SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2022] SC GLW 16

GLW-PD554/17

JUDGMENT OF SHERIFF S REID

in the cause

ALEXANDER GEMMELL

Pursuer

against

THE SCOTTISH MINISTERS

Defenders

Pursuer: Mr A Gillies; BTO Solicitors LLP, Glasgow
Defender: Mr R Fairweather; Anderson Strathern LLP, Edinburgh

GLASGOW, 22 November 2021

The sheriff, having resumed consideration of the cause, Sustains the defenders' objection to the pursuer's line of questioning and the eliciting of evidence anent Prison Officer Lucy Ridgeway allegedly shouting at the prisoner, DD, prior to and/or during the intervention of prison officers Alexander Gemmell and Stuart Walker in the incident on 7 December 2014 in the High Dependency Unit within HMP Barlinnie, Glasgow referred to on Record; Excludes said evidence from probation; thereafter, MAKES the following findings-in-fact:

(1) HMP Barlinnie, 81 Lee Avenue, Glasgow is a prison is operated by the defenders.

(2) The prison consists of five main Halls; each Hall accommodates 200 to 300 prisoners; D-Hall accommodates approximately 250 prisoners; D-Hall is itself split into four units: D-Hall North Lower, D-Hall South Lower, D-Hall North Upper and D-Hall South

Upper; D-Hall North Lower is also known as the Admissions Unit; D-Hall South Lower is also known as the High Dependency Unit ("HDU").

(3) The HDU accommodates approximately 50 to 55 prisoners; it is smaller and quieter unit than a mainstream hall and accommodates vulnerable prisoners, including those with mental health problems and learnings difficulties;

(4) Prisoners with mental health problems can also be accommodated in other Halls within the prison.

(5) The pursuer has been employed by the defenders as a prison officer since 1991 and has worked at HMP Barlinnie since 2001; Stuart Walker ("Mr Walker") has been employed by the defenders as a prison officer since around 1993; Lucy Ridgeway ("Ms Ridgeway") has been employed by the defenders as a prison officer since 2006.

(6) On 7 December 2014, the pursuer, Mr Walker and Ms Ridgeway were all working as prison officers at HMP Barlinnie in the course of their employment with the defenders: the pursuer was working in the Admissions Unit, where he was based, although he had had prior experience of working in the adjacent HDU; Mr Walker was also based in the Admissions Unit, but on 7 December 2014 he was working his first shift in the HDU; Ms Ridgeway was working in the HDU where she had been based since January 2012.

(7) The HDU was busy with approximately 40 prisoners moving around in the vicinity: the cells were unlocked, some prisoners were going for breakfast, some were accessing shower facilities, some were receiving medication, some were leaving the HDU to attend church in another section of the prison.

(8) In order to attend church, prisoners were aware that they required to intimate to a prison officer in advance their intention to attend church in order that the prisoner's name could be put down on a list of permitted attendees ("the church list").

(9) Ms Ridgeway was supervising prisoners leaving the HDU to attend church that morning; she had possession of a copy of the church list; she was also keeping an eye on the medication area in the corridor between the Admissions Unit and the HDU.

(10) A prisoner called DD ("DD" or "the prisoner"), whose cell was located on the upper level of the HDU, had left his cell, descended a flight of stairs to the lower level of the HDU, and attempted to walk past Ms Ridgeway in order to leave the HDU to attend church elsewhere in the prison.

(11) DD's presentation was agitated and dishevelled; he was still brushing his teeth; his t-shirt was inside out and back to front; he had toothpaste all over himself; and his jeans were dirty.

(12) Ms Ridgeway asked DD where he was going; he stated he was going to church; DD had not intimated in advance his intention to attend church that morning; his name was not on the church list; moreover, because of DD's agitated and dishevelled presentation, Ms Ridgeway was concerned that, if she allowed DD to attend church, there was a risk that he might become involved in a disorderly incident at church with other prisoners; having particular regard to DD's dishevelled presentation and agitated demeanour, and to the fact that his name did not feature on the church list, Ms Ridgeway told DD that she could not allow him to leave the HDU to attend church.

(13) DD was displeased that Ms Ridgeway would not allow him to leave the HDU to attend church; he mumbled incoherently in a raised voice while still brushing his teeth; he then threw his toothbrush into a bin and rinsed his face in a nearby sink; he turned his t-shirt around, but it was still inside out; Ms Ridgeway re-iterated that she could not allow him to attend church; DD became irate and began to raise his voice at Ms Ridgeway; Ms Ridgeway asked him to return to his cell; DD became threatening

and abusive towards Ms Ridgeway; he said "Fuck you, I can go where I want"; he told Ms Ridgeway that she couldn't tell him what to do; he advanced towards Ms Ridgeway; she stepped back to maintain space between herself and DD; he continued to shout threatening and abusive comments at her, and began to flail his arms around.

(14) At this point in time, Ms Ridgeway was the only officer in the HDU.

(15) In accordance with her training, Ms Ridgeway did not mirror the prisoner's loud and aggressive behaviour; she remained calm; she did not shout back at him; she maintained eye contact and kept her hands low to indicate that she was not a threat to him; she asked DD to return to his cell, and said she would come and speak to him there; she spent around three minutes trying to persuade DD to return to his cell, during which time DD failed to comply with her instructions.

(16) Mr Walker, who had been supervising prisoners at the medication hatch, became aware of the situation between DD and Ms Ridgeway; DD had received his medication earlier that morning, and Mr Walker had observed him acting bizarrely; Mr Walker called through to the Admissions Unit and summoned the assistance of the pursuer; Mr Walker closed the medication hatch and returned the prisoners into the HDU; the pursuer left his post in the Admissions Unit; Mr Walker and the pursuer appeared in the HDU in order to assist Ms Ridgeway with DD.

(17) Ms Ridgeway then provided Mr Walker and the pursuer with a brief synopsis of what had happened; the pursuer and Mr Walker asked DD to return to his cell; neither the pursuer nor Mr Walker used raised voices; DD refused to comply; he refused to return to his cell; the pursuer and Mr Walker began guiding or "coaxing" him towards the staircase which led to the upper level of the HDU where DD's cell was located; the pursuer and Mr Walker did not place their hands on DD at this point; DD began

moving in the direction of the stairs, but continued to shout and flail his arms; he was encroaching upon the personal space of the pursuer and Mr Walker; DD was behaving "erratically" as he moved; he kept stopping; Mr Walker and the pursuer spent approximately 5 minutes coaxing DD to the bottom of the stairs located about 12 to 15 feet away.

(18) The stairs to the upper level of HDU consist of a set of eight steps, then a small landing, and then a further eight steps.

(19) As the pursuer and Mr Walker approached the bottom of the stairs they placed the prisoner in "come along" holds, based on their dynamic assessment of the risk that they then observed, having regard to the prisoner's presentation and aggressive behaviour, the fact that a number of other prisoners were in the vicinity, and to the fact that they were now seeking to negotiate a staircase.

(20) The pursuer and Mr Walker guided the prisoner up the stairs in "come along" holds; Ms Ridgeway followed behind them, but did not put her hands on DD; DD initially complied with the escort in "come along" holds; the pursuer and Mr Walker continued to talk to DD to re-assure him; they continued in dialogue with him and continued to try to de-escalate the situation.

(21) As they reached the middle landing, DD tensed up; he began to resist the restraint; DD placed his feet on one of the steps and pushed back against the pursuer and Mr Walker; DD's arm broke free from Mr Walker; DD swung round and punched Ms Ridgeway in the face with his free arm; Ms Ridgeway's glasses were knocked off; the pursuer, Mr Walker and Mr Ridgeway gained control over the prisoner and managed to get him to the top of the stairs on the upper level of the HDU; the three officers then restrained the prisoner on the floor using C&R techniques; a staff alarm

was activated and other officers quickly arrived and assisted with the restraint; DD became tired; he was fully restrained within a minute of initially lashing out.

(22) DD was subsequently assessed by a member of NHS healthcare staff; he was able freely to communicate; he did not appear to be distressed; he had sustained a little scratch to his lower right eyelid for which no treatment was required.

(23) HMP Barlinnie contains a significant number of prisoners who are detained on the basis of violent offences; approximately 1 in 3 prisoners in the prison are detained on the basis of a violent offence; approximately half of the prison population has a history of violence.

(24) HMP Barlinnie also contains a significant number of prisoners who suffer from mental health issues.

(25) The defenders provide all prison officers with Personal Protective Training ("PPT") and Control & Restraint ("C&R") training.

(26) Training and assessment is carried out at the Scottish Prison Service ("SPS") College over a five day period when officers first commence their employment with the defenders; and the defenders then provide one full day of refresher training on an annual basis thereafter, during which each officer's training competencies are assessed.

(27) PPT and C&R training are intended to provide the defender's prison officers with the knowledge and understanding of when and how to use force to control prisoners.

(28) In the course of their training, prison officers employed by the defenders are taught the rules relating to the lawful use of force as set out in the Prisons & Young Offenders Institution (Scotland) Rules 2011 ("the 2011 Rules"), of which production 6/12 is a true copy.

(29) PPT is intended to provide the defenders' employees with the ability to identify so-called "pre-cues" relating to a prisoner's increasing levels of anger and anxiety; to provide skills and techniques to de-escalate situations involving aggressive and potentially violent prisoners; to provide self-defence techniques in the event that a situation cannot be safely de-escalated; these so-called "pre-cues" include shouting, clenched fists, flailing arms, certain facial expressions, and the closing of space between the prisoner and an officer; and the so-called "de-escalation techniques" include not "mirroring" the prisoner's behaviour, tone of voice or body language, remaining calm, not shouting back at a prisoner, adopting a non-threatening stance, using calming hand movements, and negotiating with the prisoner.

(30) C&R training is intended to provide the defenders' employees with skills and techniques safely to control, restrain and relocate an uncompliant or violent prisoner.

(31) C&R training includes training in the use of "come along holds" (also known as "loose locks"); this is a technique for controlling and relocating an uncompliant prisoner; it is the least physical form of restraint; it is designed to gain a level of control over the movement of an uncompliant prisoner; and it requires three prison officers: the first officer takes control of the prisoner's right elbow and right wrist; the second officer takes control of the prisoner's left elbow and left wrist; the third officer follows behind.

(32) In September 2011, the defenders conducted two assessments of the risks to which their employees were exposed while working in the course of their employment as prison officers in D-Hall: the first assessment identified the risk of dealing with violent prisoners; this first assessment was reviewed on 14 January 2015; the second assessment identified the risks associated with the removal of prisoners using C&R techniques; this second assessment was also reviewed on 14 January 2015; the outcome of the two

reviews was that the defenders concluded that the risks presented to prison officers arising from their dealings with violent prisoners were adequately addressed by existing PPT and C&R training; and productions 6/10 & 6/11 are true copies of those first and second risk assessments.

(33) As at 7 December 2014, the pursuer, Mr Walker and Mr Ridgeway had all received PPT and C&R training; as at 7 December 2014, they were all assessed as competent in PPT and C&R techniques; the pursuer had received refresher training on 9 January 2014; Mr Walker received refresher training on 20 March 2014; Ms Ridgeway received refresher training on 25 September 2014; and productions 6/2, 6/3 & 6/4 are true copies of their respective associated training records.

(34) In addition, Ms Ridgeway is a trained prison negotiator for the defenders; she has been receiving training from the defenders as a prison negotiator since 2011; in her capacity as such a negotiator, she has been, and is still, called upon to attend incidents throughout the prison where potentially violent situations require to be de-escalated.

