SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2022] FAI 21

GLW-B1297-20

DETERMINATION

BY

SHERIFF G BONNAR

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

into the death of

SCOTT HANNAH

GLASGOW, MAY 2022

The Sheriff, having considered all the evidence, the written and oral submissions presented at the Inquiry, the productions and the terms of the joint minute, FINDS AND DETERMINES:

(1) In terms of section 26(2)(a) of the Inquiries into Fatal Accidents and Sudden Death etc (Scotland) Act 2016, Scott Hannah died on 27 November 2019 within his cell 1/22, A Hall, HMP Barlinnie, 81 Lee Avenue, Glasgow, G33 2QX. The time of his death was 06.50 hours on that date.

(2) In terms of section 26(2)(c) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, the cause of death was hanging.

(3) I make no findings under paragraphs (b), (d), (e), (f) or (g) of section 26(2) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016.

(4) I have no recommendations to make under section 26(1)(b) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016.

NOTE

Legal Framework

Appendix 1 sets out the legal framework for the inquiry.

Introduction

[1] The family's representatives submitted that I should make a finding under section 26(2)(g) "any other facts which are relevant to the circumstances", firstly, in respect that there was a failure to identify, and act upon, the fact that the late Mr Hannah was suffering from acute anxiety, particularly in the week leading up to his death. And, secondly, a finding further to their concerns relating to the processing of his complaint form dated 25 November 2019. The other parties moved the court to make a determination in what is termed "formal findings". Ms Bowley and the family have suffered a terrible loss but for the reasons I set out below, I did not consider it would be appropriate to make the findings sought by the family and I have made formal findings only.

Procedure and evidence

[2] Evidence was heard on 31 January 2022 and a hearing on submissions fixed for 4 March 2022. All parties lodged written submissions and Mr Smith lodged brief supplementary submissions on behalf of the Scottish Prison Service. Thereafter, parties confirmed they had nothing to add to their written submissions and the hearing on submissions was discharged.

[3] The court convened preliminary hearings at which the agreement of evidence and procedure was discussed. These considerably reduced the length of the hearing. The family were keen to be represented by the firm of solicitors with which they had an established relationship. At the outset of the proceedings the firm were not registered for civil legal aid. They had to apply to be registered and only thereafter were able to apply for legal aid for these proceedings. This resulted in a number of additional preliminary hearings. No party objected and given the reason for the additional time was to ensure the family had representation by a firm with which they had an established relationship the court was prepared to accede to the required continuations.

[4] All callings were conducted by WebEx. It had been my intention that the substantive hearing itself should proceed in person. A date was fixed for 31 January 2022. In the period immediately before that date there was much concern due to the emergence of the Omnicom variant of Covid 19 and accordingly, in order to remove

the risk of the hearing having to be postponed, and with the agreement of all parties, I ordered the hearing to proceed by WebEx.

Representation

[5] Ms Allan, Procurator Fiscal Depute represented the Crown. Ms Ryan, Solicitor, represented the interests of the late Mr Hannah's family including his partner Natalie Bowley. Mr Rodgers, Solicitor appeared on behalf of the Scottish Prison Officer Association with Mr Smith, Solicitor, representing the Scottish Prison Service. Ms Paton, Solicitor, of the NHS Central Legal Office, appeared on behalf of Greater Glasgow Health Board. I am grateful to the parties' representatives for the manner in which they conducted the inquiry.

[6] A detailed joint minute was entered into agreeing the majority of the relevant evidence.

Witnesses

[7] The court heard evidence from the following witnesses:

1 Natalie Bowley, the deceased's partner.

2 Colin Robert Clark, Prison Officer.

I am grateful the witnesses who gave evidence to assist the inquiry. I found them to be credible and reliable.

Scott Hannah

[8] I gained some insights about Mr Hannah from the evidence and documents before me but particularly from those who gave evidence about him and their memories of him.

[9] Ms Bowley had been in a relationship with Mr Hannah for six years but had known him for much longer. She spoke about his problems with addiction to alcohol and drugs and difficulties he faced with anxiety and depression and she was directed to some of the medical records which referred to these issues. She described her concern for him. She visited every week and they spoke every day. She showed considerable strength to get through her evidence, in spite of the upset of having to go over events and in particular recalling conversations. Her love and affection for him and her grief was very clear. Ms Bowley is also the mother of Mr Hannah's daughter who was born on 3 January 2020.

