SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2022] FAI 34

GLW-B629-21

DETERMINATION

BY

SUMMARY SHERIFF PATRICIA A PRYCE

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

into the death of

PAUL HAMILTON

GLASGOW, 22 September 2022

The sheriff, having considered the information presented at the Inquiry, Determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (herein after referred to as "the 2016 Act") the following:

(1) In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred) that Paul Hamilton, born 15 May 1976, died at Glasgow Royal Infirmary, Glasgow on 24 October 2019 at 1245 hours.

(2) In terms of section 26(2)(c) of the 2016 Act (the cause or causes of death), that the cause of death was hanging.

(3) In terms of section 26(2)(e) of the 2016 Act that there are no precautions which could reasonably have been taken that might realistically have resulted in the death being avoided.

(4) In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death) that there are no other facts which are relevant to the circumstances of the death.

(5) In terms of section 26(1)(b) of the 2016 Act, there are no recommendations which might realistically prevent other deaths in similar circumstances arising from the information provided.

NOTE:

Introduction

[1] This Inquiry into the death of Mr Hamilton was held on 21 and 22 June 2022 by way of an in person hearing at Glasgow Sheriff Court. Ms Guy, Procurator Fiscal Depute, represented the Crown. Mr Sloan, represented the next of kin, Ms JH, the widow of Mr Hamilton. Ms Paton of the NHS Central Legal Office, represented the interests of the relevant Health Board. Mr Smith, Solicitor, for the Scottish Prison Service, represented the interests of the SPS. Finally, Mr Rodgers, Solicitor, represented the interests of the Prison Officers Association of Scotland.

[2] The parties entered into a detailed and comprehensive Joint Minute of Admissions in advance of the hearing dates. I am grateful for the care and attention given to the agreement reached.

Purpose of this Inquiry

[3] The 2016 Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 Rules") govern Fatal Accident Inquiries. A Fatal Accident is held under section 1 of the 2016 Act and its purpose in terms of section 1(3) 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 purpose of the Inquiry is not establish civil or criminal liability. The process is inquisitorial in character. The procurator fiscal represents the public interest at the Inquiry. The present Inquiry was mandatory in terms of sections 2(1) and (4) of the 2016 Act as Mr Hamilton was in legal custody at the time of his death.

[4] As regards the circumstances, the sheriff must make findings regarding:

(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; and

(g) any other facts which are relevant to the circumstances of the death.

[5] In terms of section 26(4) the sheriff is entitled to make recommendations regarding:

(a) the taking of reasonable precautions;

(b) the making of improvements to any system of working;

(c) the introduction of a system of working; and

(d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

Witnesses

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

1 Ms Lorraine Roughan, Deputy Governor of HMP Barlinnie.

2 Dr Gordon Skilling, Consultant Psychiatrist.

3 Dr Dinesh Maganty, Consultant Psychiatrist.

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

[7] The Inquiry also considered evidence from numerous witnesses by affidavit, namely, Ms JH, wife of Paul Hamilton, Ms Gillian Crossan (First Line Manager, employed by the SPS) and Mr Barrie Kelly (Residential Officer, employed by the SPS).

Factual circumstances

Events leading to Mr Hamilton's death

[8] On 20 July 2018 at the High Court of Justiciary in Glasgow, Paul Hamilton was sentenced to a period of 3 years and 4 months' imprisonment having tendered a plea of guilty to a charge of attempting to pervert the course of justice. This sentence was backdated to 16 March 2018 and his earliest date of liberation was calculated as 14 November 2019.

[9] Mr Hamilton was incarcerated in three HMP establishments during his period in custody. However, he was incarcerated in HMP Barlinnie housed in "D" Hall, South Upper Cell 23, at the time of his death.

[10] Talk2Me Strategy ("TTM") is the Suicide Prevention Policy of the SPS which can be initiated following a risk assessment or following certain events such as court or Parole Board hearings or through concern being highlighted at any time. This is fully rehearsed within the Joint Minute of Agreement ("JMA" hereinafter) and I refer to paragraphs 3 through 6 inclusive of the JMA.