(35) The defenders provide prison officers with very little specific mental health awareness training; such training has never been made compulsory for all prison officers in either Scotland or in England and Wales; and such limited training as is provided in Scotland's prisons is consistent with the approach taken by HM Prison Service in England and Wales.

(36) In November 2011, legal responsibility for the provision of healthcare (including mental healthcare) to prisoners in Scottish prisons was transferred from the defenders to the National Health Service in Scotland ("NHS").

(37) Since November 2011, NHS Greater Glasgow & Clyde Health Board has been responsible for delivering healthcare to prisoners detained in HMP Barlinnie.

(38) Since November 2011, NHS healthcare staff have been based permanently within the prison and provide healthcare to prisoners on a daily basis; in addition, psychiatrists employed by NHS Greater Glasgow and Clyde Health Board visit the prison twice a week to provide psychiatric assessments of prisoners and these assessments are shared with NHS healthcare staff within the prison.

(39) Since November 2011, the medical records of prisoners have been held by the NHS, either in paper format or on the NHS's electronic system called "Vision".

(40) Only NHS employees have access to prisoners' medical records.

(41) Neither the defenders nor prison officers employed by the defenders have access to prisoners' medical records.

(42) The medical records of prisoners are protected by patient confidentiality.

(43) The defenders operate a separate electronic database known as "PR2" which contains records on every prisoner detained in custody within *inter alia* HMP Barlinnie.

(44) PR2 has various sections, including a section entitled "Incidents and Intelligence" and a section entitled "Risks and Conditions" pertaining to each prisoner within the defenders' care.

(45) Access to the Incidents and Intelligence section of PR2 is restricted to first-line managers and more senior employees within the prison;

(46) DD was remanded into custody at HMP Barlinnie on 22 October 2014.

(47) Between 30 October 2014 and 1 December 2014, DD had been involved in five incidents involving varying degrees of violence and disorder within the prison; these five incidents were logged in the "Incidents & Intelligence" section of the defenders' PR2 computer system pertaining to DD; but neither the pursuer, nor Mr Walker or

Ms Ridgeway, had access to, or knowledge of, these five incidents, as none of these prison officers was of sufficient seniority to entitle them to access that section of PR2.

(48) Occasionally, incidents occurring within the HDU or another Hall within the prison would become known to prison officers within that Hall or within the prison generally, either through discussions during shift change-overs, or from a Hall diary where certain incidents were recorded, or otherwise, but such dissemination of information was not uniform, systemic or formalised.

(49) The five incidents involving DD as recorded on the defenders' PR2 system were as follows: (i) on 30 October 2014, DD's cell was unlocked so that he could have a shower before attending court; he began throwing punches at a male prison officer; DD was restrained using approved C&R techniques and was relocated to B-Hall; DD was uninjured; the prison officer involved received minor cuts to his hands and his right knee; and, following this incident, DD was referred to the NHS's mental health team; (ii) on 7 November 2014, while located in HDU, DD smashed his TV set; prison officers attended his cell; as they were leaving, DD lunged at one of the officers; he was restrained using approved C&R techniques; no prison officers were injured; (iii) on 7 November 2014, while accommodated in B-Hall, DD required to be restrained as prison officers attempted to change him into anti-ligature clothing; the wearing of anti-ligature clothing was a condition of his management under the defenders' suicide prevention policy; no prison officers were injured; (iv) on 9 November 2014, while accommodated in HDU, DD repeatedly punched another prisoner; prison officers intervened; no injuries were suffered by the prisoners or the prison officers; (v) on 1 December 2014, while in the exercise yard of D-Hall, DD was arguing with another prisoner; prison officers intervened and attempted to return him to his cell; DD failed to

comply, walked away and sat in the corner of the yard; after five minutes, he complied and returned to the hall.

(50) In addition, prior to 7 December 2014, DD had exposed himself to Ms Ridgeway and other female staff within the prison; Ms Ridgeway had reported this behaviour to her line manager (Mr Findlay Laird); and on 29 November 2014, Mr Laird had applied a note or "marker" to DD's profile within the defender's PR2 system (under the heading "Risk and Conditions") which read as follows:

> "DD has been exposing himself to female staff. He has been warned about this behaviour but continues. He attempts to get female staff to his cell door and exposes himself. In light of his behaviour all staff to be aware and restrict female interaction with DD. F Laird, 29/11/14."

(51) Prior to the incident on 7 December 2014, the prisoner had never behaved in a violent manner towards Ms Ridgeway herself or towards any other member of female staff within HMP Barlinnie.

(52) Prior to 7 December 2014, multi-disciplinary mental health team (MDMHT) meetings took place in the prison on a weekly basis; these meetings were typically attended by an officer from each Hall, as well as by NHS healthcare staff; the purpose of these meetings was to discuss certain prisoners who had been referred to the NHS's mental health team; patient confidentiality meant there was a limit to the information that the NHS staff were able to provide to the defenders' employees who attended the MDMHT meetings; the NHS would only disclose to the defenders' employees at the meeting certain details about a prisoner's condition, diagnosis and treatment where that prisoner had provided consent for such disclosure; and brief minutes of the meetings were kept by the NHS.

(53) Mr Walker and Ms Ridgeway had experience of attending such meetings.

(54) At three separate MDMHT meetings, prior to 7 December 2014, DD was briefly discussed, together with a number of other prisoners.

(55) The first such MDMHT meeting took place on 30 October 2014 while DD was accommodated on C-Hall; the minutes from the meeting contain the following entry in relation to DD:

> "Remains on caseload, assessed by psychiatrist, history of bi-polar disorder, appeared manic during interview at times was overfamiliar. Known to services in community however defaulted. Now recommenced on medication and remains on caseload."

(56) The second such MDMHT meeting took place on 6 November 2014 while DD was accommodated on C-Hall; the minutes from the meeting contain the following entry in relation to DD:

> "Seen by psychiatrist. Slight improvement in mental state. Medication increased. Diagnosed bipolar disorder. Chaotic drug and alcohol in the community. Now responding to treatment. Remains on caseload. Hall staff stated he can have his own clothes, attended Rec Thursday."

(57) The third such MDMHT meeting took place on 4 December 2014 while DD was accommodated in the HDU; Ms Ridgeway was present at that meeting; the minutes from that meeting contain the following entry in relation to DD:

> "Due to be transferred to hospital when next bed becomes available. This could be within the next two weeks. L Ridgeway, D Hall, raised that [DD] has issues with female staff."

(58) Prior to 7 December 2014, forensic psychiatrists employed by NHS Greater Glasgow & Clyde Health Board, visited HMP Barlinnie twice a week.

(59) During such visits, since the date of his remand on 22 October 2014, DD had been assessed by forensic psychiatrists on a number of occasions.

(60) Neither the defenders, nor the defenders' employees, had knowledge of the content or conclusions of any such psychiatric assessments.

(61) In any event, in none of these psychiatric assessments was it disclosed or concluded that DD posed any material risk of violence to prison staff or to fellow prisoners.

(62) Prior to the incident on 7 December 2014, Ms Ridgeway was aware that DD had some form of mental health issue or issues, but she did not know of any specific mental health diagnosis affecting him; she was aware that he had "up and down episodes"; she was aware he had been involved in violent and disorderly conduct; she was aware he had been involved in fights; she was aware that he would generally respond to her in a compliant manner; she was aware that he tended to engage less positively with male prison officers; but, overall, she had a good relationship with him.

(63) It is not, and as at 7 December 2014 it was not, ordinary practice in prisons within Scotland or in the United Kingdom for all prison officers within a prison to have access to information of the kind recorded within the "Incidents and Intelligence" section of PR2.

MAKES the following findings-in-fact and in-law:

(1) As at 7 December 2014, the defenders, as employer of the pursuer, discharged the common law duties of care that were then owed by them to the pursuer.

(2) It was not the duty of the defenders at common law to procure that their prison officers avoid physical contact with DD during the incident that occurred within the HDU on 7 December 2014.

(3) It was not the duty of the defenders at common law to put in place arrangements to prevent contact between Ms Ridgeway and DD prior to or during the incident that occurred within the HDU on 7 December 2014.

(4) It was not the duty of the defenders at common law to disclose information to the pursuer and prison officers within HMP Barlinnie, on or prior to 7 December 2014, anent the prisoner's behavioural and psychiatric background.

(5) It was not the duty of the defenders to provide "mental health training" to the pursuer and prison officers within HMP Barlinnie on or prior to 7 December 2014.

(6) *Esto* said duties were incumbent upon the defenders (which is denied), the breach of any such duties did not cause the pursuer to suffer the loss, injury or damage sought by him.

(7) It was not necessary, reasonable, proportionate or practicable for Ms Ridgeway *et separatim* all prison officers working in the HDU *et separatim* all prison officers who might, from time to time, be likely to work in the HDU *et separatim* the pursuer or Mr Walker *et separatim* all prison officers within HMP Barlinnie, to have access to or knowledge of the content of the "Incidents and Intelligence" section of PR2 pertaining to DD.

(8) Rule 91 of the Prisons and Young Offenders Institution (Scotland) Rules 2011 ("the 2011 Rules") sets out rules pertaining to the lawful use of force in prisons against prisoners;

(9) The pursuer, Officer Ridgeway and Officer Walker complied with the terms of Rule 91 of the 2011 Rules when dealing with DD during the incident that occurred within the HDU of HMP Barlinnie on 7 December 2014;

MAKES the following finding-in-law:

(1) The pursuer not having suffered loss, injury and damage through the fault or negligence of the defenders or those for whom the defenders are responsible, the defenders are entitled to be assoilzied;

THEREFORE, Grants decree of absolvitor in favour of the defenders, whereby, Assoilzies the defenders from the crave of the initial writ; Finds the pursuer liable to the defenders in the expenses of the cause to date, as taxed, so far as not already dealt with; Allows an account thereof to be given in and Remits the same, when lodged, to the auditor of court to tax and to report.

SHERIFF

NOTE:

Summary

[1] In this action, the pursuer seeks reparation for personal injuries allegedly sustained by him in the course of his employment with the defenders as a result of an incident in HMP Barlinnie on 7 December 2014.

[2] A proof restricted to the issue of liability was allowed some time ago. The proof lasted 10 days in total: initially from 9 to 11 December 2019, then on 13 December 2019, thereafter on 17 to 21 May 2021, and concluding with a hearing on closing submissions (detailed written submissions having been lodged in advance) on 31 August 2021. The significant interruption in the proof (between 2019 and 2021) was attributable to successive governmental lockdowns following the outbreak of the coronavirus pandemic.

[3] Having carefully considered the evidence and submissions, I have concluded that the pursuer's claim fails. I explain my reasoning below, which draws heavily on large parts of the defender's comprehensive written submissions with which I agreed.

[4] I wish to record my sincere thanks to both agents, Mr Gillies and Mr Fairweather, for the excellence of their advocacy. They elicited the evidence with great skill and tenacity, and their written and oral submissions were of the highest quality.

The evidence & submissions

[5] At the proof, I heard evidence from the pursuer himself, and from the following witnesses for the pursuer: Stuart Walker, John Patrick Findlay Laird, Dr Louise Ramsay, and Joanne Caffrey. For the defenders, I heard evidence from Lucy Ridgeway and Phillip Wheatley.

[6] The parties also lodged two joint minutes of admissions, the first dated 10 December 2019 and the second dated 26 May 2021.

[7] Following the close of the evidence, meticulous and extensive written submissions were lodged for both parties, supplemented by full oral submissions on 31 August 2021.

