SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT PERTH

[2022] FAI 13

B154/20

DETERMINATION

BY

SHERIFF W WOOD

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

THOMAS LAMB COOPER CAMPBELL

Perth, 22 March 2022

Determination

The sheriff having considered the information presented at the inquiry, determines in terms of section 26 of the Act that:

1. The deceased is Thomas Lamb Cooper Campbell, born 6 August 1935. At the time of his death, he was a prisoner at HM Prison, Perth. He was an 84 year male who was a life prisoner, having been incarcerated on and off since his conviction for murder in 1967.

2. In terms of section 26(2)(a), the death occurred at 2137 hours on 24 November 2019 at Perth Royal Infirmary.

3. In terms of section 26(2)(b), the death did not occur as a result of an accident.

4. In terms of section 26(2)(c), the causes of death were:

I(a). Carcinoma of the bladder and its complications; and

II. Vascular dementia and frailty, tobacco smoking.

In the post mortem report prepared by Dr Helen Brownlow, it is noted that the deceased was a heavy smoker with a previous history of excess alcohol consumption. He had been admitted to Perth Royal Infirmary on 12 October 2018 for palliative care following a steady deterioration in his health as a result of vascular dementia and bladder cancer. The latter had been diagnosed in September 2016 following investigation of blood in the deceased's urine and associated anaemia. A cancerous tumour measuring 4cms x 5cms had been found in the deceased's bladder by the insertion of a camera. Although his surgeon had advised that this be removed, the deceased had declined surgical intervention. Medical records document increasingly laboured breathing, cough and signs of fluid within the lower part of his right lung on 12 November 2019, raising the suspicion of infection. Despite treatment with antibiotics, his breathing and level of consciousness continued to decline until his death on 24 October 2019. The complications of bladder cancer can include renal infection and/or failure due to the obstructions of the ducts responsible for draining urine by the tumour, and pneumonia secondary to the associated inability, frailty and immunosuppression associated with advanced cancer. Tobacco smoking is a significant risk factor for the development of bladder cancer and long-term heavy smoking could also cause chronic damage to the lung tissues such as chronic bronchitis and emphysema, further lowering resistance to infection.

Vascular dementia is regarded as contributory, as this condition is also associated with an increased risk of pneumonia and would further reduce the deceased's resilience to infection.

5. I make no findings in relation to section 26(2)(d) to (g).

NOTE

Introduction

[1] An inquiry was held into the death of Thomas Lamb Cooper Campbell, born 6 August 1935, at Perth Sheriff Court on 3 February 2021. The inquiry is a mandatory inquiry under section 2(3) of the Inquiries into Fatal Accidents and Sudden Deaths, etc. (Scotland) Act 2016 ("the Act"), the death having occurred in Scotland while the deceased was in legal custody. The death was reported to the Crown Office and Procurator Fiscal Service on 5 December 2019. Following advertisement of the preliminary hearing and inquiry hearings, notification of intention to participate was received on behalf of the Scottish Prison Service and Tayside Health Board. Both were represented at all hearings.

[2] At the inquiry hearing on 3 February 2021: the Crown was represented by Mr Mohammad Sadiq, procurator fiscal depute; the Scottish Prison Service by Ms L Thornton, solicitor; and Tayside Health Board by Ms K Fairlie, solicitor. No witnesses were led and the inquiry proceeded on the basis of a joint minute of agreement setting out agreed facts that should be admitted as evidence, and the

available productions. I then heard submissions on behalf of the represented parties, before closing the inquiry.

The legal framework

[3] The requirements to hold an inquiry under the Act are principally governed by sections 1 and 2, which are in these terms:

> "**1. Inquiries under this Act**
>
> (1) Where an inquiry is to be held into the death of a person in accordance with sections 2 to 7, the procurator fiscal must -
>
> (a) investigate the circumstances of the death, and
> (b) arrange for the inquiry to be held.
>
> (2) An inquiry is to be conducted by a sheriff.
>
> (3) The purpose of an inquiry is to -
>
> (a) establish the circumstances of the death, and
> (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances.
>
> (4) But it is not the purpose of an inquiry to establish civil or criminal liability.
>
> (5) In this Act, unless the context requires otherwise -
>
> (a) 'inquiry' means an inquiry held, or to be held, under this Act,
> (b) references to a 'sheriff' in relation to an inquiry are to a sheriff of the sheriffdom in which the inquiry is, or is to be, held.
>
> **2. Mandatory inquiries**
>
> (1) An inquiry is to be held into the death of a person which -
>
> (a) occurred in Scotland, and
> (b) is within subsection (3) or (4).