[11] Mr Hamilton had served an earlier sentence within HMP Low Moss, from 31 January 2017 to 30 November 2017 and during that earlier period of imprisonment he had been placed on TTM. On 20 November 2017, Mr Hamilton's wife, Ms JH, had contacted the prison to inform them that Mr Hamilton had taken an overdose. He was transferred to the local emergency department for assessment but did not require any medical treatment and was returned to HMP Low Moss and placed on TTM (as shown at Crown production number 5, pages 427-456). Within the TTM records it is noted that

the deceased had exaggerated the extent of the overdose following which his observations were reduced to 30 minutes. On 21 November 2017, the deceased was found to have made a ligature with his bedding and was relocated to a "safer cell" and placed on 15 minute observations. Mr Hamilton offered no explanation about the ligature and his intention to use it. At a subsequent TTM conference Mr Hamilton "admitted on numerous occasions that he was not suicidal and only said that to get at his girlfriend". The case conference was satisfied that Mr Hamilton was at no apparent risk of suicide or self-harm at that time and removed him from TTM.

[12] During Mr Hamilton's imprisonment from 22 August 2017 until his death on 24 October 2019, he was initially placed within HMP Low Moss and thereafter transferred to HMP Addiewell. Whilst within HMP Addiewell Mr Hamilton referred himself to the prison mental health team and underwent a Mental Health Assessment on 28 August 2018 (as shown at Crown production number 3, page 20). Mr Hamilton related a history of anxiety and depression and stated that his current medication (of propranolol and mirtazapine) was ineffective. He stated he had experienced suicidal thoughts but denied that he would act upon them due to his wife and family being protective factors. He was seen by the prison psychologist on 30 August 2018 and, during this consultation with the Psychologist, Dr Ewan Lundie, Mr Hamilton stated that his current distress was due to being unfairly accused of being involved in drug dealing. Mr Hamilton stated he did not cope well with change but that he had been moved wing. He reported a childhood history of exposure to violence and difficulty managing emotions at times. He reported feeling like "getting back at senior staff" by

behaving aggressively or self-harming in order to get taken to segregation. Dr Lundie noted that by the end of the session Mr Hamilton was calmer and reflective, stating that he no longer had any intention of doing either, leaving Dr Lundie with the impression that there was no imminent risk of serious harm to Mr Hamilton.

[13] On 8 October 2018, Mr Hamilton was placed on TTM due to concerns with his presentation and that he had a suicide pact with his wife (see Crown production number 3, (page 19)). At the case conference on 9 October 2018, Mr Hamilton engaged well and denied any intention to harm himself or attempt suicide and that he stopped his medication sometime previously. Mr Hamilton was removed from TTM but was placed back on TTM on 12 October 2018. He was reviewed by the triage nurse on 13 October 2018 who noted Mr Hamilton to be "tearful, hopeless and variable in mood". Mr Hamilton denied any suicidal thoughts as he "could not do that to his wife". He was placed on 60 minute observations and was removed from TTM on 15 October 2018.

[14] Mr Hamilton attended a Mental Health Review on 19 October 2018 where he was described as agitated and emotional and struggling after the drug related death of another prisoner but denied any active suicidal thinking or plans. He had stopped taking his prescribed medication and refused an alternative prescription for sertraline. Further reviews were conducted on 15 October 2018 and 23 October 2018. Mr Hamilton declined to attend four further psychology appointments on 26 and 30 November, 3 and 10 December, all 2018. Mr Hamilton was discharged from psychology follow up at that time.

[15] On the night of 4 December 2018, Mr Hamilton was attacked in his cell by more than one prisoner. He was assaulted with a sharpened bone and sustained a penetrating wound to the left side of his nose and was treated at St John's Hospital, Livingston.