[8] I am acutely conscious that this action is now almost 4 years old. It relates to an incident that occurred almost 7 years ago. The proof was significantly interrupted by 18 months due to the pandemic. In those circumstances, to avoid further delay, and in the interests of brevity, I do not propose to repeat the extensive testimony heard by me over 9 days, or to seek to paraphrase the parties' meticulous submissions. Instead, I shall refer to the salient evidence and issues in my reasoning below.

Discussion

The nature of the pursuer's legal claim

[9] The pursuer's case is founded upon common law negligence. He alleges that the following specific duties were owed to him by the defenders in the exercise of reasonable care: (i) that the defenders ought to have taken reasonable steps to risk assess and minimise the danger presented by DD, to the pursuer and his colleagues; (ii) that the defenders ought not to have allowed for Ms Ridgeway to be left alone with DD; (iii) that the defenders ought to have provided to staff in the HDU, such as Ms Ridgeway, specific information about HDU prisoners, such as DD, concerning their particular psychiatric condition and tendencies, such as to allow for appropriate prisoner management and to minimise the dangers posed to staff (and the prisoner) by their condition; (iv) that the defenders ought to have provided sufficient training to officers within D Hall who were exposed to any prisoner who suffers from a psychiatric condition or mental health disorder, including prisoners within the HDU. I shall address each of these specific alleged duties in turn below.

[10] During the proof, the pursuer sought to introduce a line of evidence which, in my judgment, was not foreshadowed in the pleadings, specifically, that Ms Ridgeway had been shouting at DD prior to the incident. Timeous objection was taken on the ground that there was no adequate foundation on Record for this line, and because it appeared that this evidence was being elicited in order to seek to establish a separate ground of fault. The defenders' objection was renewed at the close of the evidence. I have sustained the objection for the reasons set out below (in para [29]).

The general common law duty of an employer

[11] An employer's general duty at common law is to take reasonable care to avoid acts and omissions which can foreseeably result in loss, injury or damage to its employees. The test of an employer's liability for common law negligence was stated by Swanwick J in *Stokes* v *Guest, Keen and Nettlefold (Bolts and Nuts) Ltd* [1968] 1 WLR 1776, 1783, as cited with approval by the Supreme Court in *Baker* v *Quantum Clothing Group Ltd* [2011] 1 WLR 1003:

> "[T]he overall test is still the conduct of the reasonable and prudent employer, taking positive thought for the safety of his workers in the light of what he knows or ought to know; where there is a recognised and general practice which has been followed for a substantial period in similar circumstances without mishap, he is entitled to follow it, unless in the light of common sense or newer knowledge it is clearly bad…He must weigh up the risk in terms of the likelihood of injury occurring and the potential consequences if it does; and he must balance against this the probable effectiveness of the precautions that can be taken to meet it and the expense and inconvenience they involve. If he is found to have fallen below the standard to be properly expected of a reasonable and prudent employer in these respects, he is negligent."

In this passage, Swanwick J was drawing a distinction between a recognised practice followed without mishap, and one which in the light of common sense or increased knowledge is clearly bad. The distinction is a valid one and sufficient for many cases, but the two categories are not exhaustive. Swanwick J's test was adopted and developed by Mustill J in *Thompson* v *Smiths Shiprepairers (North Shields) Ltd* [1984] QB 405, 415–416, also cited with approval in *Baker, supra*. A breach of duty may be said to consist of a failure to take precautions known to be available as a means of combating a known danger, but it may also arise where the omission involves an absence of initiative in seeking out knowledge of facts which are not in themselves obvious. As Mustill J observed:

> "Between the two extremes is a type of risk which is regarded at any given time (although not necessarily later) as an inescapable feature of the industry. The employer is not liable for the consequences of such risks, although subsequent changes in social awareness, or improvements in knowledge and technology, may transfer the risk into the category of those against which the employer can and

> should take care. It is unnecessary, and perhaps impossible, to give a comprehensive formula for identifying the line between the acceptable and the unacceptable. Nevertheless, the line does exist, and was clearly recognised in *Morris* v *West Hartlepool Steam Navigation Co Ltd* [1956] AC 552. The speeches in that case show, not that one employer is exonerated simply by proving that other employers are just as negligent, but that the standard of what is negligent is influenced, although not decisively, by the practice in the industry as a whole. In my judgment, this principle applies not only where the breach of duty is said to consist of a failure to take precautions known to be available as a means of combating a known danger, but also where the omission involves an absence of initiative in seeking out knowledge of facts which are not in themselves obvious. The employer must keep up to date, but the court must be slow to blame him for not ploughing a lone furrow."

[12] The upshot is that the question of whether an employer has discharged its common law duty of care to an employee requires a consideration of the nature, gravity and imminence of the risk and its consequences, as well as of the nature and proportionality of the steps by which it might be addressed, and a balancing of the one against the other. Respectable general practice is no more than a factor, having more or less weight according to the circumstances, which may, on any view at common law, guide the court when performing this balancing exercise (*Baker, supra*, para [82]).

Risk assessment

[13] The steps an employer is required to take to discharge its common law duty of reasonable care should be informed by a risk assessment. The purpose of a risk assessment is to identify whether a particular operation gives rise to any risk to safety and, if so, what is the extent of that risk, and what can and should be done to minimise or eradicate the risk.

[14] However, a failure to carry out a risk assessment can never be the direct cause of an injury. It can only be indirectly causative if it is shown that a hypothetical suitable and sufficient risk assessment would have resulted in a precaution being taken which would

probably have avoided the injury (*Uren* v *Corporate Leisure (UK) Ltd* [2011] EWCA Civ 66, per Smith LJ, paragraph 39).

The employer's common law duty to provide a safe place of work

[15] An employer is under a duty at common law to provide a safe place of work. However, the duty upon the employer is not to make the place of work absolutely safe so that no accident could possibly occur. Furthermore, the fact that a single person has suffered an injury is not, in and of itself, proof that the workplace was unsafe (*Baker, supra*, paragraphs 62-80).

The employer's common law duty to provide a safe system of work

[16] Systems by their very nature have to cover many eventualities. Consideration requires to be paid to the likely effectiveness of the particular steps in the system to deal with the danger that has arisen. In the absence of evidence that a system of work was failing to control the risk identified, there will be no duty on an employer to implement a more stringent system. By way of illustration, in *Delroy Thompson* v *Home Office* 2001 WL 172015, where a prisoner assaulted the claimant by slashing him with a razor blade, the claimant sought to argue that a more stringent system (in respect of the distribution of razor blades within the prison) ought to have been implemented. In dismissing the claimant's case on appeal, the Court of Appeal held that the defender was not under any duty to adopt a more stringent system in respect of the distribution of razor blades in circumstances where there was no evidence that the prison had a particularly bad problem with razor blade violence.

[17] Subject to the dicta referred to in *Baker, supra* (see para [12], above), this may be seen as an application of the law's approach generally to allegedly negligent "omissions".

Generally, an omission will not be deemed negligent unless it is shown that the omission was a thing commonly done by other persons in like circumstances, or it was so obviously wanted that it would be folly in anyone to neglect to provide it (*Morton* v *William Dixon Ltd* 1909 SC 807, 809). Thus, in *McKevitt* v *National Trust for Scotland* 2018 Rep LR 76, the sheriff stated (paragraphs 96-97):

> "… it does not do to show that something could have been done; rather it is necessary to show that it should have been done, in the exercise of reasonable care"

Information and training

[18] An employer has a duty to provide employees with sufficient information and training on the tasks they are expected to perform. However, for an alleged inadequacy in information or training to be of relevance, it must be possible to point to something which the employee did not know but which he would have known had he received adequate information and training, and which, had he known, would have prevented the accident (*Neil* v *East Ayrshire Council* 2005 Rep LR 18, paragraph 26, per Lord Brodie).

Assessment of witness testimony

[19] Four critical conclusions from the evidence are worth noting at the outset, because they form the fundamental basis of my decision.

[20] First, a huge amount of time was spent at proof analysing DD's NHS medical records. In particular, Dr Louise Ramsay, a forensic psychiatrist, was taken through DD's prison medical records and intra-NHS correspondence at great length. In my view, this exercise proved to be largely futile.

[21] These records were in the possession and control of the NHS; they were not in the possession or control of the Scottish Ministers or the Scottish Prison Service ("SPS"); neither

the defenders nor the SPS had knowledge of the content of these records; and it was not in the gift of the defenders to disclose the content of these medical records to prison officers employed by them, such as the pursuer.

[22] Besides, the medical records were confidential; the NHS was under a positive legal obligation not to disclose them to any third party (including SPS), except with the consent of DD, which consent was neither averred nor proved to have been granted.

[23] So, irrespective of the content of these records, and whether or not the NHS was aware of any specific mental health diagnosis affecting DD, it did not advance the pursuer's claim against the defenders one iota, because the defenders had neither possession nor control of these records, they had no (material) knowledge of the content of these records, they had no ability to disclose these records to their employees (such as the pursuer), and they no entitlement to demand disclosure of them to the pursuer or to any other prison officer within their employ.

[24] Second, in any event, none of these medical records (including the psychiatric assessments) disclosed that DD presented a material risk of violence to prison staff or to fellow prisoners. True, he suffered from mental ill-health; true he had a chaotic, drug-addicted lifestyle; but he presented as no greater a risk to the safety of the prison officers within Barlinnie than a large proportion of his fellow prisoners, approximately half of whom had a history of violence. In short, nothing in the medical records was of material significance to the risk faced by the defenders' prison officers.

[25] Third, a critical plank of the pursuer's case was founded upon the expert testimony of Joanne Caffrey. Ms Caffrey was a thoroughly engaging and impressive witness in her own field - but opinion evidence was sought to be elicited from her on matters which, in my respectful judgment, clearly fell outwith her area of expertise, given her total lack of prison

experience. Her background, experience and expertise was in police custody settings, which are not analogous to prison settings in many respects, including size, purpose, ethos, size and diversity of population, daily routines, physical layouts, management logistics or regulatory structure. The two are not comparable. Accordingly, she did not have the relevant expertise to offer reliable opinion evidence on the key issues in this case (Neil v *East Ayrshire Council* 2005 Rep L.R. 18, at paragraph 26.17, per Lord Brodie). For this reason, in my respectful opinion, large sections of her report were entirely irrelevant. She also relied upon irrelevant factors when forming her opinions, notably intra-NHS correspondence after the accident which, for the reasons explained in paras [21] to [23] above, are not pertinent to the issue. Accordingly, I attached little weight to Ms Caffrey's evidence.

[26] Fourth, in stark contrast, the testimony of the defenders' expert witness (Phillip Wheatley) was formidable. It was acutely pertinent, it had the attraction of irresistible logic, and it carried with it an authority and gravitas that derived from the witness's remarkable depth of experience in the operation of prisons, the management of prisoners, and the training of prison officers. Despite the commendable efforts of the pursuer's agent to challenge his testimony in cross-examination, this body of expert evidence was virtually unassailable. For these reasons, I preferred and accepted Mr Wheatley's expert testimony.

[27] Individually, and certainly cumulatively, these four conclusions effectively torpedoed the pursuer's case.

