SHERIFFDOM OF LOTHIAN AND BORDERS AT LIVINGSTON

[2022] FAI 36

LIV-B299-21

DETERMINATION

BY

SHERIFF PETER G.L. HAMMOND, Advocate

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

into the death of

STEVEN SWEENEY

LIVINGSTON, October 2022

The sheriff, having considered the information presented at the Inquiry, determines in terms of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, (hereinafter referred to as "the 2016 Act"):

In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred)

The late Steven Sweeney, born 21 March 1985, died on 14 January 2020 at approximately 19.00 hours within Reception Holding Cell 2, HM Prison Addiewell, 9 Station Road, Addiewell, West Lothian.

In terms of section 26(2)(c) of the 2016 Act (the cause or causes of the death)

The cause of the death of said Steven Sweeney was: 1 (a) Diabetic Ketoacidosis; and 1 (b) Diabetes Mellitus.

In terms of section 26(2)(e) of the 2016 Act (any precautions which (i) could reasonably have been taken and (ii) had they been taken, might realistically have resulted in death being avoided)

There are no precautions which could reasonably have been taken that might realistically have resulted in the death being avoided.

In terms of section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death)

There were no defects in any system of working which contributed to the death.

In terms of section 26(2)(g) (any other facts which are relevant to the circumstances of the death)

There are no other facts relevant to the circumstances of the death of said Steven Sweeney.

In terms of sections 26(1)(b) of the 2016 Act (recommendations (if any) as to (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)

There are no recommendations made.

NOTE

The legal framework

[1] This Inquiry was held in terms of section 1 of the 2016 Act and was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (hereinafter referred to as "the 2017 Rules"). This was a mandatory Inquiry in terms of section 2 of the 2016 Act as Mr Sweeney was a prisoner in legal custody at the time of his death.

[2] The purpose of the Inquiry is set out in section 1(3) of the 2016 Act as being to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. It is not intended to establish either criminal or civil liability. The Inquiry is an exercise in fact finding - not fault finding. The Inquiry is an inquisitorial process. The Procurator Fiscal represents the public interest on behalf of the Crown.

[3] In terms of section 26 of the 2016 Act the Inquiry must determine certain matters, namely; where and when the death occurred; the cause or causes of the death; any precautions which could reasonably have been taken and might realistically have avoided the death; any defects in any system of working which contributed to the death, and any other factors relevant to the circumstances of the death. It is open to the Sheriff to make recommendations in relation to matters set out in section 26(1)(b) and section 26(4) of the 2016 Act. As the death was not the result of an accident, it is unnecessary to make any findings in terms of section 26(b) and (d) of the Act.

Introduction

[4] This Inquiry was held into the death of Steven Sweeney. Mr Sweeney died on 14 January 2020 at HMP Addiewell, after becoming unwell and later collapsing in a Reception Holding cell while awaiting transfer to hospital. Efforts at resuscitation were unsuccessful and he was formally pronounced life extinct at 19.00 hours that evening. He had a long history of health problems and alcohol and substance misuse. In particular, he suffered from Type 1 Diabetes Mellitus, and his medical history notes that he had a poor record of management of his diabetic condition within the community. A post-mortem examination found traces of controlled drugs in his body but concluded that it was unlikely these drugs would have played a significant role in his death. The cause of death was certified as 1a –Diabetic Ketoacidosis and 1b Diabetes Mellitus.

[5] Following a number of preliminary hearings, this Inquiry heard evidence and submissions remotely by Webex video link over the course of three days; namely 1, 2 and 8 September 2022. In addition to the Crown, the parties represented at and participating in the Inquiry were Lothian Health Board, Sodexo (as operators of HMP Addiewell) and the Scottish Prison Service ("SPS"). Mr Sweeney's family were not represented at the Inquiry; having declined an invitation to participate.