[16] Mr Hamilton was transferred to HMP Barlinnie on 14 December 2018 as part of a usual operational draft according to SPS records. On arrival, Mr Hamilton underwent a TTM reception risk assessment where he confirmed that he had asked for a transfer to be closer to his family, that there was no requirement for protection and that he had no thought of self-harm or suicide. During the health care assessment it was noted that he had no thoughts of suicide at present but was noted to be paranoid and of low mood. Reference was made by Nurse A Raphael to numerous previous attempts at suicide by various methods including overdose and hanging whilst in custody a year earlier and to the recent stabbing within HMP Addiewell. It was further noted that the person alleged to have stabbed Mr Hamilton had also been transferred to HMP Barlinnie (see Crown production number 6.4, pages 503 and 505). SPS records confirmed that the alleged perpetrator was not transferred to HMP Barlinnie at this time. Mr Hamilton was placed on TTM in a safe cell, with safer clothing to preserve life and limit his ability to self-harm by ligature/cutting and the maximum contact interval was noted as 15 minutes.

[17] Mr Hamilton underwent Mental Health Reviews whilst in HMP Barlinnie on numerous occasions from 17 December 2018 onwards. At the assessment on 17 December 2018 with Mental Health Nurse Ms D Graham, Mr Hamilton stated that he had not reported any thoughts of wanting to harm himself or end his life and was unhappy at being placed on TTM. It was noted that one of his attackers had been

transferred to HMP Barlinnie from HMP Addiewell but SPS records confirmed that this individual was not in Barlinnie at that time. When he was advised to consider possible protection, he said that "he would never consider that", was not afraid of the person who had attacked him and that he could handle himself. Mr Hamilton confirmed that he would seek support should he have any thoughts or urges to harm himself or end his life. It was noted by Ms Graham that there was no evidence of major mental illness including mood disorder and no current suicidal thinking but noted possible personality issues to be discussed with psychology regarding ongoing support. Mr Hamilton was thereafter discussed at a psychology referral meeting and deemed unsuitable for psychology support at that time as he had not previously engaged with group therapy at HMP Addiewell. At a review with Ms Graham on 27 December, Mr Hamilton denied having any thoughts of self-harming or wanting to end his life and she noted no evidence of psychotic illness.

[18] On 11 February 2019, Mr Hamilton was reviewed by Ms Graham where he reported a worsening of his anxiety, felt that he needed to be reconsidered for medication and was keen to engage in psychological intervention or counselling prior to release. No psychotic symptoms and no thoughts of self-harm were noted at this time. Ms Graham referred Mr Hamilton to the GP and at a GP appointment on 19 February 2019, Mr Hamilton's propranolol medication was increased.

[19] In a letter dated 9 April 2019, (Crown Production 13 at page 799), Mr Hamilton wrote to the Mental Health Team confirming that he had tried to take his own life on

two occasions, once in HMP Low Moss and again in HMP Addiewell and made reference to lies about himself contained within the SPS PR2 system.

[20] At a mental health review on 23 April 2019, Mr Hamilton advised that he was unhappy that his propranolol prescription had been discontinued after he suffered a seizure. Mr Hamilton opined that the prescribed sertraline was ineffective and that he experienced an increase in his symptoms of anxiety. Although presenting as upset, it was noted that Mr Hamilton had no thoughts to harm himself or to end his life.

[21] At a GP appointment on 29 April 2019, Mr Hamilton's propranolol prescription was restarted and his antidepressant was changed to citalopram.

[22] On 16 May 2019, at a GP appointment, his prescription for citalopram was increased and at his mental health review on 23 May 2019, he confirmed that he was feeling slightly calmer.

[23] On 4 June 2019, Ryan Canning, one of the alleged perpetrators of the assault on Mr Hamilton in HMP Addiewell, was transferred to HMP Barlinnie and after one night in "D" Hall, North Lower, was housed in "B" Hall, between 5 June 2019 and 24 June 2019. Mr Canning was then housed in "C" Hall between 24 June and 9 July, both 2019. On 9 July 2019, Mr Canning was moved and housed in "D" Hall, North Upper, where he remained until 4 October 2019 when he was moved to "D" Hall, North Lower. On 7 October 2019, Mr Canning was moved to "A" Hall. Throughout this time, Mr Hamilton remained in "D" Hall, South Upper.