[28] For completeness, a fifth (albeit less significant) conclusion is worth recording at this juncture. There was really little disagreement between the non-expert witnesses on the factual circumstances surrounding the accident, aside from the issue to which objection was taken (see below) and a few inconsistencies in circumstantial embellishments. The pursuer

and his admirable professional colleagues struck me as being entirely honest, and all generally appeared to be making a genuine effort to give open and forthright recollections of events that had happened almost 7 years ago now. To the extent that there were, understandably perhaps, factual inconsistencies around the edges, I preferred the account of the defenders' witness, Lucy Ridgeway. Her account impressed me as being a more accurate and reliable recollection of events, and it was also more consistent with the contemporaneous documentation.

Objection to line of evidence

[29] During the proof, the pursuer sought to introduce a line of evidence to the effect that Ms Ridgeway had been shouting at DD prior to the intervention of officers Gemmell and Walker. Timeous objection was taken on the ground that there was no adequate foundation on Record for this line, and because it appeared that this evidence was being elicited in order to seek to establish a separate ground of fault. The defenders' objection was renewed at the close of the evidence.

[30] I have sustained the objection for the following reasons.

[31] It is a fundamental rule of pleading that a party is not entitled to establish a case against an opponent of which the other has not received fair notice upon Record. On any view, the pursuer's case on Record is one which seeks to establish *primary* liability against the defenders for *inter alia* purportedly failing to provide mental health training to officers who are required to deal with prisoners with mental health problems. The pursuer's case on Record is not founded upon *vicarious* liability.

[32] The Record contains the following averments by the pursuer:

> "At or around 10am the same day, the pursuer heard raised voices coming from the South Lower Unit of D-Hall…Whilst walking along said corridor, the pursuer observed a prisoner arguing with a colleague, Prison Officer Lucy Ridgeway."

In the course of the proof, an effort was made on behalf of the pursuer to elicit evidence to the effect that Ms Ridgeway was shouting at the prisoner, that this conduct was inappropriate, contrary to her training, and (so it seemed) that it was a potential cause of the action. The defenders objected to the line.

[33] I have sustained the defenders' objection for two reasons: first, because no fair notice is given on record for the proposition that Ms Ridgeway was actually shouting at the prisoner; and, second, because there is no adequate foundation on record for the use to which, it can be inferred, the pursuer proposes to apply such evidence, namely to support the contention that Ms Ridgeway's conduct was inappropriate, contrary to her training, causally connected in some sense with the pursuer's injury, and that the defenders are therefore vicariously liable for Ms Ridgeway's conduct. In any event, as a matter of fact, I have found that Ms Ridgeway was not shouting at the prisoner.

[34] To explain, firstly, the pursuer's averments do not give fair notice to the defenders that he was seeking to establish that Ms Ridgeway was shouting at the pursuer. The pursuer points to the averments in para [32], above, as providing a sufficient foundation for the line. I disagree. One passing reference, in a 40 page record, to "raised voices" in a Barlinnie prison hall, with no specification of whose voices were raised, provides no notice to the defenders that the pursuer was seeking to establish that it was Ms Ridgeway who was allegedly behaving inappropriately by shouting at DD. Accordingly, this is not a fact that the pursuer is entitled to prove. For that reason alone, the objection is sustained.

[35] Even if I am wrong to sustain the objection on that first basis, I have concluded, as a matter of fact, that Ms Ridgeway did not shout at the prisoner at all. The pursuer and Mr Walker both gave evidence to the effect that Ms Ridgeway was shouting at DD. However, Mr Walker conceded that the passage of time might have affected his memory. More significantly, there was absolutely no mention of this conduct in any of the post-accident statements that either the pursuer or Mr Walker provided shortly after the incident. Indeed, there was no mention of shouting or raised voices in any of the post-accident investigation paperwork. Such an omission, from broadly contemporaneous accounts, is significant, and tends to undermine the reliability of the testimony of the pursuer and Mr Walker to the contrary, so many years after the event. Instead, in my judgment, the most reliable and persuasive evidence on this discrete issue of fact was provided by Ms Ridgeway herself. She struck me as an impressive witness. It was clear from her testimony that she had significant experience of assisting people with mental health problems, through her previous job in the community, and through her 3 years working in the HDU. (Indeed, her experience in that regard was greater than that of the pursuer or Mr Walker.) She also had day-to-day experience of working with DD, with whom she had a good relationship. She had received PPT, which emphasised the importance of de-escalation. She was also a trained negotiator and was (and is) relied upon by the defenders themselves to de-escalate potentially violent situations throughout the prison. Ms Ridgeway was absolutely clear in examination-in-chief that she adopted a calm approach, kept her voice low, and did not "mirror" DD's behaviour. This was all part of her effort to de-escalate the situation. She stated in evidence:

> "I'm not a shouty person at all. I'm not one to raise my voice. I don't like conflict or engaging in conflict...I'm not a person who argues or raises my voice".

Though a minor point, this testimony did seem consistent with my observations of her general demeanour under examination, which was calm, measured, and considered.

[36] Secondly, and perhaps more crucially, it appeared to me, from the line of questioning, that the pursuer was indeed seeking to establish that Ms Ridgeway, in allegedly shouting at DD, was at fault in some sense by acting contrary to her training, and that this caused or contributed to the incident in some manner. This seemed to me to be quite separate and distinct from the claim as averred on Record, which is that the defenders had incurred a primary liability by allegedly failing to provide adequate training or disclosure of information. In other words, the pursuer was seeking to lay the foundation for a separate ground of claim based on vicarious liability, for which there was indubitably no foundation on record. The pursuer's agent pointed to the following averments in article 2 of condescendence as purportedly forming the basis of a vicarious liability case:

> "The defenders are the Scottish Ministers. They are sued as being responsible for the acts and omissions of the Scottish Prison Service and prison officers in Her Majesty's Scottish prisons".

In my judgment, these averments are insufficient to support a vicarious liability ground of action. They do not specify which prison officer(s) was at fault or why. Perhaps recognising the weakness of his position, in the course of addressing the objection, the pursuer's agent indicated to the court that there was actually no criticism of Ms Ridgeway. He stated:

> "It's not quite the fault of Officer Ridgeway - we say she hasn't received appropriate training."

That being so, the pursuer's claim reverts to one of direct or primary liability for allegedly not providing appropriate training to Ms Ridgeway (presumably in de-escalation, by not shouting or arguing with prisoners). If that is indeed the pursuer's claim, in my judgment it fails to get off the ground because there was no dispute that all the prison officers had

indeed received PPT, which addressed de-escalation skills and techniques. Ms Ridgeway expressly recounted that PPT taught officers not to "mirror" an aggressive prisoner's behaviour, tone of voice or body language; to remain calm; to not shout back at a prisoner; to adopt a non-threatening stance; and to use calming hand movements. None of this was disputed by the pursuer or challenged in cross-examination; and no other witness said anything to contradict the content of that training.

[37] For the foregoing reasons, I sustained the defenders' objection to this line of questioning and have excluded all such evidence.

The alleged duty to "risk assess"

[38] I shall now turn to examine the evidence in relation to each of the specific duties advanced and relied upon by the pursuer. In my view, the evidence does not support the existence of any of these alleged duties and/or their alleged breach.

[39] Firstly, the pursuer avers:

> "The defenders were aware of the prisoner's ongoing mental health problems. They ought to have taken reasonable steps to risk assess and minimise the danger presented by the particular prisoner to the pursuer and his colleagues".

The pursuer therefore seeks to establish that the prisoner posed a specific risk of violence to prison officers as a result of his mental health condition. In my judgment, this is not borne out by the evidence.

[40] Mr Wheatley testified that around 34% of prisoners will have been remanded into custody on the basis of a violent offence but that, taking into account previous offending, that figure could rise to as much as 50%. The pursuer and Mr Walker, both of whom had significant experience working in HMP Barlinnie, knew that the prison population consisted

of violent offenders. The pursuer conceded that he was "acutely aware" of the risk of violence.

[41] The pursuer sought to rely upon the content of the prisoner's Incidents and Intelligence record from PR2 as purportedly evidencing DD's propensity for violence. This record indicated that the only prior occasion on which the prisoner assaulted and injured a prison officer was on 30 October 2014. The officer in question sustained minor cuts to his hands and right knee. The only prior assault during his period of custody (between October and December 2014) occurred on 9 November 2014, 4 weeks before the incident. DD assaulted another prisoner and Hall staff required to intervene; no injuries were sustained by either of the prisoners or by the officers who intervened. The prisoner was not involved in any violent interactions with anyone for the month leading up to the incident on 7 December 2014. When cross-examined on the nature of DD's Incidents and Intelligence record, the responses from the pursuer, Mr Walker and Mr Laird, were significant. Each officer confirmed that, within a prison context, the nature and extent of the behaviour of DD, as shown within his Incidents and Intelligence log, was not at all untypical or unusual. Mr Walker agreed that there was nothing in the prisoner's records to suggest DD had a propensity for violence or that he was a specific risk to prison officers. The pursuer confirmed that the record did not stand out. Mr Laird described DD as "just a general prisoner". He stated that "most prisoners have a history of violence" and that it was not unusual for prisoner to behave violently at some point or other while in prison. He stated there was always a risk to prison officers but nothing in DD's case which was out of the ordinary. Despite stating in her report that DD represented a greater risk to prison officers because of his mental health problems, Ms Caffrey stated in cross-examination:

> "I've not said he is a greater risk than any other prisoner".

She ultimately conceded that she could not say that DD presented a greater risk of violence than any other prisoner.

[42] All this is reinforced by Mr Wheatley's Report (item 6/24 of process, paragraph 28). He also took the view that DD was not an unusual prisoner at all. His view was that DD's behaviour would be typical of a prisoner with drug issues in the early days of custody, adjusting to life on a big Hall (prior to his transfer to HDU), going through a period of detoxification and going back onto treatment. Having regard to the prisoner's Incidents and Intelligence log, and having regard to the prison population, Mr Wheatley stated that he would not have picked out DD as posing a specific risk to prison staff.

[43] As I mentioned above, much time was spent taking Dr Louise Ramsay through DD's prison medical records and correspondence that she had sent to the NHS healthcare team within Barlinnie. The records and letters contained details of DD's psychiatric background, condition, behaviours and treatment; and evidence was also led of minutes of MDMHT meetings at which DD was discussed. A few of the defenders' employees participated in these meetings. I have already explained why, ultimately, I concluded that this tranche of evidence was irrelevant (see paras [21] to [23], above). However, for present purposes, a critical issue to note is that nowhere in DD's medical records, or in the (intra-NHS) correspondence from Dr Ramsay to healthcare staff within the prison, or in the minutes of the MDMHT meetings, was there ever a suggestion that DD's mental health condition meant that he posed a specific or enhanced risk of violence towards prison officers.

[44] Dr Ramsay stated that, if she had a specific concern about a threat of violence, she would have reported this. But there was no evidence of any such concern - and there was no such report.

[45] In conclusion, contrary to the pursuer's assertion, in my judgment the evidence warrants the conclusion that this particular prisoner (DD) did *not* pose a specific risk of violence to prison officers, and certainly not to any materially greater degree than the vast bulk of prisoners detained within HMP Barlinnie.

