEIR FELLOWS. SUCH AGGRESSION IS IMPOSSIBLE TO PREVENT, WITHOUT STOPPING ALL ASSOCIATION AMONGST YOUNG OFFENDERS WHO MOSTLY SERVE THEIR SENTENCES WITHOUT DIFFICULTY AND CO-OPERATE WITH STAFF.

THE WORKING GROUP CRITICISE THE PROCEDURES WHEREBY INMATES THOUGHT TO BE SUICIDE RISKS ARE KEPT IN WHAT IS KNOWN AS STRICT SUICIDE OBSERVATION FOR LENGTHY PERIODS. I SHOULD REMIND THE HOUSE THAT THESE PROCEDURES HAVE BEEN IN USE THROUGHOUT THE BRITISH PENAL SYSTEM FOR MANY YEARS. THESE PROCEDURES INVOLVE OBSERVATION BEING MAINTAINED ON AN INMATE IN A CELL AT 15 MINUTE INTERVALS, DAY AND NIGHT. ALL CLOTHING, BEDDING AND FURNITURE WHICH COULD BE USED TO CAUSE SELF-INJURY MAY BE REPLACED WITH CLOTHING AND BEDDING OF CANVAS AND WITH CARDBOARD FURNITURE. NO ONE LIKES USING THESE MEASURES BUT IN GLENOCHIL THEY HAVE BEEN EFFECTIVE TO THE EXTENT THAT NO IMNATE AT GLENOCHIL HAS COMMITTED SUICIDE WHILE UNDER STRICT OBSERVATION. INDEED THE 2 MOST RECENT DEATHS AT GLENOCHIL OCCURRED AFTER THE INMATES WERE REMOVED FROM STRICT SUICIDE OBSERVATION AND IN THE CASE OF ANGUS BOYD THE SHERIFF PRINCIPAL COMMENTED THAT DEATH MIGHT HAVE BEEN AVOIDED, IF HE HAD NOT BEEN REMOVED FROM STRICT SUICIDE OBSERVATION. THIS ILLUSTRATES HOW DELICATE AND COMPLEX IS THE QUESTION OF CARING FOR THESE UNFORTUNATE INDIVIDUALS. NONETHELESS I ACCEPT THAT THE USE OF THESE PRECAUTIONS FOR OTHER THAN VERY SHORT PERIODS IS UNDESIRABLE IN RELATION TO YOUNG OFFENDERS.

THE WORKING GROUP OFFER ADVICE ON IDENTIFYING POSSIBLE SUICIDE RISKS AND MAKE A NUMBER OF RECOMMENDATIONS AS TO HOW THOSE INMATES WHO ARE MENTALLY DISTURBED OR WHO ARE VULNERABLE IN SOME OTHER WAY MIGHT BE MANAGED. I WHOLEHEARTEDLY ACCEPT THE IMPORTANT RECOMMENDATION OF USING A TEAM APPROACH INVOLVING ALL THE PROFESSIONALS AND PRISON STAFF TO COUNSEL INMATES AND TO MINIMISE THE RISKS OF SUICIDE. THIS IS THE GENERAL DIRECTION IN WHICH WE INTEND TO GO IN THE FOLLOW-UP TO THE REPORT. INDEED, SOME OF THE RECOMMENDATIONS IN THE REPORT HAVE ALREADY BEEN MET IN WHOLE OR IN PART BY MEASURES TAKEN SINCE THE DEATH OF DEREK HARRIS IN APRIL. WORK HAS NOW BEEN COMPLETED ON A SECURE HOSPITAL FACILITY AT GLENOCHIL, CONSISTING OF A WARD, AND A SINGLE CELL, SO THAT STRICT MEDICAL OBSERVATION CAN BE PROVIDED IN APPROPRIATE CASES. IN ADDITION, IMMATURE AND VULNERABLE INMATES REQUIRING A MORE CLOSELY SUPERVISED SUPPORTIVE REGIME ARE NOW HOUSED IN 'D' HALL OF THE YOUNG OFFENDERS INSTITUTION OR TRANSFERRED TO CARRICK HOUSE AT POLMONT YOUNG OFFENDERS INSTITUTION.

A NUMBER OF THE RECOMMENDATIONS HAVE STAFFING AND RESOURCE IMPLICATIONS AND WILL REQUIRE CAREFUL CONSIDERATION. THERE WILL ALSO HAVE TO BE CONSULTATION WITH THE STAFF ASSOCIATIONS AND OTHER INTERESTED BODIES. OTHERS CREATE PROBLEMS OF ADAPTING EXISTING STRUCTURES. RECOMMENDATIONS OF THIS LONGER-TERM KIND WILL NEED TO BE EXAMINED VERY CAREFULLY SO THAT THE CUSTODY AND CARE OF INMATES IS NOT PUT AT RISK IN THE SHORT-TERM.

IN A NUMBER OF RESPECTS THE WORKING GROUP HAVE GONE BEYOND THAT REMIT AND DISCUSSED ISSUES AFFECTING THE OVERALL MANAGEMENT OF ESTABLISHMENTS AND THE PRISON SERVICE AS A WHOLE WHICH, AS A SMALL SPECIFICALLY QUALIFIED GROUP, THEY WERE NOT CONSTITUTED TO COMMENT ON. A MINORITY OF THE WORKING GROUP FELT THAT, SUCH WAS THE AURA OF SUICIDE PERMEATING GLENOCHIL, THE ONLY SOLUTION LAY IN ITS TEMPORARY CLOSURE. I CONCUR WITH THE VIEW OF THE MAJORITY WHO REJECTED THAT IDEA.

E.R.

I TRUST THAT THE WORKING GROUP'S FINDINGS, TAKEN TOGETHER WITH THE DETERMINATIONS OF SHERIFF PRINCIPAL TAYLOR, WILL BE ACCEPTED BY HON MEMBERS AND BY THE GENERAL PUBLIC AS REFUTING ANY SUGGESTION THAT THE UNFORTUNATE DEATHS WHICH HAVE TAKEN PLACE AT GLENOCHIL ARE ATTRIBUTABLE TO THE REGIMES, PARTICULARLY THAT OF THE DETENTION CENTRE, OR THE BEHAVIOUR OF STAFF. THERE IS NOT A SHRED OF EVIDENCE TO SUPPORT THESE ALLEGATIONS.

MY HOPE NOW IS THAT THE GOVERNOR AND STAFF OF GLENOCHIL WILL BE LEFT TO GET ON WITH THEIR DIFFICULT AND DEMANDING TASK AND THAT THE INSTITUTION WILL BE AFFORDED AN OPPORTUNITY TO SETTLE DOWN AFTER RECENT EVENTS, AND TO MAKE THE USEFUL CHANGES WHICH I HAVE ACCEPTED FROM THE RECOMMENDATIONS IN THIS REPORT.