[24] Mr Hamilton completed a further self-referral form on 20 June 2019, (Crown production 3 at page 58) to the Mental Health Team noting that he had ongoing anxiety,

paranoia and that he was tired of fighting whilst no one helped. On 12 July 2019, Mr Hamilton submitted a complaint writing a letter to the Governor of HMP Barlinnie (Crown production 13, pages 804, 805 and 806) in relation to complaints about seating at visits. In this letter, Mr Hamilton referred to concerns caused by the transfer of Ryan Canning to the same prison. Mr Hamilton wrote that he was being intimidated and threatened.

[25] At a mental health review with Ms Graham on 19 July 2019, it was noted that Mr Hamilton's anxiety affected his day to day functioning. Ms Graham noted that this appeared to have been triggered by the fact that a prisoner who had been involved in an attack on Mr Hamilton had been moved to "D" Hall. Mr Hamilton was described objectively as appearing "uptight and worried due to the current situation". Mr Hamilton, however, denied having any thoughts of wanting to harm himself or others or end his life and gave no cause for concern. On 5 August 2019, at a GP appointment, Mr Hamilton's citalopram prescription was increased with the GP noting that Mr Hamilton has constant passive suicidal ideation but that he would not act upon it (Crown production 3, page 14).

[26] On 15 August 2019, Mr Hamilton submitted another complaint raising concerns about Mr Canning being within HMP Barlinnie and alleging that Mr Canning was "stalling", waiting for him at the stairs and "at the door of DNU watching me constantly" and that threats had been made. The written response to his complaint submitted that Mr Hamilton had refused protection which is the primary response to support people at risk and asked him to reconsider going on protection.

[27] On 4 September 2019, Mr Hamilton was once again placed on TTM after stating that he "needs help" and that "he was going to kill himself". It was further noted that Mr Hamilton has "ongoing issues with the health centre regarding his medication". Within Crown production number 6.4 at page 514, it is stated that Mr Hamilton had not eaten for four days. Mr Hamilton was consequently placed on 15 minute checks and moved to a safer cell with safer clothing. He was reviewed by Ms Graham on 5 September 2019. Ms Graham noted that Mr Hamilton stated that he did not want help from anyone, he had not been listened to by SPS staff and that he would kill himself by starvation, having not eaten since 1 September 2019. Mr Hamilton told her that he had complained continuously to SPS staff that the prisoner who had attacked him in HMP Addiewell remained in the same Hall as him and that threats had been made against him and his wife. He stated he was not afraid but wanted out to see his partner. He stated that he felt "if he ends his life, then his partner will be safe". Ms Graham noted that there was no objective evidence of disturbance in Mr Hamilton's mental state. She noted no evidence of distress, distraction or agitation on interview and noted that Mr Hamilton denied any psychotic symptoms and was adamant that "he will end his life and that the blame will be on SPS and his partner will be safe if he is dead". Mr Hamilton was encouraged to reconsider mediation and to eat and drink. A care plan was in place (Crown production 3, page 51) and liaison had taken place with the Hall nurse.

[28] Ms Crossan in her affidavit detailed the preparation for, and procedure at, a case conference and also confirms that TTM is not a long term solution. It is a balancing act

as it can both save people but make them worse. On 7 September 2019, at the TTM case conference, Mr Hamilton discussed his previous emotional state and assured the case conference that his thoughts in relation to suicide had changed. He stated that "He cannot run away from his issues" and that he will deal with it. He was then noted to be "no apparent risk" and removed from TTM. Mr Hamilton still reported feeling "down" and felt that this medication required to be reviewed. He denied any ongoing thoughts of suicide. He had a visit from his wife which had made him feel better and that he had been eating and drinking.