[46] In any event, DD was the subject of continual assessment throughout his period in custody with the defenders. To the extent that his behaviour posed a risk to prison officers, the medical records (evidencing continuing assessment and review) support the conclusion that this risk was being managed and controlled appropriately. Specifically, it was precisely due to his mental health problems that the defenders took the decision to transfer DD to a cell in the HDU. The HDU was a more suitable environment for prisoners with mental health problems as it was much smaller and quieter than the other mainstream halls. There was a higher officer-to-prisoner ratio in the HDU than in the larger Halls, which meant that a greater level of time and support was available to prisoners there. No witness criticised the suitability of the HDU to accommodate such prisoners. Indeed, Mr Walker agreed that the HDU was a more appropriate place to accommodate prisoners with mental health problems rather than on a mainstream Hall. Mr Wheatley's view was that the HDU was a "good quality unit" and is a "better resourced facility than many other prisons are able to operate". It was also apparent from the PR2 "Incidents and Intelligence" record that it was the defenders who had referred DD to the prison's NHS mental health team in the first place. The medical records disclosed that he was in regular contact with the NHS mental health team throughout his custody, and that they were managing his psychiatric condition and treatment as best they could. A decision was ultimately taken by the NHS that he should be transferred to a secure hospital for assessment. (As Dr Ramsay confirmed, this was not a decision that could ever have been taken by the defenders; the decision and

referral could only be made by the treating clinicians employed by the NHS.) There was evidence that the defenders' prison officers had identified that DD presented as a suicide risk (hence his being placed on the prison's suicide prevention strategy, Act 2 Care, as it was then called, including the wearing of anti-ligature clothing); and that he presented a risk of wilful exposure to female prison officers (again, a risk that was identified and managed by placing a marker in the "Risks" section of PR2). There was also evidence that the defenders had conducted an assessment of the risks to which officers in D-Hall were exposed as a result of violent prisoners in D-Hall. That risk was deemed to be adequately controlled by existing inter-personal skills and C&R training. Further, the pursuer, Mr Walker and Ms Ridgeway all spoke to conducting a "dynamic risk assessment" in respect of DD on the morning of the incident. This involved an assessment of his presentation and his behaviours.

[47] From all of the foregoing, I conclude that the defenders discharged their duty to assess the risks which this prisoner posed, not only to others, but to himself. There was no evidence to support the conclusion that there was a specific risk of violence to prison officers, still less a risk of a magnitude that was any greater than the risk posed by the many other prisoners then detained within HMP Barlinnie.

[48] In any event, any failure to carry out a risk assessment can never be the direct cause of an injury. It can only be indirectly causative if it is shown that a hypothetical suitable and sufficient risk assessment would have resulted in a precaution being taken which would probably have avoided the injury. No such case is made out on the evidence.

The alleged duty to avoid unaccompanied contact between Ms Ridgeway & the prisoner

[49] The pursuer avers:

> "The defenders ought not to have allowed for Officer Ridgeway to be left alone with the prisoner, DD."

The pursuer's argument appears to be that, because the prisoner had been exposing himself to female officers, and because a PR2 "Risk and Conditions" marker had been applied stating that interaction between female staff and prisoners should be restricted, the defenders allegedly had a duty to prevent unaccompanied contact between DD and Ms Ridgeway. In effect, the submission appears to be that the accident was caused, in part, by virtue of Ms Ridgeway's gender.

[50] In my judgment, the asserted duty simply does not exist and is not supported by the evidence.

[51] As an aspect of her employment duties within the HDU, Ms Ridgeway confirmed she would have had daily contact with DD, both before and after the PR2 marker was applied. Her evidence was that she had a good relationship with him. He had never been violent towards her. Indeed, there was no evidence he had been violent towards any female, at any point, prior to or since the date of the incident. The only assault on a prison officer during DD's time in custody was on a male officer.

[52] True, DD had exposed himself to Ms Ridgeway and to another female member staff, and Ms Ridgeway had reported this to her first line manager, Mr Findlay Laird (who, on 29 November 2014, had applied a Risk and Conditions marker to DD's PR2 record). But it is plain from that entry - and was confirmed by Mr Laird in his testimony - that the risk identified here was the risk of the prisoner exposing himself to female officers. Neither the

marker, nor the report from Ms Ridgeway, identified the prisoner as presenting a risk of violence towards female officers.

[53] At proof, an attempt was made by the pursuer's agent to suggest that an isolated and unexplained reference in the *post-accident* paperwork to the prisoner previously "picking on female staff" was a reference to something other than DD merely exposing himself to female staff. Firstly, there was no foundation on Record for this line; but, in any event, secondly, there was also no evidence to support such an inference. The irresistible weight of the evidence was that DD's sole "issue" with female staff was his propensity to expose himself to them. There was no evidenced propensity for violence towards females (or female staff).

[54] The pursuer's expert, Ms Caffrey stated in her report:

> "The prisoner also had a diagnosed sexual disinhibition which can place female officers at increased risk."

There was no factual evidence or qualified expert psychiatric evidence to support such a conclusion. In cross-examination, Ms Caffrey appeared, properly, to retreat from that assertion, and conceded that she was not saying that Ms Ridgeway's gender was a cause of the problem that arose on 7 December 2014. That seemed to me to be a proper concession. Besides, in her letters to the NHS healthcare team within the prison, Dr Ramsay (who would perhaps have been far better qualified to express such an opinion, if it were warranted) documented DD's sexual disinhibition and over-familiarity, but she did not express any concern for the physical safety of any female officers or healthcare staff. Tellingly, Dr Ramsay noted that DD:

> "… just doesn't like [prison officers] telling him to do things he doesn't want to do".

Dr Ramsay stated that this was not psychotically driven - he was just someone who was not keen on authority.

[55] Lastly, Mr Wheatley confirmed that he had seen nothing in the documentation which would suggest that the prisoner's previous history of exposing himself to female officers played any causative part in the incident on 7 December 2014. Besides, his view (see item 5/10 of process, Wheatley Report, paragraph 73) was that:

> "It would be quite unmanageable to try to ensure that in detailing of staff to their duties prison managers could ensure that female officers could be kept separate from particular male prisoners."

He testified that:

> "To try and keep particular officers away from certain prisoners, it would be impossible to do. If someone told me to do it as Prison Governor, I'd tell them they were daft. It is unachievable."

This is a significant point because it highlights that the duty as asserted by the pursuer is simply too nebulous, general and vague to be practicable. The pursuer does not say how the defenders were supposedly to prevent Ms Ridgeway from being "left alone" with DD. How exactly was this to be done?

[56] In my judgment, the alleged duty is, in its nebulous terms, quite unworkable, short of (i) constantly having Ms Ridgeway accompanied by a male colleague or (ii) preventing her working on the HDU at all merely because of her gender. Both of those propositions would be untenable, anachronistic, and unwarranted. In fairness to the pursuer, neither such extreme proposition was advanced by him - but nor was any alternative practicable proposition advanced by him. No persuasive evidence was advanced on behalf of the pursuer as to what steps the defenders should have taken to prevent unaccompanied contact or interaction between the prisoner and Ms Ridgeway, even if that was thought to be justified (which, in my judgment, it was not).

[57] Further, as a matter of fact, when one looks at the circumstances of the incident, it is clear that Ms Ridgeway did not approach DD at all. Rather, she was merely carrying out

her duties, by supervising prisoners who were leaving the HDU to attend church. It was DD, in a dishevelled and agitated state, and with no prior permission, who approached Ms Ridgeway and attempted to walk past her out of the HDU. It was at this point that Ms Ridgeway, perfectly properly, asked him where he was going, and took the decision that he could not attend church, and that he should return to his cell. Her concern was for the safety of the prisoners and others at the church service. Mr Wheatley's expert view was that, notwithstanding the presence of the PR2 marker, it was entirely appropriate for Ms Ridgeway to intervene at this juncture, as DD attempted to leave the HDU. As he put it:

> "She had to intervene - because if she didn't stop him, no-one would have done, and an incident could have occurred in the chapel".

Mr Laird also confirmed that, in stopping the prisoner, and asking him to return to his cell, Ms Ridgeway was acting in accordance with her duties as a prison officer. Mr Walker also agreed that it was reasonable for Ms Ridgeway to stop the prisoner and that in doing so she was acting in accordance with her duties as a prison officer. Only the pursuer suggested that, in stopping the prisoner, Ms Ridgeway was somehow acting in breach of some ill-defined duty.

[58] In any event, the violent incident itself (which led to the pursuer's injury) did not occur when Ms Ridgeway was "left alone" with DD: she was with two experienced male colleagues (the pursuer and Mr Walker), and had been in their company for some time, while they sought to escort him back to his cell. So she had not been "left alone" with the prisoner at all, at least at the critical point in time.

[59] In conclusion, therefore, in my judgment, there was no duty on the defenders of the nature asserted by the pursuer (namely, to prevent Ms Ridgeway being "alone" with DD). The evidence does not support the existence of such a nebulous duty; nor, even if it could be

said to have existed in some form, was it practicable and workable; nor, even if it existed, was it breached.

[60] In my judgment, Ms Ridgeway's gender played no role in the incident. She enjoyed a good relationship with DD. There was no evident sexual component to the circumstances of the incident. In all probability, DD's anger, abusive behaviour and violent outburst arose simply as a consequence of being given an instruction that he did not like. It is more likely than not that had a male officer intervened initially, instead of Ms Ridgeway, the same sequence of events would have unfolded.

The alleged duty to disclose information

[61] The pursuer further avers:

> "The defenders ought to provide to the staff in the High Dependency Unit, such as Officer Ridgeway, specific information about those prisoners, such as the prisoner, about their particular psychiatric condition, tendencies such as to allow for appropriate prisoner management and to minimise dangers posed to staff and indeed the prisoner by their condition."

[62] It is correct that access to the content of DD's "Incidents and Intelligence" record within PR2 was restricted to first-line managers and above, so it was not available to the pursuer, Mr Walker or Ms Ridgeway. But, crucially, the information on the "Incidents and Intelligence" log, on any reasonable interpretation, did not disclose that DD posed any *specific* threat of violence to prison officers. Crucially, disclosure of that further information would have made no practical difference to what could or should have been done. In other words, the non-disclosure of that information had no causative effect on the occurrence of the incident or injury.

[63] All three prison officers - Mr Gemmell, Mr Walker and Ms Ridgeway - were well aware of the *general* risk of violence presented by the prisoner when they were dealing with

him on 7 December 2014. The pursuer stated that, upon attending to assist Ms Ridgeway, and in dealing with the prisoner, he had identified that there was a threat of violence. Similarly, Mr Walker stated in examination-in-chief that the prisoner was "potentially becoming violent". The application of "come along" holds was a physical manifestation of their appreciation of that risk. Knowledge of the content of the "Incidents and Intelligence" record within PR2 would have added nothing material to their understanding of the risk, or their strategy for dealing with it. This was the emphatic expert opinion of Mr Wheatley. He opined that the level of knowledge that Ms Ridgeway had regarding the pursuer's potential for disruptive and volatile behaviour was about the level that he would expect for an officer charged with DD's supervision. Mr Wheatley did not believe that the degree of risk evidenced by the entry within the prisoner's PR2 "Incidents and Intelligence" record was so unusual that it required additional briefing to officers who worked on the HDU, such as Ms Ridgeway and (on that morning) Mr Walker. In Mr Wheatley's view, the risk presented by DD fell well below the level that would have justified any briefing of officers like the pursuer, who did not even typically work in the HDU.