(2) Subsection (1) is subject to section 3.

(3) The death of a person is within this subsection if the death was the result of an accident which occurred -

(a) in Scotland, and
(b) while the person was acting in the course of the person's employment or occupation.

(4) The death of a person is within this subsection if, at the time of death, the person was -

(a) in legal custody, or
(b) a child required to be kept or detained in secure accommodation.

(5) For the purposes of subsection (4)(a), a person is in legal custody if the person is -

(a) required to be imprisoned or detained in a penal institution,
(b) in police custody, within the meaning of section 64 of the Criminal Justice (Scotland) Act 2016,
(c) otherwise held in custody on court premises,
(d) required to be detained in service custody premises.

(6) For the purposes of subsections (4)(b) and (5)(a) and (d), it does not matter whether the death occurred in secure accommodation, a penal institution or, as the case may be, service custody premises.

(7) In this section -

'penal institution' means any -

(a) prison (including a legalised police cell within the meaning of section 14(1) of the Prisons (Scotland) Act 1989), other than a naval, military or air force prison,
(b) remand centre, within the meaning of section 19(1)(a) of that Act,
(c) young offenders institution, within the meaning of section 19(1)(b) of that Act,

> 'secure accommodation' means accommodation provided in a residential establishment, approved in accordance with regulations made under section 78(2) of the Public Services Reform (Scotland) Act 2010, for the purpose of restricting the liberty of children,
>
> 'service custody premises' has the meaning given by section 300(7) of the Armed Forces Act 2006."

[4] The inquiry into the circumstances of the death of Thomas Lamb Cooper Campbell is, therefore, a mandatory inquiry in terms of section 2(4) of the Act. In terms of section 36 of the Act, the inquiry is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2007 ("the Rules").

[5] In terms of section 1(3) of the Act the purpose of the inquiry is to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. The specific matters to be determined by the court are set out in section 26 of the Act, which is in these terms:

> "**26 The sheriff's determination**
>
> (1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out -
>
> (a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and
> (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.
>
> (2) The circumstances referred to in subsection (1)(a) are -
>
> (a) when and where the death occurred,

(b) when and where any accident resulting in the death occurred,
(c) the cause or causes of the death,
(d) the cause or causes of any accident resulting in the death,
(e) any precautions which -

(i) could reasonably have been taken, and
(ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided,

(f) any defects in any system of working which contributed to the death or any accident resulting in the death,
(g) any other facts which are relevant to the circumstances of the death.

(3) For the purposes of subsection (2)(e) and (f), it does not matter whether it was foreseeable before the death or accident that the death or accident might occur -

(a) if the precautions were not taken, or
(b) as the case may be, as a result of the defects.

(4) The matters referred to in subsection (1)(b) are -

(a) the taking of reasonable precautions,
(b) the making of improvements to any system of working,
(c) the introduction of a system of working,
(d) the taking of any other steps,

which might realistically prevent other deaths in similar circumstances.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to -

(a) a participant in the inquiry,
(b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature."

[6] It will be evident from the above that it is not the purpose of an inquiry to establish civil or criminal liability. The nature of the inquiry hearing is that it is part of an inquisitorial process, in which the procurator fiscal represents the public interest and other interested parties can participate to assist the court in reaching its findings.

Summary

[7] Thomas Lamb Cooper Campbell was born 6 August 1035. At the time of his death, he was 84 years of age and serving a life sentence in HM Prison, Perth. A life prisoner, he had been incarcerated on and off since 1967, following his conviction for murder. He had a history of heart problems, high blood pressure, type two diabetes and issues with his prostrate and bladder as well as vascular dementia. Bladder cancer had been diagnosed in September 2016 when a camera examination of his bladder (flexible cystoscopy) had revealed a 4cm x 5cm cancerous tumour of which his surgeon had advised the removal. Mr Campbell had declined any surgical or other intervention.