[29] On 12 September 2019, a further review with Mr Hamilton took place and Ms Graham noted that Mr Hamilton was no longer on TTM. She described him as "facially flat and low of mood". Mr Hamilton reported poor sleep and hypervigilance. He described as "self-isolating and having intrusive thoughts with regard to a possible further attack and that implications of having to defend himself". He is described as feeling:

> "overwhelmed with stressors and reports that his medication is ineffective and unable to stop racing thoughts. He finds this distressing. He denies any plans of wanting to end his life and reports he is safe. A protective factor is his wife, who supports him."

Ms Graham arranged for a review with the prison psychiatrist and noted at a further review on 2 October 2019 that Mr Hamilton was "self-isolating" and was having "panic symptoms". Mr Hamilton was fearful of attending a forthcoming visit. He denied thoughts of wanting to harm himself and agreed to be referred to the prison psychiatrist (Crown production number 3, page 14).

[30] Mr Hamilton was reviewed by Dr Melanie Baker on 8 October 2019 who noted him to be of low mood, of poor sleep, reduced appetite and a reported lack of enjoyment. Mr Hamilton denied any suicidal intent and stated he did not wish to change his medication. Dr Baker's impression was that Mr Hamilton had anti-social personality disorder straits and chronic low mood. Dr Baker referred Mr Hamilton for a psychological assessment and intervention (Crown production 19 at page 1,104). No psychiatric follow-up was noted.

[31] On 17 October 2019, HMP Barlinnie hall staff telephoned the NHS staff to report a deterioration in Mr Hamilton's mental state (Crown production number 7, page 759). Mr Hamilton was seen by Ms Graham and told her that he had had an altercation with another prisoner some days earlier and that this was in relation to his having enemies and being attacked in HMP Addiewell. Prison records do not indicate a link between this altercation and the previous attacks suffered by Mr Hamilton in HMP Addiewell. Mr Hamilton stated that "things were now sorted". Ms Graham noted Mr Hamilton as being tired and of low mood. Mr Hamilton stated that he had been unhappy after seeing the psychiatrist and felt that his medication was ineffective. He considered that the NHS were not doing anything for his mental health. He complained about being placed on report and not having his television, a decision he had appealed. Ms Graham had a lengthy discussion with Mr Hamilton and encouraged him to engage with psychology and addiction services upon release. Ms Graham noted that Mr Hamilton wanted to discuss past childhood abuse he had suffered and that he related his present issues to past trauma. He was reassured that, if he engaged with support networks,

interventions would be put in place to help him deal with issues as specific organisation were discussed. Ms Graham noted Mr Hamilton to be "tired and facially flat, though he engaged in conversation and maintaining good eye contact". She noted no evidence of psychotic illness or major mood disorder. She did note, however, that there was evidence throughout the interview of personality issues and noted that Mr Hamilton denied having any thoughts of wanting to harm himself or end his life. He gave no cause for concern at interview. He was able to smile and demonstrated a level of humour was in his conversation. He reported that he would lie in bed and be obstructive for the rest of his sentence. Mr Hamilton was then discharged from the mental health team case load with no plans for review unless required.

[32] During his time in custody, Mr Hamilton made several complaints and was placed on report on a number of occasions. To this end, I refer to paragraphs 33 through to 45 inclusive (pages 20 to 28) of the JMA.

[33] On 19 October 2019, after the morning visiting session there was an altercation between Ms JH and the visitor for another prisoner, Mr S. Mr S was housed in the same area of the prison as Mr Hamilton and due to animosity and perceived threats to Mr S a decision was made to move Mr Hamilton to "B" Hall (as shown by Crown production number 7, page 757).