[64] Again, the averred duty, as articulated by the pursuer, seems at first blush to be uncontroversial. However, when one moves away from the superficial attraction of the duty in its generality, and turns to consider how, in practice, such a supposed duty of disclosure would work, it becomes clear that the supposed duty is wholly impracticable and unworkable. In the first place, Ms Ridgeway, who is now an intelligence manager at HMP Low Moss, explained a rationale for the policy of restricting access to certain information. The defenders, she explained, are legitimately seeking to ensure that intelligence remained secure and that sensitive information could not end up being unintentionally (or intentionally) passed on to prisoners by prison officers. However, Mr Wheatley also spoke

convincingly to another rationale, namely the very real practical difficulties involved in sharing information on so many prisoners, with so many officers, and with such frequency as to allow the information to remain topical, relevant and of value. According to Ms Ridgeway there was a high turnover of prisoners on a daily basis within HMP Barlinnie, with as many as 60 admissions per day; there were around 250 prisoners on D-Hall alone; and as many as 50 prisoners in HDU at any one time. It was also necessary to add into the mix the turnover and varying deployment of the prison officers themselves, with changing daily rotas and duties. Having regard to the sheer numbers of staff and prisoners involved, as well as the fluidity of prisoner location and staff deployment within the prison, Mr Wheatley opined that it would be an "impossible task to keep officers up to date with every prisoner" and that such an approach "would drown staff in information". Mr Wheatley's view was that, in addition to it not being possible to share this information with officers, there could be no reasonable expectation that prison officers could memorise and retain this information, or put it to any practical use. He was not alone in this view. Mr Walker and the pursuer himself conceded they would have difficulties remembering the specific behavioural background of 50 prisoners (in the HDU alone) in a spontaneous situation that may arise involving any one of them. In my judgment, the rating and restricted disclosure of intelligence and information was entirely warranted on various grounds including security, privacy and, most compellingly, simple practicality. Mr Wheatley's view, which I accepted as persuasive, was that the information pertaining to DD within the PR2 "Incidents and Intelligence" section did not actually disclose or constitute any specific risk of violence to prison officers and accordingly he would not expect to see it disseminated more widely to prison officers such as the pursuer, Mr Walker

or Ms Ridgeway. In short, he was "not surprised" that no such marker appeared in the (more widely accessible) "Risks and Conditions" section of PR2.

[65] In summary, the utter impracticability of the pursuer's averred duty points to the conclusion that no such duty was incumbent upon the defenders at all.

[66] Finally, the pursuer and Mr Walker testified as to what they would have done had they known about the prisoner's previous incidents in custody. This tranche of evidence was relevant to the issue of causation. They confirmed that, even if they had seen DD's complete "Incidents and Intelligence" PR2 record prior to the accident, it would not have changed the manner in which they dealt with the prisoner: they would have done exactly as they in fact did. Ms Ridgeway also stated that, had she seen the records, she "would have done exactly the same thing".

[67] In my judgment, therefore, even if the asserted duty was incumbent upon the defenders (which it was not), its breach had no causative effect on the occurrence of the incident or injury. Disclosure of the PR2 entry would not have altered the sequence of events in any way.

Non-disclosure of the NHS medical records

[68] In November 2011, responsibility for delivering healthcare, including mental healthcare, to prisoners within Scottish prisons was transferred from the defenders to the NHS.

[69] DD's mental health condition and treatment was documented within his medical records. As at 2014, these records were held and controlled by the NHS, predominantly on their "Vision" computer system. DD's condition and treatment was also documented in letters that Dr Ramsay sent to NHS healthcare workers within HMP Barlinnie's Health

Centre. It was clear from the evidence of every witness who was addressed on the point that, due to the principle of patient confidentiality, the defenders were not, and could not have been, in possession of any of these medical records. The defenders' knowledge of DD's psychiatric condition was confined to what little the NHS staff had disclosed to them.

[70] It is correct that DD was discussed at three separate MDMHT meetings, at which certain employees of the defenders attended. However, the nature of the information disclosed to the defenders' employees was very limited. For her part, Ms Ridgeway, who attended the last such meeting prior to the incident, confirmed that she was aware, in very general terms, that DD had mental health issues. (The minutes of that MDMHT meeting which she attended did not disclose DD's diagnosis.) She explained that he was "very typical" of the type of prisoner she would deal with on HDU. She confirmed that, following an MDMHT meeting, she would have a mini-team meeting with other officers in HDU to discuss the limited information she had received about prisoners on the HDU. The pursuer, of course, did not even work in the HDU as at 7 December 2014, so it follows (as he testified) that he would have known nothing of DD's psychiatric background. That said, given that DD was accommodated in the HDU, it is a safe assumption that the pursuer was aware that he was likely to have some form of mental health problem. Similarly, Officer Walker stated:

"on the day of the accident, I could see that his [DD's] mental health wasn't good."

All three officers therefore knew they were dealing with a prisoner with mental health problems in a general sense, albeit they did not know his particular psychiatric diagnosis. According to Mr Wheatley's testimony of ordinary practice in prisons throughout the United Kingdom, that is no more and no less than he would expect a prison officer, such as Ms Ridgeway, who worked in a HDU, to know of a prisoner such as DD - namely, that he had mental health issues. As for the pursuer, Mr Wheatley opined that it would have been

perfectly consistent with ordinary prison practice for the pursuer to know nothing about DD, because the pursuer worked in a different unit. (Indeed, even Ms Caffrey testified that the pursuer would have had no need to know the psychiatric condition of a prisoner such as DD, who was not accommodated in the unit in which the pursuer worked.)

[71] Ms Ridgeway was asked whether it would have made any difference to the approach she took, were she to have had knowledge of the minutes from the previous MDMHT meetings (which she did not attend), where a diagnosis of bipolar disorder was mentioned. She confirmed, unequivocally, that it would not have changed her approach.

[72] The pursuer too was asked about the significance of the MDMHT minutes. Despite stating in examination-in-chief that the content of the minutes would have been "useful to know", he changed his position in cross-examination (as he frequently did). He stated that the minutes were "useless", "poor and pathetic", "of no assistance at all" and that they "wouldn't have helped in any shape or form". He stated that, had the content of the MDMHT minutes been shared with him prior to the incident, they would not have changed the way he approached the incident.

[73] Mr Walker and the pursuer also confirmed that, in any event, there would also be serious difficulties in being able to memorise and recall the behavioural and psychiatric background of all the prisoners under their supervision. The pursuer stated:

> "There's no-one will ever remember all of that".

For this reason (among others) Mr Wheatley also testified that, from the perspective of ordinary prison management throughout the country, he would not expect this information to be shared with prison officers. Mr Wheatley also opined:

> "Putting myself in the shoes of the officers, and I have had the luxury of reading of all the documents, I would not have handled the situation any differently".

[74] In summary, in order for there to be a duty to disclose information about the prisoner's psychiatric condition, it must first be shown that the defenders were in possession or control of this information. The defenders were not in possession or control of, and could not reasonably be expected to be in possession or control of, the confidential medical records that were held by healthcare staff of NHS Greater Glasgow & Clyde. The content of these records is therefore irrelevant. The defenders patently cannot be under any duty to disclose that which they did not, and were not entitled to, possess or control.

[75] It follows that the only relevant question is whether the defenders were under a duty to disseminate more widely (but to whom, precisely?) such limited information as they did possess regarding the prisoner's psychiatric condition (being, at most, the meagre information in the short entries in three MDMHT meetings).

[76] In my judgment, the first important point to note is that the short entries in these minutes do not indicate that the prisoner presented a specific risk of violence to anyone. The second important point is that, in any event, even if it was construed as sufficiently significant in the nature or magnitude of its risk to justify wider dissemination (which, on the evidence, it was not), in my judgment it was not reasonably practicable to expect the defenders to share the psychiatric background and condition of a prisoner with *every* prison officer in the prison who might conceivably come into contact with that prisoner from time to time. Put another way, even if there was a duty to disseminate more widely the (limited) information in the three MDMHT minutes, any such wider dissemination would probably have been limited to the HDU prison staff - which means that the pursuer would never have known of it anyway (as he did not typically work in the HDU). The third point is that, in my judgment, on the evidence, the disclosure of this information would not have made a blind bit of difference, because, according to their own testimony, it would not have resulted

in a different approach being taken by any of the prison officers. Therefore, the essential causal connection between the alleged breach and the alleged loss is not established on the evidence.

The alleged duty to provide "mental health training"

[77] The pursuer avers:

> "The defenders ought to have provided sufficient training to their employees, including the pursuer, Officer Walker and Officer Ridgeway, within D Hall who are exposed to any prisoner that suffers from psychiatric condition/mental health disorders, including such prisoners within from the High Dependency Unit…in particular, given the dangerous and unpredictable behaviours of such prisoners, the likelihood of assaults for such prisoners is not a remote possibility."

The pursuer's case is that the training that was provided to officers in 2014 by the defenders (namely, PPT and C&R training for all prison officers, and mental health first aid training for the officers in HDU) was insufficient and that the defenders were under a duty to provide some enhanced form of mental health training.

[78] There was no dispute that all of the officers involved in the incident had been trained in PPT and C&R training and, at the time of the incident, were competent in the various learning outcomes that are covered in the training. That training involved the identification of rising aggression in prisoners and how to de-escalate the potential for violence; if force required to be used, it is taught to be deployed at a level which is proportionate to the risk posed and no more than necessary in the circumstances. This approach is underpinned by Rule 91 of the Prisons and Young Offenders Institution (Scotland) Rules 2011 ("the 2011 Rules"), which explicitly envisages the use of physical force in certain circumstances.

[79] There was also no real dispute that the PPT and C&R training did not teach officers to deal with prisoners with mental health problems any differently from prisoners without

mental health problems. There was no discrete part of PPT and C&R training which applied separate techniques to the handling of aggressive prisoners with mental health issues. Ms Ridgeway testified that officers were trained to deal with the risk that was presented in front of them, irrespective of whether a prisoner had mental health problems.

[80] Mr Wheatley testified that prison officers in England and Wales were trained in a similar manner. Indeed, he had been directly involved in the development of the PPT and C&R training in England and Wales, and had approved its content. He described the introduction of PPT and C&R as a "game changer" that had "revolutionised" the way in which force is used. He stated that PPT and C&R training consists of "very effective techniques which have much reduced the risk of injury" and that such training has been:

> "… an absolutely essential tool for helping control violence and reduce injuries to both staff and prisoners. The techniques work well in nearly every case…The overall effect has been to reduce disruptive protests and resistance. Together with PPT these techniques have meant staff are kept safe and are a major reason why, in spite of the inevitable risk caused by the make-up of the prisoner population, really serious consequences of violence like murder and serious injury of staff in UK prisons is a much rarer event than in many other jurisdictions"

He saw no inconsistency between the training in Scotland and the training in England and Wales.

[81] Mr Wheatley was clear in his opinion that, when prison officers are confronting someone who was threatening the good order of the prison and who was behaving in a potentially violent way, they should adopt the same approach to that prisoner regardless of any mental health condition. His view was that there was no need to train officers differently on how to deal with prisoners with mental health issues.

[82] None of the witnesses criticised the defender's PPT or C&R training as such. Indeed they typically spoke to its adequacy. Mr Laird confirmed that the pursuer, Mr Walker and Ms Ridgeway were adequately trained to deal with the risk of violent prisoners. Even the

pursuer accepted in cross-examination that the PPT and C&R training was entirely adequate for dealing with uncompliant and threatening prisoners. In cross-examination, it was also put to the pursuer's expert witness (Ms Caffrey) that PPT and C&R training, as well as the statutory basis for using force, were entirely reasonable to deal with prisoners who are displaying threatening and abusive behaviour, regardless of their mental condition. Ms Caffrey replied:

> "Absolutely. I have no qualms with the control and restraint techniques and training."

[83] In those circumstances, it is difficult to understand what further "mental health training" ought to have been provided to the defenders' prison officers.

[84] In my judgment, the defenders were under no such duty for the following four reasons.