[8] On 12 October 2018, Mr Campbell was transferred from prison to Perth Royal Infirmary due to acute deterioration of his physical health. His condition was assessed on admission and he was found to have probable vascular dementia with global cerebral atrophy that was advanced for his age. A certificate of incapacity dated 12 October 2018 is among his medical notes. His treatment was thereafter managed under section 47 of the Adults with Incapacity (Scotland) Act 2000.

[9] Due to his poor health, Mr Campbell was not expected to return to prison. He was assessed by Dr Louise Beveridge, Consultant Physician at Perth Royal Infirmary,

who wrote to the prison governor on 2 November 2018, indicating that the deceased had a life expectancy prognosis of less than three months. From early November 2018, it was agreed that a palliative approach would be adopted in relation to his care. Dr Beveridge completed a "Do Not Attempt Cardiopulmonary Resuscitation" ("DNACPR") pro-forma on the basis of the deceased's advancing bladder tumour and his lack of capacity.

[10] Following Mr Campbell's admission, the Multi-Disciplinary Team ("MDT") commenced discharge planning, but there were difficulties in identifying suitable accommodation for him. Although Mr Campbell's medical condition improved, he continued to require 24 hour nursing care. Case conference calls on 26 November and 14 December 2018 took place involving Fife social work, the prison head of nursing, Perth CHP and the ward 3 staff. Fife social work reported that they had attempted to find a placement for Mr Campbell, but could not find a community hospital that would agree to accept him, due to his complex needs.

[11] Following his admission to Perth Royal Infirmary on 12 October 2018 until on or about 2 September 2019, Mr Campbell was handcuffed, with three G4S/GeoAmey Prison Custody Officers ("PCOs") in attendance. After 2 September 2019, Mr Campbell remained uncuffed, except following incidents of aggression.

[12] Throughout his hospital stay, there were frequent episodes of Mr Campbell being verbally aggressive towards nursing staff and the PCOs, with occasional episodes of physical aggression towards nursing staff and more frequent episodes of physical aggression towards the PCOs. In particular, the following incidents were noted:

13 October 2018	Mr Campbell was aggressive and tried to punch PCO Robb, which had to be parried.
31 October 2018	Mr Campbell was aggressive and tried to kick PCOs Robb, Mann and Miller.
15 October 2018	Mr Campbell was aggressive and kicked PCO Robb in the stomach.
29 October 2018	Mr Campbell attempted to leave his hospital room. He was stopped at the door by PCO Heeps, whom he punched in the face.
1 December 2018	Mr Campbell was kicking out in his bed. He required to be double cuffed. PCO Heeps sustained a break of the fifth metacarpal. Control and restraint techniques were used.
13 October 2018	Mr Campbell kicked PCO Paterson in the face and PCO Opaleye in the stomach.
15 December 2018	Mr Campbell hit PCO Grabowski with his hand.
18 January 2019	Mr Campbell threw a punch at PCO Grabowski, who blocked the punch causing the deceased to punch the handcuffs and injuring his own hand.
21 January 2019	Mr Campbell tried to head-butt PCO Whyte but missed, hitting the door frame and falling to the floor thereby sustaining a cut eyebrow.

18 January 2019	Mr Campbell was agitated and aggressive. In turning round to lie on the bed in the opposite direction, the escort chain wrapped around his body. When asked to move, he punched PCO Baxter on the nose, causing a scratch and some bleeding.

[13] From his admission to hospital until 26 January 2019, the PCOs responsible for Mr Campbell's supervision were employed by G4S Care and Justice Services Ltd ("G4S"); from 26 January 2019, PCOs were employed by GeoAmey. Relevant copies of the contracts between the Scottish Ministers (on behalf of the Scottish Prison Service) and the prisoner escort service provider were produced. These agreements cover, *inter alia*, the agreed guidance for the use of mechanical constraints, such as handcuffs and escort chains. The use of mechanical restraints is not to be used at a higher level than necessary to reasonably mitigate against assessed or identified risks, or to maintain appropriate security. The security procedures used must be commensurate to the assessed or identified risks associated with each prisoner, the level of threat and the location of the escort on a case-by-case basis; and the assessed need to use handcuffs from a security perspective must be balanced against the impact of such a decision on a prisoner's dignity. There is a presumption against the use of mechanical restraints.