[34] On the morning of 22 October 2019, Mr Hamilton made seven phone calls between 0830 hours and 1405 hours to a number registered to Isa Beattie, however, he was speaking with his wife, Ms JH. At 1150 hours Mr Hamilton was placed on report by Officer Cochran for disobeying an order by refusing to move to "B" Hall. Mr Hamilton

made two further calls to his wife prior to being served with paperwork in relation to that breach of order report. Mr Hamilton talked of being unhappy at being moved Hall and told his wife that she should call the police regarding two unnamed prisoners. Ms JH said that she was en route to visit him at the prison and would talk with him further. During the course of these calls, there is no suggestion from Mr Hamilton of any likelihood of suicide. Ms JH attended at HMP Barlinnie and visited with Mr Hamilton on the afternoon of 22 October 2019. Ms JH reported within her affidavit that her husband reiterated that he did not wish to move Hall. However, he appeared upbeat and bright, displaying no signs of suicidal intention or self-harm.

[35] CCTV from HMP Barlinnie reveals that at 1715 hours on 22 October 2019 Officers Cochrane and Greenshields approached Mr Hamilton's cell in "D" South Upper, 4/23 with food and engaged in conversation with him thereafter, leaving the cell at 1718 hours still carrying the food. The officers returned to Mr Hamilton's cell and entered it at 1748 hours, carrying Rule 95 paperwork which they had intended to serve on him (Crown production 9, page 774 and Crown label 20). They discovered Mr Hamilton suspended from a ligature that had been anchored to the window frame. Officer Cochrane shouted for lock up and a radio message was immediately put out for a Code Blue. Officers Cochrane and Greenshields tried to loosen the ligature but were unable to do so and Officer McAlpine ran to the "crash pack" to get a "fish knife". This was subsequently used to cut the ligature from around Mr Hamilton's neck. Once the ligature had been removed, the officers placed him on his back on the cell floor and commenced CPR. Medical staff attended at the cell and continued to provide medical

care until the arrival of paramedics. The paramedics worked on Mr Hamilton for a protracted period and eventually re-established vital signs whereupon Mr Hamilton was transferred to Glasgow Royal Infirmary with the full treatment he received described within paragraphs 52 and 53 of the JMA.

[36] The door of Mr Hamilton's cell was secured by Security Manager Anthony Brown and remained secure until the police arrived on 23 October 2019 to seized productions and take photographs.

[37] On arrival at Glasgow Royal Infirmary at 1855 hours on 22 October 2019, Mr Hamilton was assessed in the Emergency Department. He had a Glasgow Coma Score of three and his pupils were fixed and dilated. He had been intubated by the paramedics at HMP Barlinnie and he continued to be ventilated, not sedated. He had a CT head scan and a CT spine cervical scan. The results of which were indicative of early anoxic injury. Mr Hamilton was admitted to the ICU at 2039 hours. On 23 October 2019 the medical staff within the ICU maintained the temperature of Mr Hamilton at 36 degrees (Crown production 18 at page 918) for the first 24 hours as the standard management after cardiac arrest. Mr Hamilton was sedated for the first 24 hours. He continued to have fixed dilated pupils but occasionally started to breathe which showed that he still retained some brain stem activity at that time. Over the course of the afternoon of 23 October 2019 his blood pressure deteriorated and medication to keep his blood pressure up was administered. He was treated within the ICU and reviewed on the morning of 24 October 2019. Two brain stem tests were carried out by Dr Daniel and Dr Paton which confirmed there was no evidence of brain activity. Life was

pronounced extinct at 1245 hours on 24 October 2019. Mr Hamilton was in legal custody in Scotland at the time of his death. His death was investigated by the Crown.

Witnesses

First witness - Ms Lorraine Roughan, Deputy Governor of HMP Barlinnie

[38] Ms Roughan gave very clear evidence about the processes and procedures involved in placing of prisoners within prison and in particular when dealing with prisoners who were on protection or who wished to be or indeed required protection. She confirmed that Prisoner S was housed in the same unit as Mr Hamilton but did not know on which floor he was located. She explained that intelligence had been received that Mr Hamilton had taken out a contract on Mr S which prompted the decision to move Mr Hamilton on 22 October 2019 and that paperwork had been served on Mr Hamilton for his breach of prison rules when he refused to move. She explained that the reason for the move was because of the incident involving Ms JH and the visitor for Mr S. She confirmed that Mr S's linked prisoners were looked at and he was not connected to either of the prisoners allegedly involved in the assault on Mr Hamilton at HMP Addiewell. SPS staff had assessed that, following the incident involving Ms JH and Mr S's visitor, it was not safe for the two men to be in the same area until they had a full picture. This decision was made before intelligence was available. She confirmed she had no concerns over the decision to move Mr Hamilton instead of Mr S.