[85] Firstly, in order to establish that there was a duty on the defenders to provide some form of "mental health training", it would be necessary to prove that there was a need for such training. In other words, the pursuer would need to prove that prisoners with mental health problems posed an increased risk of violence to prison officers and that there was a particular problem with violence or disorder in the HDU which was not being controlled by the current training regime. There was no clinical evidence that prisoners with mental health problems posed a greater risk of violence to others (or of disorder) than prisoners without mental health problems. In Mr Wheatley's experience, there are prisoners with no diagnosable mental disorder who are extremely violent, and there are prisoners with very serious mental health problems who are not remotely violent. In his view, there was no factual basis to say that mental health problems inevitably make a person more violent. The pursuer also accepted that he had never stated that he was struggling to deal with the

management and supervision of prisoners with mental health conditions. Indeed no witness communicated any such difficulties in evidence. Dr Ramsay's observation was that prison officers do an "extraordinarily good job" in dealing with such prisoners. Crucially, there was no evidence at all regarding the level of violence in the HDU compared to, for example, other areas in the prison. There was no evidence that violence was a particular problem in HDU which staff were finding difficult to control. On the contrary, Officer Ridgeway stated that "there weren't a lot of incidents in HDU". The only evidence of anyone ever being injured in the HDU was in relation to this index incident on 7 December 2014. The fact that a single person has suffered an injury is not, of itself, proof that the workplace was unsafe. The prisoner's Incidents and Intelligence record contained the only other evidence of violence; but it referred to only three occasions on which DD had lashed out at officers and another prisoner; C&R techniques were deployed; and the incidents were brought to an end without serious injury to anyone. (The only injury noted in the record was minor cuts to an officer's knee and hands.)

[86] Therefore, in the absence of any evidence that prisoners with mental health problems posed a specific risk of violence to others, and in the absence of any evidence that there was a specific problem with violence in the HDU which was not being effectively controlled by prison officers, in my judgment the pursuer has failed to prove that there was any need for further training to be provided by the defenders (*Delroy Thompson* v *Home Office* 2001 WL 172015 29; *Baker* v *Quantum Clothing Group Ltd* 2011] 1 W.L.R. 1003, paragraphs 62-80 34).

[87] Secondly, in order to succeed, the pursuer required to prove that there was a form of "mental health training" which advocated an approach which materially differed from the training that had already been provided by the defenders. Here again the pursuer's case runs into difficulties. The pursuer seeks to rely on Ms Caffrey as someone who could testify

to an alternative form of training which would keep officers more safe. In her report, she refers to a programme called "Safer Custody", which purportedly included various topics including "Mental ill health". However, unlike the PPT and C&R training delivered by the defenders, the content of this "Safer Custody" training was not put before the court. There was no specific and detailed evidence in relation to what this training actually included, what the recipients of this training are taught to look out for in persons with mental ill health, or what skills or techniques to adopt when dealing with such prisoners. To the extent that Ms Caffrey made any reference to how to deal with a prisoner with mental health issues this was not inconsistent with the training already provided by the defenders. Therefore, in my judgment, the pursuer has failed to establish that there was some other form of training which advocated an approach which differed from the training already provided by the defenders.

[88] Thirdly, since the defenders' alleged failure (to provide some form of enhanced "mental health training" to all prison officers) amounts, in law, to an alleged negligent omission, it is necessary for the pursuer to prove that the delivery of this enhanced form of mental health training was something that was done by other persons in like circumstances . He failed to do so. There was no such evidence. Mr Wheatley confirmed that mental health training to all prison officers had never been made mandatory in prisons in either Scotland or England and Wales. In Mr Wheatley's evidence he saw no inconsistency between the level of training delivered to officers in Scotland and in England and Wales. The delivery of PPT and C&R training to all officers, and some mental health awareness training for some officers, was all that he would expect. Ms Caffrey's attempt to draw an analogy with a police custody setting was unpersuasive, as previously explained.

[89] Fourthly, in order to succeed, the pursuer required to prove that there was something that he did not know, but which he would have known had he received adequate information and training, and which, had he known, would have prevented the accident. Although the pursuer (and Mr Walker) complained that they had never been shown any specific "skills and techniques" for how to deal with prisoners with mental health problems, it was never put to them what these omitted "skills and techniques" actually were - or how they differed from the skills and techniques that they had already been taught in PPT and C&R training. Without the officers knowing what this further "enhanced" training would actually have entailed, and how it differed to the training already provided to the defenders, the officers were unable to say whether and how any such further training would have assisted in the circumstances of the incident. For his part, Mr Wheatley could not see how any additional mental health training would have made any difference to how prison staff handled the matter, or how it could have prevented the risk coming to fruition. If the defenders were under a duty to provide some sort of "mental health training" (which, in my judgment, they were not), there would presumably have been a corresponding (and, my respectful view, unreasonable) expectation upon staff when dealing with such prisoners instantaneously (i) to recall whether a prisoner had a psychiatric condition (ii) to recall what that specific psychiatric condition was (iii) to recall the associated symptoms and behaviours, and (iv) to attempt to modify his or her own speech, body language and behaviour, and C&R techniques, depending on the prisoner's particular diagnosis and associated behaviours. This would have a paralysing effect on prison officers who are required to take rapid decisions, on the spur of the moment, about a number of matters including their own safety and the safety of other prisoners. Mental health illness - its diagnoses, symptoms, and consequences - takes numerous forms. It is unreasonable to

expect the defenders to devise and deliver some sort of ill-defined "mental health training" to prepare prison officers to deal with the vast range of behaviours attributable to every conceivable mental health disorder, particularly in circumstances where, due to patient confidentiality, the prison officers may have no idea which prisoner suffers from which mental health disorder at any given time.

[90] For completeness, I observe that, in 2014, the defenders did provide staff in the HDU with some mental health first aid training ("MHFA"). This was spoken to by Ms Ridgeway. This training, which was prioritised for HDU staff, provided officers with an awareness of certain mental health conditions that might be present among the prisoner population such as bipolar disorder and schizophrenia. It did not involve training in different forms of PPT or C&R techniques to deal with prisoners with mental health issues. As Mr Wheatley put it, MHFA was simply something which was "nice to do". It was of no material relevance to the case.

[91] In my judgment, there was no adequate evidential foundation to conclude that some form of specific "mental health training" ought to have been provided by the defenders to their prison officers.

[92] I accept the testimony of Mr Wheatley that PPT and C&R training promotes a consistency in approach to all perceived threats of violence, irrespective of whether the prisoner who is threatening violence has or does not have a mental health condition. In delivering PPT and C&R training to all prison officers, and in providing annual refresher training to assess the officers' training competencies, the defenders discharged their common law duties to their employees. The defenders had also conducted an assessment of the risk of violent prisoners in D-Hall; that risk was deemed to be adequately controlled by,

inter alia inter-personal skills, body language and C&R techniques. The suitability and sufficiency of this risk assessment was not challenged in evidence.

Causation

[93] In the closed record, the defenders placed a call upon the pursuer to specify how knowledge of the pursuer's psychiatric background or mental health condition and any mental health training would have prevented the accident. The call remained unanswered in the pleadings. The pursuer's position remained equally unclear in evidence.

[94] The question of causation has already been touched upon above. In their testimony, the pursuer, Mr Walker and Ms Ridgeway all stated that knowledge of the prisoner's behavioural and psychiatric background would have made no difference to the way in which they handled the situation. In fairness to them, whether or not any "mental health training" would have made a difference was a question that could never really have received a fully informed answer from them given that the content of an alternative mental health training package was never put to these witnesses.

[95] In fairness, some effort was made on behalf of the pursuer to establish that other options were available. There was an apparent effort to grasp at something being a more viable option than the course of action that was taken, though I must confess that it was not at all clear to me what these other "options" were; or how they differed from the existing de-escalation and minimal intervention techniques postulated by the C&R training. I shall try to address each of these other supposed "options" in turn.

Option 1: do not touch the prisoner

[96] First, the most extreme "option" proposed by Ms Caffrey was to avoid all physical contact with the prisoner. In Ms Caffrey's report, she states:

> "Where appropriate a person in crisis should be contained rather than restrained as physical touch can exacerbate the situation".

She concludes:

> "In this case the officers had no idea that the prisoner had schizophrenia or psychotic episodes and touched the prisoner, this therefore having a likelihood of escalating the prisoner's response."

The clear inference was that the application of "come along" holds was inappropriate and caused the accident.

[97] I was not persuaded by this testimony for a number of reasons.

[98] First, there was no clinical (ie suitably qualified medical) evidence to explain what was meant by a "mental health crisis" (how does it differ from a prisoner merely angrily refusing to comply with a reasonable instruction?), nor was there an adequate evidential basis to conclude that DD in the midst of a "mental health crisis" at the relevant time. All Dr Ramsay could say was that DD's moods were variable and that his presentation was unlikely to have been normal on the morning of the incident. In the post-accident paperwork, it was noted that the prisoner was assessed by a member of NHS healthcare staff, and that he was able to freely communicate and he did not appear to be distressed, which is at odds with a suggestion that he was in a "crisis". In my judgment, on the evidence, on the morning in question, DD, who undoubtedly had mental health issues, was simply behaving in an abusive and threatening manner in response to being told he could not attend church. To approximate that behaviour to a "mental health crisis" is a leap too far in the absence of any clinical evidence to support this.

[99] Second, it is clear from the evidence that a significant effort had been made by both Ms Ridgeway and then by the pursuer and Mr Walker to de-escalate the situation and to gain DD's compliance prior to "come along" holds finally being applied. All the officers agreed that, having regard to all the circumstances, the decision to apply "come along" holds was entirely proportionate to the risk that was presented and that the level of force used was no more than was necessary.

[100] Taken at its highest, Ms Caffrey's testimony appeared to be that a mentally disordered prisoner having a "crisis" (whatever that meant) should never be touched. That was a startling proposition. Of course, there was no clinical, medically qualified, evidence to support it. That apart, from a purely practical perspective, were the prison officers simply to cross their arms, stand back, and allow such a prisoner to run riot through the prison, or to provoke mass disorder in a Hall? Under cross-examination, however, Ms Caffrey appeared to step back from that more extreme articulation. She accepted that the effort to return DD to his cell was, in fact, an effort to contain him. Ms Caffrey also clarified that she was not saying that the decision to take DD into "come along" holds was wrong. She stated that she did not criticise the approach taken by the prison officers and agreed it was entirely legitimate for the officers to take the prisoner into "come along" holds. By the end of her evidence, though, it was not at all clear to me what exactly Ms Caffrey was saying the officers could or should have done differently (despite asserting in her report that the response of the officers would have been "completely different" had they known about the prisoner's background and received mental health training). In short, this tranche of expert testimony did not bear critical analysis. It was not accepted by me.

[101] In contrast, Mr Wheatley expressed the opinion that:

> "… there is nothing that I can discover that laying hands on someone with mental health problems is something you shouldn't do. There is no factual basis to make that statement".

Mr Wheatley stated that "going hands-on" can have consequences regardless of a prisoner's mental health status, and should only be used if there is a risk to the health and safety of other people. He stated that he would never say that a prisoner should not be touched simply because he or she had mental health issues. Mr Wheatley stated that in psychiatric hospitals, prisoners are touched and restrained as a last resort, a point which was confirmed by Dr Ramsay. Mr Wheatley's opinion was that the decision the officers made to apply "come along" holds was a "good, sound decision under pressure". They weighed up the situation, and "took a reasonable decision which minimised the risk they were facing."