[14] Both the G4S and GeoAmey contracts make reference to an "Escort Monitor". According to the respective contracts, this means "the person or person appointed by the [Scottish Ministers acting through the Scottish Prison Service] to monitor and

oversee the [G4S/GeoAmey] operational performance, attainment and compliance with the various requirements of the contract for services. The Escort Monitor is a team of three people, one of whom is a police sergeant seconded to the SPS with the other two team members being SPS unit managers. There is no set standard for how many visits the escort monitor carries out as these are dependent upon the areas of concern. If the SPS is aware that there is someone in the hospital for a lengthy period, such as Mr Campbell, then the escort monitor would carry out a visit, in general, unannounced.

[15] On 23 July 2019, Mark Melloy of the escort monitor carried out an inspection of Mr Campbell's escort at the hospital and completed an audit report the same day. He had spoken to the PCOs about the continued use of the handcuffs and closet chain. He noted that the mechanical restraints were not being used for the purpose of escape prevention but for the purported purpose of deterring Mr Campbell from "kicking out". Mr Melloy noted that Mr Campbell had a bandage on his wrist to prevent the handcuffs rubbing and breaking the skin.

[16] SPS policy (document GMA 32A/13, dated 27 June 2013) requires prisoners detained in hospital for extended periods to be visited weekly by the duty manager of the relevant prison. At HMP Perth, this normally takes place over the weekend. One of the duty managers, Richard Coupe, recalled having visited Mr Campbell on about four occasions. Noting that he was handcuffed, he had challenged the PCOs on their use; the PCOs had said that they had been advised to keep Mr Campbell handcuffed because he was violent. In such circumstances, the SPS did not have any jurisdiction to intervene as it was a matter for the escort, in terms of the contract. Mr Coupe recalled that other duty

managers had told him that they, too, had raised concerns about Mr Campbell being handcuffed. On one occasion, Mr Coupe had noted Mr Campbell's wrists to have been bleeding and that he was "double cuffed", and it was after this that Mr Campbell's wrists had been bandaged.

[17] From in or around January 2015, Mr Campbell's Life Liaison Officer ("LLO") was Dugald Alexander Munro Lawson. LLOs provide the casework for life sentence prisoners, attend meetings in relation to their welfare and appear at Parole Board and other hearings and relevant tribunals. Mr Lawson noted that Mr Campbell had been returned to HMP Perth for a mental health assessment in June 2014, due to an increase in his disorientation that had given cause for concern in relation to his safety and wellbeing. There had been collaboration within the community to seek a guardianship order through the courts and the Risk Management Team ("RMT") had sought advice regarding possible compassionate release for Mr Campbell. However, he was not considered to be manageable within the community due to his encounters with other prisoners and his verbal abuse.

[18] In April 2015, a Parole Board tribunal carried out a two-year review. They noted that Mr Campbell's risks were not manageable in the community and, although there was no clear psychiatric diagnosis he still presented as someone who was aggressive, disinhibited and uncontrollable with no real insight into his presentation or personality. In or around 2017 or 2018, the Parole Board had asked for plans to be provided, with a view to Mr Campbell being accommodated within the community. He required 24 hour care in an enclosed environment. An issue arose because neither Perth nor Fife social

work could decide who ought to deal with Mr Campbell (Mr Campbell having come from Fife). In any event, both councils had been unable to identify any suitable accommodation. A solicitor appointed for Mr Campbell for the purpose of the Parole Board declined to act as he appeared to lack capacity to provide instructions. Perth and Kinross Council were then obliged to obtain a legal guardianship order. Thereafter, Mr Campbell did not attend tribunal meetings as his behaviour was becoming so erratic. Gerard Boyle, a former unit manager at the prison, recalled having started an application for compassionate release, but as Mr Campbell did not meet the necessary criteria of "imminent death", this could not be taken further.