[4] The Inquiry heard from a number of witnesses called by the Crown, and statements taken from a number of other witnesses were also available, along with an affidavit by John Morrison, Head of Operations at HMP Addiewell. In addition, the Inquiry considered a number of documentary productions including Mr Sweeney's GP medical records, prison medical records, and various reports.

The witnesses examined were:

a. Lorraine Bell, Prison Custody Officer (PCO), HMP Addiewell.

b. William Johnstone, Senior PCO, HMP Addiewell.

c. Scott Anderson, PCO, HMP Addiewell

d. Daniel Logue, Staff Nurse, NHS Lothian Health Board, HMP Addiewell

e. Vicky Thomson, Advanced Nurse Practitioner, NHS Lothian Health Board, HM Addiewell.

f. William Watt, former PCO at HMP Addiewell.

[5] Almost all of the evidence was uncontroversial, and was encompassed in two extensive joint minutes of agreement.

Evidence

[6] Mr Sweeney was born on 21 March 1985 and died on 14 January 2020, aged 34 years old.

[7] At the time of his death, Mr Sweeney was in lawful custody at HMP Addiewell.

[8] Mr Sweeney's death occurred within Reception Holding Cell 2, HMP Addiewell, 9 Station Road, Addiewell, West Lothian. Mr Sweeney's death occurred on 14 January 2020 and life was formally pronounced extinct at 19.00 hours.

HM Prison Addiewell

[9] On 1 November 2011, the responsibility for the provision of healthcare to prisoners transferred from the SPS to the NHS. Since then individual regional NHS

health boards have been responsible for the delivery of health care services within prisons in Scotland which fall within their geographical ambit for the provision of medical care.

Productions

[10] Crown Production Number 1 comprises a redacted version of Mr Sweeney's medical records held by his General Practitioner. Said records are a true and accurate copy of the originals, the contents of which are agreed.

[11] Crown Production Number 2 comprises the prison medical records held in relation to Mr Sweeney. Said records are a true and accurate copy of the originals, the contents of which are agreed.

[12] Crown Production Number 3 comprises the "Death in Custody Pack" of documentation and records held by Sodexo in relation to Mr Sweeney. Said records are a true and accurate copy of the originals, the contents of which are agreed.

[13] Crown Production Number 4 comprises the "Death in Prison Learning and Audit Review" (referred to as the 'DIPLAR') report carried out at HMP Addiewell following Mr Sweeney's death. After any death in custody this type of report is carried out by Sodexo and/or the Scottish Prison Service. Said report is a true and accurate copy of the original, the contents of which are agreed.

[14] Crown Production Number 5 comprises the Final Post Mortem Report authored by Doctor Kerryanne Shearer and Doctor Robert Ainsworth, Consultant Forensic

Pathologists, following post mortem examination of the body of Mr Sweeney. Said report is a true and accurate copy of the original, the contents of which are agreed.

[15] Crown Production Number 6 comprises the Healthcare Roster for HMP Addiewell for the week commencing 13 January 2020 through to 19 January 2020. Said roster details the healthcare staff on duty within HMP Addiewell on each day of said week.

[16] Crown Production Number 7 is a medical report prepared by Dr. Craig Thurtell, Consultant in General Internal Medicine and Endocrinology and Diabetes.

[17] Crown Production Number 8 is an addendum to Crown Production Number 6 and was prepared by the said Dr Thurtell.

[18] Crown Production Number 9 comprises an email in Question and Answer format sent to the Procurator Fiscal Depute by the said Dr Thurtell.

Affidavits and Statements

[19] Sodexo Production Number 1 is an affidavit of John Morrison, Head of Operations at HM Prison Addiewell, sworn on 25 May 2022. Said affidavit should be treated as the parole evidence of said John Morrison.

[20] The statement of SMc, former prisoner at HMP Addiewell, should be treated as the parole evidence of said SMc.

History and Background - Custody

[21] On 5 April 2019 Mr Sweeney appeared from custody at Glasgow Sheriff Court charged on petition with assault to severe injury, danger of life and attempted murder. Mr Sweeney was detained for further examination under petition procedure and was remanded into custody at HMP Barlinnie.