[10] Mr Clark, who was a Prison Officer at HMP Barlinnie, with 10 years' experience, knew Mr Hannah well. Mr Hannah was a pass man, trusted to carry out duties in relation to cleaning and laundry and serving food. Mr Hannah worked hard and did his job well and he enjoyed physical training. Mr Clark described him as a "decent guy", with whom he had no issues.

Findings

[11] Having regard to the joint minute and the evidence of Ms Bowley and Mr Clark, I found as follows.

[12] Mr Hannah was sentenced to 27 months' imprisonment on 11 June 2019 for a charge under the Misuse of Drugs Act 1971 and his earliest date of release was 24 July 2020. He had served four previous periods of imprisonment and was first sent to prison on 17 August 2011. At his induction at HMP Barlinnie on 12 June 2019 he was asked if he had ever attempted suicide or self-harm or whether he had any thoughts of self-harm or suicide and he answered no to both questions. It was noted in his medical records that he had had an incident of self-harm by cutting his wrists in or around 2015. Ms Bowley had found him to be agitated in the early stages of his sentence, in particular recalling the way he presented on the phone and in a particular visit.

[13] On 5 August 2019, Mr Hannah self-referred to the mental health team requesting an alternative to his then current prescription of diazepam. He had a consultation on 8 August and was referred to a GP seeing Dr Khoda Buksh on 15 August 2019. Ms Bowley was aware he had made a request although she had not been aware that he had completed a form (page 201 of Crown Production 4). She also confirmed that Mr Hannah's mother had called in to the prison as noted (p186 of CP 4, entry dated 9/8/19). Mr Hannah had expressed a view that his concerns were not being listened to. Mr Hannah had a further seven consultations or meeting with medical staff between 15 August and 25 November 2019. He returned negative drug tests on 3 September and 23 October 2019.

[14] Mr Hannah cancelled some visits in November and expressed concern that he would still be in custody at the time Ms Bowley was due to give birth. He had told

her around that time that he could not deal with visits although he also seemed in good spirits at other times. On 20 November 2019, Mr Hannah saw Michelle McAleer, a nurse and reported a seizure. Although no evidence of seizure activity was noted, Nurse McAleer noted his condition being anxiety related and listed him to see the GP the following day. He consulted the same day with another nurse, Lauren Fairley, presenting similar symptoms. He was placed with his cell that night to keep an eye on him. The following day, 21 November, he saw Nurse Helen Stewart presenting similar complaints. He advised he was stressed about his partner being pregnant and asked about a move to Castle Huntly (an open prison). He was seen that afternoon by Dr Sutchi Senthill, he had an ECG and blood was taken, his pulse was 110 beats per minute. Dr Senthill considered there was no evidence of a stroke and that he was unwell as a result of a viral infection and anxiety. The following day, 22 November 2019, Mr Hannah had another ECG and bloods were taken and analysed. All test results where within normal levels. Two days later, on 24 November, Mr Hannah consulted Nurse Holly Holtby, complaining of dizziness. His pulse was a 103 bpm. It was noted a viral infection had been previously diagnosed and he was advised this may take time to resolve.

[15] On 25 November, Mr Hannah, was referred to the nurse in station by staff in A Hall complaining of central chest pain, radiating to his face which was tight. His pulse was ranging between 98 and 197 bpm. Nurse Holtby arranged an ambulance for a transfer to Glasgow Royal Infirmary. In a statement from Nurse Holtby she expressed her shock at Mr Hannah's subsequent death. This was at least in part due

to the conversation they had whilst waiting for the ambulance. Mr Hannah had spoken about his pregnant partner and the daughter she expected. He told Nurse Holtby that this was a strong reason not to return to prison and spoke about starting a new life when liberated and he mentioned a course that he was undertaking in prison which he did not wish to miss. Ms Bowley was able to advise that he had also called his mother that morning expressing anxiety.

[16] Mr Hannah was admitted to Glasgow Royal Infirmary, Accident & Emergency Department. He complained of chest pain over two weeks and a seizure, he was noted to be very anxious in triage with a history of depression and anxiety and a heart rate of 93 bpm. Thereafter, however, he indicated he did not wish to wait in the Emergency Department and was discharged back to HMP Barlinnie. He attended the nursing station again complaining of chest pain and his heart banging in his ribs. He was agitated and pacing. He denied taking any illicit substances at the time he was prescribed mirtazapine and co-codamol. He demanded to be sent back to hospital and was told this would not happen and left the nurses station. He was seen by Nurse Holtby in his cell. He reiterated his request to return to hospital indicating he wished to be prescribed morphine to help his sleep. Nurse Holtby explained that this would not be appropriate, indicating no concerns but provided worsening advice. In her statement, she went on to explain that she erred on the side of caution and would have recorded any concerns about Mr Hannah's mental health and placed him on Talk to Me had she had such concerns.