[19] Mr Lawson had visited Mr Campbell twice in hospital so that he could prepare a report for the Parole Board. He noted that Mr Campbell had been handcuffed and presented as being very agitated. Mr Lawson thought it was understandable why handcuffs might be applied. He explained that Mr Campbell was not handcuffed to the bed, but to a PCO using a "closet chain" - so called, because it was long enough for people to have privacy if they go to the bathroom. Mr Lawson prepared his LLO overview report on 6 September 2019, noting that Mr Campbell's behaviour had deteriorated over the previous three months and that his return to HMP Perth was not envisaged by NHS staff. He required a wheelchair if going any distance, and was otherwise unsteady on his feet. He remained handcuffed to escort staff at all times and spent most of his time on his bed, quite heavily sedated. Mr Lawson noted that, even then, Mr Campbell retained the ability to hurt someone due to his unpredictability and behaviour. Mr Lawson understood that there was to be "a management plan protocol"

between SPS and GeoAmey for individuals in hospital for prolonged periods, which is now part of the duty manager's weekend duties.

[20] The hospital medical notes indicate the deterioration in Mr Campbell's health during the week before his death. Due to being too drowsy for the oral intake of food and fluctuating consciousness, he was marked "nil by mouth" for the four days prior to his death. The notes kept by the PCOs (completed half-hourly, in accordance with their duties) note the rapid deterioration in Mr Campbell's condition over the three days prior to death and that he had become bedbound. At around 1800 hours on 24 November 2019, PCOs Odette Livingston and Kyle Robb commenced their duties at Perth Royal Infirmary. Shortly prior to 2137 hours that day, they noted Mr Campbell take a deep breath and thereafter make no respiratory effort. The officers activated the alarm, prompting the attendance of nursing staff. The latter conducted observations and established that Mr Campbell had no pulse. The "DNACPR" decision that had been made in light of Mr Campbell's advancing bladder tumour meant that no attempt was made to revive him. Dr Verity Ford attended and, having carried out her own observations, pronounced life extinct at 2137 hours on 24 November 2019.

[21] At the instance of the Procurator Fiscal, Dundee, Dr Helen Brownlow carried out an autopsy examination on Mr Campbell's body on 28 November 2019, certifying the cause of death as:

I(a) Carcinoma of the bladder and its complications;

II. Vascular dementia and frailty, tobacco smoking.

These results are contained within the post mortem examination report dated 3 January 2020.

[22] Tayside Health Board carried out a "Local Adverse Event Review" ("LAER") between 17 February and 10 July, both 2020 and produced a report dated 8 September 2020. The review group noted that Mr Campbell was deemed to be clinically fit for discharge on 19 January, both medically and psychiatrically. The MDT had discussed and created an "anticipatory care plan" in the event of his discharge, and although it was noted that he required a high level of care that could not be provided within HMP Perth, there were difficulties in finding alternatives. Following a further assessment in July 2019, it was agreed that Mr Campbell could go outside with the PCOs - which was noted to have a marked improvement on his demeanour and reduced the episodes of violent behaviour. By the end of the summer of 2019, it was clear that Mr Campbell would not be able to return to HMP Perth as he then required 24 hour care. The MDT and senior hospital management explored options for suitable discharge but were unsuccessful in finding a care home that was willing to accept Mr Campbell. It had been considered whether Mr Campbell's case should be escalated to the Scottish Government. Thereafter, however, Mr Campbell's physical and mental condition continued to decline and he died of natural causes on 24 November 2019 within Ward 3. It was concluded that Mr Campbell had a terminal illness and that his death could not have been prevented, but it was noted that an earlier functional and mobility assessment might have improved Mr Campbell's physical and mental wellbeing due to an increased

opportunity to mobilise and to access the outdoors, as well as supporting the earlier discussion regarding the less frequent need for the use of handcuffs.