[22] On 12 April 2019 Mr Sweeney again appeared from custody at Glasgow Sheriff Court on said petition. He was again remanded into custody at HMP Barlinnie, to be detained until liberated in due course of law.

[23] Subsequently the Crown served upon Mr Sweeney an Indictment containing a charge of assault to severe injury, danger of life and attempted murder, and further charges alleging contraventions of the Misuse of Drugs Act 1971.

[24] Following sundry procedure at the High Court of Justiciary at Glasgow, a dedicated floating trial was fixed to commence in the week beginning 10 February 2020 at the High Court of Justiciary at Glasgow, and the relevant custody time limits under the Criminal Procedure (Scotland) Act 1995 were fixed to expire on 14 February 2020.

[25] Mr Sweeney was housed within HMP Barlinnie until 6 May 2019 at which point he was transferred to HMP Addiewell.

[26] On 6 May 2019 Mr Sweeney's healthcare records were updated on transfer to HMP Addiewell. From 6 May to 5 June 2019, Mr Sweeney underwent a number of medical assessments at HMP Addiewell, and the following health conditions or issues were noted:

- Type 1 diabetes – for which he was prescribed Humulin m3 and Humulin S insulin solutions for injection
- Depression – for which he was prescribed mirtazapine
- Recurrent thrush – for which he was prescribed clotrimazole.
- Acne – for which he was prescribed lymecycline and adapalene.
- A noted history of alcohol and substance misuse issues, including alcohol dependence syndrome, opiate and benzodiazepine abuse.

[27] Aside from Mr Sweeney's latest period of imprisonment at HMP Barlinnie and HMP Addiewell (from 5 April 2019 until his death), he had spent the following periods of his life in lawful custody:

- 1 September 2005 to 8 September 2005 at Her Majesty's Young Offenders Institution (HMYOI) Polmont;
- 24 January 2006 to 7 February 2006 at HMYOI Polmont;
- 23 May 2006 to 14 June 2006 at HMP Barlinnie;
- 7 July 2006 to 12 July 2006 at HMP Barlinnie;
- 1 September 2006 to 15 September 2006 at HMP Barlinnie;
- 20 December 2006 to 20 March 2007 at HMP Barlinnie and HMP Low Moss;
- 29 March 2007 to 4 April 2007 at HMP Kilmarnock.
- 12 July 2013 to 25 February 2014 at HMP Barlinnie and HMP Addiewell.
- 3 December 2014 to 6 January 2015 at HMP Barlinnie;
- 9 September 2015 to 21 December 2015 at HMP Barlinnie;

- 22 April 2016 to 16 August 2016 at HMP Barlinnie and HMP Low Moss;
- 7 November 2016 to 10 April 2017 at HMP Barlinnie;
- 18 April 2018 to 9 May 2018 at HMP Barlinnie;

History and Background - Health

[28] Mr Sweeney was diagnosed with Type 1 diabetes mellitus in February 2004, when he was 18 years old. He was commenced on a regime of twice daily mixed insulin injections in order to manage the condition, with such injections being self-managed in the community.

[29] Mr Sweeney is noted to have a medically recorded history of alcohol and substance misuse issues dating from 2006.

[30] Mr Sweeney is noted to have a poor record of management of his diabetic condition within the community, and in particular:

- On 8 April 2011 he attended at the Accident and Emergency Department of Victoria Infirmary, Glasgow having ran out of his insulin supply. He was provided with an emergency supply of insulin and instructed to contact his General Practitioner (see page 18 of Crown Production 1);
- On 28 June 2013 he was taken to the Accident and Emergency Department of Victoria Infirmary, Glasgow by officers of the Police Service of Scotland. Mr Sweeney was in a state of hypoglycaemia. He was treated with hypostop gel and a sugary drink to raise his sugar levels. He was discharged with advice on insulin use (see page 21 of Crown Production 1);