[17] Mr Hannah had been assessed on his return to Barlinnie on 25 November. Mr Hannah had been assessed under Talk to Me upon his return to Barlinnie on 25 November and marked as no apparent risk. Ms Bowley spoke to him that evening and felt he was anxious and not in good form. He explained that he had felt uncomfortable about people staring at him, in handcuffs, at the hospital and that he wanted to leave. He had been advised at one stage that he had been at high risk of cardiac arrest. He wanted something to take the edge off his anxiety. He advised that he had completed a complaint form (p194-5 of CP4).

[18] Talk to Me is the Scottish Prison Service Suicide Prevention policy. All members of prison staff and NHS staff are trained on this policy. Any member of staff can complete a concern form initiating the Talk to Me process and a case conference. If a case conference is called multi-disciplinary trained individuals make an assessment of the prisoner. If a prisoner is assessed at risk an appropriate care plan, which can involve observations or an anti-ligature cell, is put in place. No action is taken if a prisoner is deemed as "no apparent risk". Talk to Me policy and guidance was lodged as a production and Mr Clark, the prison officer was asked questions in that regard. He confirmed he had been trained on Talk to Me and that Talk to Me can be invoked by any member of staff at any time and any prisoner can approach staff and be referred. He did not consider that there were any barriers and that any concern could be raised through Talk to Me and he agreed that the approach was to err in the side of caution and initiate Talk to Me if there was a concern. It was something that was done regularly and was dependent on what was observed.

[19] Various examples of behaviour from the Talk to Me guidance were put to Mr Clark, on the basis they were relevant to Mr Hannah and ought to have led to further action. I accepted his explanation that there was a constant dynamic risk assessment involved. He felt that in Mr Hannah's case Talk to Me was not merited at any point. He acknowledged in his evidence that about two weeks before his death Mr Hannah's presentation had "gone downhill" and he displayed anxiety.
Mr Hannah had complained to prison officers and his complaints were acted on by being escalated to nurses. He had seen nurses numerous times. On one occasion he had been taken to hospital but had returned quite quickly. Mr Clark had been advised that Mr Hannah had signed himself out. Mr Clark had limited dealings with him after his hospital visit but he had seemed a bit better on his return. Mr Clark agreed that it was part of the role of prison officers to monitor and refer prisoners. If behaviour is bizarre or erratic officers can refer, some behaviours can be alarming. As a passman Mr Hannah was regularly out of his cell and could be speaking to staff regularly. Typically a passman might speak to a member of staff 4 or 5 times in a shift. Once referrals were made to medical staff he would leave it to them as they are appropriately trained.

[20] Mr Hannah completed a prisoner complaint form on 25 November 2019. This complaint was allocated to F Gibbons on 27 November 2019.

[21] On 26 November 2019, Mr Hannah had a dental appointment and agreed a treatment plan and no concerns regarding his physical and mental health were noted at that point. He spoke to Ms Bowley that evening telling her that he felt a little

better. She had wanted to complain but Mr Hannah discouraged her. He said that he knew what he had to do and she now considers that he had made a decision at that point.

[22] Mr Hannah was last seen at 21.15 hours on 26 November 2019 during lockdown and no concerns were noted.

[23] During the morning checks around 06.45 hours on 27 November, Prison Officer, Alan Murray observed Mr Hannah to be hanging from the top row of his bunk bed. He raised a code blue alarm, prison officers, nurses and paramedics found no sign of life and his life was pronounced extinct by paramedic, Neil Divers at 06.50 hours on 27 November 2019. The ligature had been formed from a pair of tracksuit trousers.

[24] The pathologist, Marjorie Turner, conducted a post-mortem examination on 10 December 2019 and found the cause of death to be hanging and the findings of the toxicologist report identified promethazine and therapeutic concentrations of mirtazapine and quetiapine which had no direct contribution to Mr Hannah's death.

[25] A joint SPS and NHS view was carried out on 15 January 2020. The review found no obvious reason why Mr Hannah should have completed suicide.