[23] There had been a lack of clarity regarding which local authority had community social work responsibility for Mr Campbell, which also hampered and delayed subsequent assessments being undertaken. The review noted input from the service manager for adult social work and social care that, from 2021, there was an intention across Scotland that those in custody would be "ordinary residents" for the duration of their sentence, notwithstanding that they did not choose to live in the local area in which the prison is situated. It was also noted that there was a "test of change" underway within the prison, part of which would involve mirroring the community social work assessment process within the prison environment. Although Mr Campbell's guardian was within Perth and Kinross, his community social worker was from Fife [from which Mr Campbell originated when sentenced]; the lack of certainty over responsibility had had a detrimental impact on Mr Campbell. Being allowed to go outside had been of "huge benefit" for both Mr Campbell and the GeoAmey staff.

[24] Following Mr Campbell's death, the Scottish Prison Service also carried out a review, leading to the "Death In Prison Learning, Audit & Review" ("DIPLAR") report dated 26 August 2020. This examined the exercise of responsibility for arranging social care of those in prison, which then rested with SPS, with input from the local health and social care partnership. This had been reviewed by the Scottish Government. It was noted that a "test of change" had been in place for six months, whereby the assessment of health and social work needs in prison would mirror what happened in the

community. It was anticipated that this change would be implemented in 2021. It was acknowledged that "had this been in place previously, the situation for Mr Campbell may have looked quite different." Attendance at the DIPLAR review meeting by Fife Health and Social Care Partnership was prevented by the then-emerging concerns over Covid-19.

[25] Further information about future improvements to the delivery of social care within the prison estate was provided Finlay Begg. Mr Begg is acting head of social justice for the SPS and is the lead representative within one workstream of a Scottish Government review into health and social care in prisons; specifically, that dealing with health and social care integration in prisons. At the time of Mr Campbell's death, SPS was responsible for commissioning, funding and facilitating the provision of social care for those in custody whilst local health and social care partnerships had responsibility for this within the community. The SPS relied upon the local partnership to undertake the necessary assessments and to identify a care plan which the SPS would then commission, fund and facilitate a care provider to deliver that. Although a number of different models were being tried (that is, the "tests of change") with different local health and social care partnerships in Scotland, if there was a dispute between two local partnership in relation to responsibility, that was unlikely to change and the SPS were unlikely to have any locus in such a dispute. There are no health care wings within prisons in Scotland and there are no NHS health care staff in SPS establishments overnight. The provision of 24/7 social or nursing within the prison establishment can be operationally problematic due to the existing security protocols that are in place

overnight. For those in custody, it is the responsibility of the local health and social care partnership to assess a person's needs and to develop the social care package; it is then the SPS's responsibility to resource, fund and facilitate that through a social care provider. On a prisoner's release, it is the relevant partnership within the area where they are going to be released who is responsible. Transitional arrangements would be a matter for the two relevant health and social care providers to put in place.

[26] The DIPLAR records that Perth and Kinross health and social care partnership were responsible for obtaining a suitable placement for Mr Campbell. They approached 42 nursing/care homes whilst he was in PRI, but none were in a position to accept him due to the risk he was still deemed to present to others.

[27] The SPS had considered whether Mr Campbell was eligible for early release on compassionate grounds, the guidance for which is attached to SPS document GMA054A/15 dated 9 September 2016. The specific criteria to be met for early release on compassionate grounds are set out at Annexe 1 to that document: the criteria for release on medical grounds are as follows:

> "(i) **Medical**
>
> - early release on compassionate grounds may be considered where a prisoner's death is anticipated within a short timescale or the prisoner is confined to bed or seriously incapacitated; and
> - the risk of re-offending or public harm is low and can be managed; and there are appropriate arrangements for the prisoner's supervision, care and treatment in the community; and
> - early release will bring some significant benefit to the prisoner and his/her family."

[28] Although the necessary application for compassionate early release was begun for Mr Campbell, it would appear that this was not progressed because: the likely timescale for Mr Campbell's death could not be assessed with any accuracy; he continued to be violent and to present a risk of re-offending; and appropriate arrangements for his supervision, care and treatment in the community could not be established.