- On 1 June 2015 he attended at the Emergency Department of South Glasgow University Hospital, Glasgow. He presented as unwell and reported having "binged" on heroin. Investigations were carried out and he was found to be in a hyperglycaemic state. He refused treatment before discharge (see page 28 of Crown Production 1).
- On 21 January 2016 he attended at the Emergency Department of the Queen Elizabeth University Hospital, Glasgow. He was found to be suffering from diabetic ketoacidosis, was dealt with as a medical emergency and admitted to the hospital. The diabetic ketoacidosis protocol was initiated and he was treated for the condition before discharge on 22 January 2016 (see page 31 of Crown Production 1);
- On 29 February 2016 he attended at the Emergency Department of the Queen Elizabeth University Hospital, Glasgow. He was found to be suffering from diabetic ketoacidosis on a background of heroin use. The diabetic ketoacidosis protocol was initiated and he was admitted to the High Dependency Unit for treatment (see page 33 of Crown Production 1);
- On 6 April 2016 he attended at the Emergency Department of Hairmyres Hospital, Glasgow. He was found to be suffering from severe diabetic ketoacidosis and was admitted to the High Dependency Unit for treatment (see page 35 of Crown Production 1);
- On 24 August 2016 he attended at the Emergency Department of the Queen Elizabeth University Hospital, Glasgow. He was found to be suffering

from diabetic ketoacidosis on a background of epigastric pain, alcohol and substance misuse. He was admitted to the High Dependency Unit for treatment (see page 36 of Crown Production 1);

- On 21 October 2016 he attended at the Emergency Department of Hairmyres Hospital, Glasgow. He was in a hypoglycaemic state and was treated with intramuscular glucagon. He thereafter discharged himself prior to further review (see page 38 of Crown Production 1);
- On 16 April 2017 he attended at the Emergency Department of the Queen Elizabeth University Hospital, Glasgow. He was found to be suffering from diabetic ketoacidosis, on a background of not eating or taking insulin. He was admitted for treatment before he discharged himself on 17 April 2017 (see page 41 of Crown Production 1);
- On 18 April 2017 he attended at the Emergency Department of the Queen Elizabeth University Hospital, Glasgow. He was found to be suffering from diabetic ketoacidosis and it was noted that he had discharged himself from hospital the day prior after admission under similar circumstances. He was admitted for treatment before being medically discharged (see page 42 and 43 of Crown Production 1);
- On 7 May 2017 he attended at the Emergency Department of Hairmyres Hospital, Glasgow. He was found to be suffering from diabetic ketoacidosis, on a background of alcohol use and intermittent and non-regular eating. He was admitted for treatment, and his insulin regime was changed to a basal bolus

regime with boluses required whenever eating. Referral was made to the diabetes review clinic on discharge (see page 75 of Crown Production 1)

- On 23 November 2017 he attended at the Emergency Department of the Queen Elizabeth University Hospital, Glasgow. He was admitted for treatment on a background of deliberate insulin overdose and suicidal ideation (see page 47 of Crown Production 1).

Circumstances and Cause of Death

[31] On 14 January 2020, Mr Sweeney was being housed within Cell 41 in Douglas Hall, Level C4, HMP Addiewell. This is a single occupancy cell.

[32] Mr Sweeney was friends with SMc, a prisoner also resident within Douglas Hall, HMP Addiewell at the time of Mr Sweeney's imprisonment there.

[33] On 14 January 2020, the PCOs on duty in Douglas Hall, HMP Addiewell were as follows:

- Lorraine Bell, Prison Custody Officer – from around 07.00 hours until around 13.00 hours
- William Watt, former Prison Custody Officer – from around 07.00 hours until around 13.00 hours
- Keith Paton, Prison Custody Officer – from around 13.00 hours until around 21.00 hours;
- Scott Anderson, Prison Custody Officer – from around 13.00 hours until around 21.00 hours;

- William Johnstone, Senior Prison Custody Officer – from around 07.00 hours until around 21.00 hours.