[26] Ms Bowley in her evidence made clear the concern she had for Mr Hannah during this time. It was her feeling that more should have been made of his anxiety and that there were signs that should have been picked up. She was also concerned that his complaint had not been acted on more swiftly because, although she acknowledged staff would be very busy, she felt that should have been given more

priority. Ms Bowley acknowledged in her evidence Mr Hannah had difficulty expressing his true feelings. This was the case even when he was speaking to her. She said he did not talk about his feelings unless he was under the influence.

[27] I heard from Ms Bowley about how the family heard about the passing of Mr Hannah. Ms Bowley had gone to hospital for urgent checks upon her, then unborn, daughter, as she was not feeling movement. A prisoner released that day had advised the deceased's brother. The family contacted the prison but were not officially informed of Mr Hannah's death until police attended in the afternoon.

Conclusion

[28] Mr Hannah was imprisoned on 11 June 2019. He had been a prisoner on several previous occasions. Mr Hannah was assessed on his admission to prison under the SPS Talk to Me strategy. He was not considered to be at risk. Mr Hannah had medical consultations in August when he self-referred to the Mental Health Team and further consultations with medical staff thereafter.

[29] From 20 November until his death on 27 November he had numerous medical consultations, he was seen by five different nurses over the course of this period and a GP within the prison. He was taken to the Accident & Emergency Department of Glasgow Royal Infirmary at the instigation of Nurse Holtby. Whilst anxiety is noted no member of medical staff nor any prison staff considered that during this time that a referral under Talk to Me was required. Mr Hannah received considerable medical attention in the form of tests and noting of symptoms. It seemed to me his concerns

and symptoms were acted upon and given proper attention and were not dismissed. Accordingly, I find no criticism of the medical or prison staff in this case given the referrals and detailed medical examinations carried out.

[30] Further, taking account of these detailed and numerous medical interventions I do not consider that it would be appropriate to make the finding sought by the family that there was a failure to act upon the signs of Mr Hannah's deteriorating mental health nor to make a recommendation that would address the way in which the assessment process to initiate Talk to Me is carried out. Such a finding would require to be based on evidence and there was no such evidence before me on which to base such a finding. It could not be said there was a failure to act upon Mr Hannah's mental state when one considers all the consultations and examinations which he had. Ms Bowley's view is her understandable reaction to the situation from her perspective. She and the family bear the grief and sadness of the loss of a loved one but it is, however, clear to me from the productions in evidence in the case that considerable thought, work and expertise has gone into the creation and implementation of a strategy. The staff who dealt with Mr Hannah were aware of and trained in that strategy and considerable attention was paid to Mr Hannah's concerns, considerable attention was paid to Mr Hannah's anxiety and to his concerns about his health.

[31] Any such strategy and guidance can be reviewed and improved over time but there was no evidence in the Inquiry before me that would allow me to make any

finding or recommendation or justify any criticism of the NHS or SPS staff who dealt with Mr Hannah.

[32] As regards the processing of the complaint form, analysed properly, the complaints procedure is not in place to deal with immediate concerns requiring medical intervention. Such matters are properly addressed through observations by staff, consultations with medical staff and raising issues directly with medical staff or by referral from prison staff. This is how Mr Hannah's health concerns were addressed. A complaints procedure in effect runs alongside the substantive medical services and accordingly, I do not consider that any finding or recommendation arises from that in this case.

[33] In relation to communication of the passing of Mr Hannah, I was saddened to hear that the family had heard about the loss of Mr Hannah before they could be properly and appropriately informed. Ms Bowley explained how this had caused them distress whilst they tried to clarify the position. I was advised on behalf of SPS that steps have been taken to ensure that such a situation does not arise again. The family's submission acknowledges this would not form part of my determination. Nevertheless it is worthy of note and I was assured that the concerns raised have been addressed and changes in processes made, in particular that there is a single point of contact in the prison.

[34] It remains for me to offer my condolences to Ms Bowley and to Mr Hannah's family, a sentiment that was expressed by all representatives before the Inquiry.

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Appendix 1

Legal Framework

[1] This inquiry was held in terms of section 1 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the 2016 Act"). Mr Hannah died while in custody as a convicted prisoner. In terms of section 2, the Inquiry was a mandatory Inquiry. The Inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 Rules").

[2] The purpose of the Inquiry is, in terms of section 1(3) of the 2016 Act, to establish the circumstances of the death of Mr Hannah and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It is not the purpose of the inquiry to establish civil or criminal liability (section 1(4) of the 2016 Act). The manner in which evidence is presented to an inquiry is not restricted.

[3] Section 26 of the 2016 Act sets out what must be determined by the Inquiry:

(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."