[102] In my judgment, on the evidence, the decision by the pursuer and Mr Walker to apply "come along" holds was a decision which was entirely reasonable in the circumstances. DD had been abusive and threatening towards Ms Ridgeway. He refused to comply with her instruction, and those of the pursuer and Mr Walker, to return to his cell, and he continued to behave in an erratic and volatile manner. Efforts had been made to de-escalate the situation by all three officers. "Come along" holds, which involved the minimum level of physical intervention, were applied to achieve a modicum of control over DD while escorting him safely up the stairway and back to his cell. The application of "come along" holds was proportionate to the risk that the officers reasonably perceived and was no more than was necessary in the circumstances. In so acting, the officers acted appropriately and in accordance with their PPT and C&R training, as well as Rule 91 of the 2011 Rules.

Option 2: let the prisoner go to church

[103] The next supposed alternative "option" that emerged in the course of the proof was that of simply allowing DD to leave the HDT to attend church.

[104] In examination-in-chief, the pursuer claimed that had he known more about DD's background he would have allowed DD to go to church. However, in cross-examination, the pursuer conceded that it was not an unreasonable approach to get the prisoner back to his cell.

[105] For her part, Ms Ridgeway testified that DD's name was not on the church list. She conceded that she had (and occasionally exercised) a discretion to allow a prisoner, whose name did not appear on the list, to attend church. However, on this occasion, Ms Ridgeway was concerned by DD's dishevelled and agitated presentation. According to her testimony, DD did not seem to be in the right state of mind to attend church. She was concerned that other prisoners might taunt him for his appearance; she could not predict how he might respond to them; she was concerned that an incident might develop in the church. Ultimately, she testified that her concern was for the safety of DD and the other prisoners attending the church service. For those reasons, reinforced by his subsequent aggressive and abusive behaviour, she decided to refuse to allow him to attend church.

[106] Mr Walker agreed with Ms Ridgeway's conclusion. He acknowledged that to allow the prisoner to attend church was not the most reasonable approach. There were 40 prisoners or so out of their cells at that time. Having regard to the safety of the prisoners and the staff, Mr Walker testified that he and the pursuer decided that the most reasonable approach was to return DD to his cell.

[107] Mr Wheatley's expert testimony on this option was especially persuasive. He explained that, over the years, there had been various incidents of disorder and violence in

prison churches/chapels. This had occurred because church/chapel services involved the gathering of large numbers of prisoners in a location where it was difficult for staff effectively to intervene. Mr Wheatley testified that the infamous prison riot in Strangeways Prison, Manchester had started in the prison chapel. It was in that historical context that the practice of requiring prisoners to put their names down in advance on a church list was introduced as an important security measure. Mr Wheatley opined that prisoners had no absolute right to attend church: it was qualified by reference to the prisoner's behaviour and the need to maintain order. Mr Wheatley considered that allowing a prisoner, with the presentation of DD, into a large gathering of other prisoners, with no forewarning to staff, "could well have gone badly wrong". He was therefore wholly supportive of Ms Ridgeway's decision to refuse to allow DD to attend church. He described that decision as "logical", "sensible" and "defensible".

[108] In my judgment, the reliable evidence points overwhelmingly to the conclusion that the decision by Ms Ridgeway to refuse to allow the prisoner to attend church on the morning of the incident was the correct decision in all the circumstances. Ms Ridgeway had balanced the risks and arrived and an entirely sensible conclusion. Had she simply allowed the prisoner to attend, that would have created a potentially more dangerous situation at the church. The pursuer's suggestion that, had he known more about the prisoner's behavioural and psychiatric background, he would have allowed the prisoner to attend church, is inherently illogical. As Mr Wheatley put it, had the officers known about the prisoner's previous incidents in custody, which indicated he could behave unpredictably, and then decided to allow him to attend church anyway in an agitated and aggressive state, such a decision would have been "even more inexplicable".

Option 3: leave the prisoner to calm down

[109] The third supposed alternative "option" was simply to leave the prisoner to calm down.

[110] To explain, it was submitted for the pursuer that the prison officers could have allowed the prisoner some time to calm down in the HDU and that he would likely then have voluntarily returned to his cell. This proposition appeared to derive from the entry in DD's "Incidents & Intelligence" record which indicated that, 4 weeks or so prior to the incident, DD was involved in an argument with a prisoner in the exercise yard; he had initially failed to comply with an instruction from staff to return to the Hall; he had walked away; but, having sat down for 5 minutes, he then returned to the Hall of his own volition. It was submitted for the pursuer that if he and his colleagues had been aware of the content of the "Incidents & Intelligence" record, the same approach could have been adopted on 7 December 2014, whereby the prisoner could have been left to calm down. So ran the argument.

[111] In my judgment, there was no persuasive evidential basis to sustain this submission. To explain, there was no dispute that the HDU was very busy on the morning of the incident as prisoners had been released from their cells to take part in the morning routine. Ms Ridgeway's testimony, which I accepted, was that DD's confrontation with her was causing an interruption to other prisoners leaving the HDU. She described how DD was moving into her space as she stepped backwards towards her desk where she was stationed. There was no evidence that DD had, at any point, sought to walk away from the officers in order to calm down (as he had apparently done 4 weeks earlier, according to the "Incidents & Intelligence" log). Consistent with this testimony, Mr Walker testified that he had had to return certain prisoners to the HDU who had been waiting for their medication. Likewise,

the pursuer had felt compelled to leave his post in the Admissions Unit to assist. This is all consistent with an escalating situation that required action, not inaction. Ms Ridgeway's testimony was that the officers

> "…couldn't leave him alone in light of his abusive behaviour. It was not an option to not return him to his cell."

Mr Walker's testimony of his risk assessment is broadly identical. He said:

> "There were 40 prisoners out at one time. Safety to prisoners, safety to staff. [We] decided to take him back to his own cell."

He agreed in his testimony that it would have been a risk to leave DD in the Hall to calm down. He also acknowledged that there was no guarantee that such an approach would have worked in any event.

[112] Then we have Mr Wheatley's expert testimony, delivered with the benefit of detachment, years of experience in prison management, and a reflective consideration of all the options. In his opinion, standing back and leaving the prisoner to calm down by himself in the Hall would have been a "very misguided approach". Mr Wheatley testified that prison officers are charged with keeping prisoners safe and maintaining order. Mr Wheatley explained that if there is a noisy confrontation with a prisoner, there is the risk that other prisoners could join in and the incident could have escalated into major disorder with several people being injured. Mr Wheatley stated that the officers had to deal with the situation and get the prisoner under control. When asked whether the officers could have spent more time talking to the prisoner, Mr Wheatley's view was that the incident had to be closed down quickly. He said:

> "Getting the prisoner back to the cell quickly was good prison officering".

[113] In my judgment, the evidence does not support the conclusion that the officers should simply have left DD to calm down. The previous incident (some 4 weeks or

so earlier) was not analogous to the index incident on 7 December 2014. In the previous incident DD had voluntarily walked away, whereas in the index incident he continued to engage with and shout at the prison officers. The officers have a prison to run, and a regime to administer; they do not have an endless amount of time to deal with the non-compliant behaviour of one prisoner. For the reasons outlined by Mr Walker and Mr Wheatley, leaving the prisoner within the Hall in the speculative hope that he might just calm down by himself carried with it a greater risk of the situation escalating out of control, putting others at a risk of harm.

Option 4: seek medical input from a nurse

[114] The fourth "option" mooted for the pursuer was that, if they had known more of DD's medical condition and previous behaviour, the officers might have summoned the assistance of an NHS nurse who was working nearby, in the corridor between the HDU and the Admissions Unit.

[115] Again, in my judgment this submission is not well-founded in fact.

[116] In her testimony, which I accepted, Ms Ridgeway confirmed that she did not consider it appropriate to summon the assistance of a nurse because she did not want to expose anyone else to DD's aggressive behaviour, especially a civilian (such as the NHS nurse) who had not had the same level of training as a prison officer. Mr Walker agreed that, if one of the three attending prison offers were to have left the locus in order to summon a nurse, that would have increased the risk as it would have left only two officers to supervise the prisoner, whereas three officers were required in order to form a restraint team. He therefore agreed that, given the volatility of the prisoner, it was not a viable option for the officers to go and enlist the assistance of a member of the NHS healthcare staff.

[117] Mr Wheatley was more damning. He stated that it would have been "wildly dangerous" and "unforgiveable" if Ms Ridgeway (who, it will be recalled, was the only officer then in the HDU) had left the HDU while the prisoner was already misbehaving and in a state of over-excitement. He would have expected such officer to be disciplined, if he or she had left their post in those circumstances.

[118] Besides, even if a nurse had been summoned, the pursuer led no evidence to support the conclusion that, on the balance of probabilities, a course of action other than returning the prisoner to his cell would have been adopted. In other words, there was no evidence that matters would have turned out any differently.

Option 5: removing Ms Ridgeway from the situation

[119] Further, it was submitted for the pursuer that, had the prison officers known the content of the MDMHT minutes and DD's behavioural background, a fifth "option" available to them would have been to procure that Ms Ridgeway removed *herself* from the situation, as she had been involved in the initial confrontation with the prisoner and because (it was said) she was the target of his abuse.

[120] In my judgment, the evidence does not support this submission.

[121] Firstly, it will be recalled that Ms Ridgeway was the only officer in HDU that morning. She could not reasonably be expected to abandon her post in the speculative hope that the prisoner might simply calm himself down.

[122] Secondly, her colleagues (Mr Walker and Mr Gemmell) arrived on the scene from other posts. They came to assist her. Ms Ridgeway explained that, consistent with their training, in order to form a restraint team, a minimum of three officers required to be present. She could also not properly have left at that point, as to do so would have exposed

her fellow officers to undue risk by excluding the option of forming a full three-person restraint team.

[123] Mr Walker was asked whether there was any need for Ms Ridgeway to be there, to which he replied that they normally do have three officers present so that, if something happens, a three-man restraint team can be formed. Something did happen: the prisoner began to resist the "come along" hold, and a three-man restraint team was formed in order to bring the prisoner under control. It was clear from the evidence of Ms Ridgeway, and from the post-accident paperwork, that Ms Ridgeway played a significant role in bringing the prisoner under control.

[124] In my judgment, based upon the evidence, it would not have been reasonable for Ms Ridgeway to have left the scene entirely prior to Mr Walker and Mr Gemmell arriving (thereby leaving the prisoner unsupervised), or later to have left her colleagues to deal with the prisoner by themselves. If the prisoner were to have resisted the restraint (which was self-evidently a real risk, and was, in fact, what happened), the pursuer and Mr Walker would have faced an even more difficult task restraining the prisoner and would therefore have been exposed to a greater risk of harm. There was no-one else available in the HDU to assume Ms Ridgeway's position. In doing what she did, Ms Ridgeway acted perfectly reasonably and in accordance with her training and her duties as a prison officer.

Conclusion

[125] For the foregoing reasons, in my judgment, based upon the credible and reliable testimony accepted by me, the defenders discharged such duties as were incumbent upon them at common law. The specific duties of care posited by the pursuer far exceed what is reasonable or warranted on the evidence. As the pursuer has failed to establish any fault on

the part of the defenders, or that the pursuer's injuries and losses were caused by any fault on the part of the defenders, the pursuer's claim fails. Accordingly, I have granted decree of absolvitor in favour of the defenders.

[126] As the defenders have been wholly successful, I have also awarded the taxed expenses of process to date in their favour, so far as such expenses have not already been dealt with.