[34] At approximately 17.20 hours on 14 January 2020, prison staff working in Douglas Hall were informed by prisoner SMc that Mr Sweeney was unwell and should be checked. PCOs Anderson and Paton attended at Mr Sweeney's cell – Cell 41. Mr Sweeney was noted to look unwell, and after discussion with him, prison healthcare staff were requested to attend.

[35] Healthcare staff, including Staff Nurse Daniel Logue and Staff Nurse Lyndsay Dickson attended at Cell 41 in response to the call out at around 17.40 hours. Observations were taken of Mr Sweeney. His blood sugar level was too high to be recorded on the monitor, his blood pressure was low at 89/74, and his heart rate was tachycardic at 141 beats per minute. Mr Sweeney self-administered 10 shots of fast acting insulin. Healthcare staff assessed that he required to be taken to hospital.

[36] Mr Sweeney was conveyed from Cell 41 to Reception Holding Cell 2 at around 18.10 hours whilst arrangements were made for transfer to hospital. He was searched prior to transfer. Due to ambulance wait times, a decision was made for prison staff to transfer Mr Sweeney to hospital.

[37] While within Holding Cell 2 Mr Sweeney's condition deteriorated. His breathing became laboured, before he vomited blood and fell into cardiac arrest. A "Code Red" emergency call was made by prison staff and an emergency ambulance was summoned. Healthcare staff, including Staff Nurses Logue, Dickson and Smith moved Mr Sweeney to the floor to begin efforts at cardiopulmonary resuscitation (CPR), and to administer

adrenaline. CPR continued until paramedics from the Scottish Ambulance Service took over on arrival at around 18.36 hours.

[38] CPR was unsuccessful. Paramedics formally pronounced Mr Sweeney's life extinct at 19.00 hours on 14 January 2020;

[39] On 20 January 2020 at Edinburgh City Mortuary, Consultant Forensic Pathologists Dr Kerryanne Shearer and Dr Robert Ainsworth conducted a post-mortem examination of the body of Mr Sweeney. On 14 April 2020 a Final Post Mortem Report (Crown production 5) was issued which certified the cause of Mr Sweeney's death as: 1a Diabetic Ketoacidosis; 1b – Diabetes Mellitus. Alcohol, amitriptyline, mirtazapine, etizolam and buprenorphine were found to be in Mr Sweeney's system; however the findings of the post-mortem concluded: "given the circumstances and post mortem findings it is unlikely that these drugs would have played a significant role in death here".

[40] Dr Craig Thurtell is a Consultant in General (Internal) Medicine, Endocrinology and Diabetes. He is a member of the Royal College of Physicians and is employed by NHS Tayside, based at Perth Royal Infirmary.

[41] Dr Thurtell is the author of the medical report forming Crown Production 7. Pages 2 and 3 of said report, under the heading "Diabetes mellitus – an introduction", are to be admitted into evidence and treated as if it were the parole evidence of Dr Thurtell.

[42] At page 6 of said report, Dr Thurtell notes:

> "From examining his medical records, it is very clear that Mr Sweeney's diabetes control was sub-optimal throughout the entirety of the 16 years he lived with diabetes. His lack of engagement with secondary care diabetes services and frequent hospital admissions with diabetes emergencies were strong predictors of adverse morbidity and mortality outcomes."

[43] At page 7 of said report, Dr Thurtell notes:

> "There is no evidence that any formal review of his diabetes management by a healthcare professional was undertaken during his time at HMP Addiewell. The only formal review in the medical notes is from a prison sentence at HMP Barlinnie in July 2013…. Although there was no proactive attempt by nursing or medical staff to reach out to Mr Sweeney to ensure his diabetes was adequately treated, it is reasonable to presume they were available had he sought their advice himself. Had there been an issue the staff were unable to resolve themselves, they would have had the option of referral to the local NHS diabetes service for expert advice. From the evidence in Mr Sweeney's medical notes documenting his diabetes care out with the Scottish Prison Service, I am satisfied that his diabetes care was no different whilst in prison and was not prejudiced in any way by being detained. It appears he managed his diabetes the same way for many years and his periods of imprisonment did not result in any significant changes in his level of diabetes control."