[39] Ms Roughan explained that Rule 95 gives the prison legal authority to take a prisoner out of circulation for 72 hours and this was being served on Mr Hamilton to

stop him meeting with Mr S until the breach of Rules Hearing had been concluded. The Hearing was about breach of discipline but Mr Hamilton would have been asked about mitigating circumstances. She admitted that decisions about who is moved is made by the management and prisoners must comply.

[40] Ms Roughan submitted that prisoners were routinely checked at various times and at a change of shift. When returning from a visit, Mr Hamilton was not under any monitoring regime and therefore would not be checked until a numbers check. Mr Hamilton would, therefore, not have been checked until a numbers check took place after he refused his meal. She described Mr Hamilton as being very aware of what he was entitled to within the prison and agreed that he was not shy to voice any complaint but she did not describe him as disruptive, instead she described him as determined. She noted that she was surprised that Mr Hamilton took his own life as he appeared to be focused on getting out of prison and returning to his wife.

Second witness - Dr Gordon Skilling, Consultant Psychiatrist

[41] The Inquiry then heard evidence from Dr Gordon Skilling, Psychiatrist. When asked about Mr Hamilton's intent when placing the ligature around his neck and whether it could be stated that Mr Hamilton intended to commit suicide, Dr Skilling stated that it was impossible to know. Whilst logic could be applied, that did not always work. His view was that Dr Maganty may be correct and that it was not an unusual conclusion, however, he took a different view and reiterated again that it was impossible to be certain as there were factors that made it difficult to understand the action taken by

Mr Hamilton leading to the extinction of his life. When considering all of the evidence including Mr Hamilton's final happy meeting with his wife, Dr Skilling was of the view that, on balance, in that moment Mr Hamilton was trying to end his life given the violent method Mr Hamilton had used, namely, hanging.

Third witness - Dr Dinesh Maganty, Consultant Psychiatrist

[42] Dr Dinesh Maganty, thereafter, gave evidence. Dr Maganty had considered Mr Hamilton's personality structure. Dr Maganty opined that self-harming soothes and calms patients and, given Mr Hamilton's personality structure, it was likely that this is what Mr Hamilton was trying to do. On the balance of probabilities, Dr Maganty, considering all of the facts and circumstances before him, including the content of Ms JH's affidavit wherein she described Mr Hamilton's happy demeanour at her last meeting with him, was of the view that Mr Hamilton did not intend to die. However, Dr Maganty did confirm that it was impossible to know for sure whether Mr Hamilton intended to die.

[43] Both doctors agreed that their opinions were based solely on the medical records of Mr Hamilton. Neither doctor had ever examined Mr Hamilton during his lifetime. Both doctors agreed that there could be no certainty about Mr Hamilton's intention. It was a matter of agreement that the medical treatment Mr Hamilton had received while in prison was appropriate.

Conclusion

[44] I make the formal findings as noted above at the start of this decision. I note that the family consider that it would be appropriate to make the finding sought in their submission in terms of Section 26(g) of the 2016 Act. I do not consider that it would be appropriate to make the finding sought by the family on the basis that two expert doctors' opinions offer differing views in light of Mr Hamilton's mental health history. Both doctors do, however, agree that there can be no conclusive view in respect of Mr Hamilton's intention at that time. Both are consultant forensic psychiatrists who reviewed the same records and interpreted them differently coming to different conclusions on the balance of probabilities in respect of Mr Hamilton's intent. Having considered all of the evidence, I am satisfied that I should make no finding in terms of Section 26(g) *supra.*

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