Discussion and conclusions

[29] From all the evidence that I have seen and considered, it is clear that Mr Campbell's death was as a result of natural causes. I have no difficulty in holding that the facts are as I have set them out in the foregoing paragraphs. Mr Campbell was appropriately taken to hospital where he received care under the direction of NHS staff before he finally passed away on 24 November 2019. There is no basis on which to make any criticism or make any adverse finding in relation to the involvement of any of the staff employed by Tayside Health Board in relation to the clinical care of Mr Campbell nor has it ever been suggested that something might have been done that was not done in order to prevent his death.

[30] Equally, it is clear that there is no basis on which I could make any adverse findings or comment in relation to the actions of SPS staff in relation to how Mr Campbell's medical or psychiatric conditions were treated and there is no basis on which any finding could be made that something might have been done that was not done by them that might have prevented Mr Campbell's death.

[31] I do, however, have some concerns over how Mr Campbell was treated - aside from his clinical care - between his initial admission to hospital on 12 October 2018 and his eventual passing on 24 November 2019. Those concerns are: firstly, the length of time that Mr Campbell remained in handcuffs; and secondly, the confusion over responsibility for his potential transfer to care within the community.

[32] According to the evidence, Mr Campbell spent almost a year (that is, from his admission up until on or about 2 September 2019) handcuffed to a PCO. I note that, although Mr Campbell was chronically unwell both physically and mentally (due to his dementia), he managed to retain some of the violent disposition that led him to commit a savage murder and numerous incidents of violence both within prison and when on parole, even in the later stages of his life. He had assaulted staff on numerous occasions in the hospital and that it would appear that his continued restraint was more of a continued deterrent rather than being aimed at preventing the assessed risk that he would "kick out". The NHS Tayside LAER identifies that, following an OT/physiotherapy assessment, it was a matter of agreement that Mr Campbell could go outside which "was noted to have a marked improvement on the patient's demeanour and reduced the episodes of violent behaviour." Although it is unclear precisely when those trips outside began, it seems to have been sometime between July 2019 (when the assessment was completed) and 2 September 2019. It is unclear whether that assessment as a whole might have been completed earlier - and if so, to what benefit to both Mr Campbell and to his PCOs.

[33] The circumstances in which restraint is appropriate are set out in the contract between the Scottish Ministers/SPS and G4S/GeoAmey. Although I was invited to find that SPS are not involved in the decision-making process with regards the deployment of handcuffs, I also note that there is provision for both the prison duty manager to visit prisoners in hospital care and for prisoners detained in hospital to be visited by the Escort Monitor. Presumably these obligations are there for a purpose, that is, in order for SPS staff and the Scottish Ministers to be assured that prisoners in hospitals are being appropriately supervised. In light of Mr Campbell's conduct in hospital - assaulting various PCOs at various times - I do not doubt that his restraint would have appeared justified but, as I have suggested above, perhaps an earlier, more holistic assessment of his needs at an earlier stage might have improved his demeanour to the extent where handcuffs were no longer considered necessary. I hesitate to criticise either the duty managers or the PCOs in relation to a prisoner of Mr Campbell's proven tendency to violence.

[34] Mr Campbell's circumstances also highlight the difficulty that can arise where there is no settled mechanism for the transfer of a chronically or terminally ill prisoner who is unable to be returned to prison, from a hospital to the community. While I do not doubt that, whoever ought to have been responsible - whether that ought to have been the Fife or Perth and Kinross health and social care partnerships - would always have had considerable difficulties in finding an appropriate placement, the absence of clear responsibilities would no doubt have led to considerable frustration for both prison and hospital management. It may be that it is rare that any such conflict is of any

particular moment and perhaps in the case of Mr Campbell - a man of complex care needs but a persistent and violent offender who had assaulted both hospital and custody staff and with reduced insight due to his dementia - the outcome might not have been any different.

[35] In light of the need for Mr Campbell to be constantly supervised due to the risk of violence that he posed, and the lack of any clear prognosis as to his end of life, I accept that he would not have been a candidate for compassionate early release in accordance with the guidelines.

[36] I find that Mr Campbell died as a result of natural causes, *videlicet*: carcinoma of the bladder and its complications; and that at the time of his death he suffered vascular dementia and frailty. None of the concerns that I have raised highlight any precautions that might have been taken in order to prevent that.

[37] I join with the participants to this inquiry to offer my condolences to Mr Campbell's family.