[44] Upon considering the actions of prison staff when alerted to Mr Sweeney's ill health at around 17.20 hours on 14 January 2020, Dr Thurtell notes the following at page 8 of said report:

> "The PCOs attended his cell immediately when alerted to the situation by another prisoner and they appropriately summoned medical assistance from the staff nurses on duty. The nursing staff attended him without delay and conducted a thorough assessment of his condition."

Dr Thurtell concludes that the actions of prison staff, when alerted to Mr Sweeney's condition at this time, were "sufficiently expedient."

[45] Upon considering Mr Sweeney's condition at the point that prison staff were alerted to his condition at around 17.20 hours on 14 January 2020, Dr Thurtell notes the following at pages 9, 10 and 13 of said report, respectively:

> "Mr Sweeney's condition deteriorated rapidly from his initial assessment by the staff nurses in his cell to the time he deteriorated and suffered a cardiac arrest in prison reception. Only 35 minutes separated the beginning of the initial assessment and the cardiac arrest. Furthermore, the total length of time from his discovery by the PCOs to the time of his cardiac arrest was only 1 hour. In my opinion, Mr Sweeney's deterioration and death could not have been prevented after the prison staff learned of his condition. I suspect that his DKA [diabetic ketoacidosis] was well established by the time he was found to be unwell and his eventual deterioration was unavoidable. Considering the short timescales involved, no amount of medical intervention would have altered the outcome in this case."
>
> "…even if a 999 ambulance had been called, he was simply too close to having a cardiac arrest for it to have altered the outcome. In conclusion, I believe Mr Sweeney's condition was too far advanced by the time he was found to be unwell for any medical assistance over and above the care he received to have altered the outcome in this case."
>
> "In my opinion, the window of opportunity to intervene and treat him successfully had closed by the time he was found to be unwell by the prison staff."

[46] Upon considering Mr Sweeney's medical history and background, Dr Thurtell notes the following general comments:

> "Mr Sweeney's background of poor diabetes control, lack of engagement with diabetes services, and multiple episodes of DKA made him someone who was at very high risk of serious complications of diabetes – not only diabetic emergencies such as severe hypoglycaemia and DKA, but also of the longer-term consequences of inadequate glucose control. Those with type 1 diabetes who attend hospital with recurrent episodes of DKA and rarely attend the outpatient clinic for follow-up are traditionally the patients at highest risk of sudden death and complications."

[47] Upon considering the non-prescribed medications and illicit substances found in Mr Sweeney's blood at post-mortem, and accounts from fellow prisoners that Mr Sweeney was under the influence of a substance the day prior to his death, Dr Thurtell notes the following at page 11 of said report:

> "Whilst none of these substances were present in concentrations sufficient to have caused death through direct drug toxicity, I would argue that the sedative effect of these substances effectively rendered him incapable of self-managing his diabetes thus provoking DKA" and "I think it is extremely unlikely that Mr Sweeney would have been capable of either checking his blood glucose levels or administering insulin during this time."

[48] Upon considering the account of former prisoner SMc that efforts were made to conceal Mr Sweeney from prison staff on 13 January 2020 whilst he appeared under the influence of a substance, Dr Thurtell notes the following at page 12 of said report:

> "Ironically, his fellow prisoners' actions in concealing his odd behaviour made it much less likely that a PCO would notice him and call for medical assessment…. but unfortunately this was a missed opportunity to intervene and potentially discover uncontrolled blood glucose and ketone levels."

[49] Dr Thurtell is the author of Crown Production 8, an addendum to Crown Production 7. In said addendum, Dr Thurtell notes the following:

> "DKA [diabetic ketoacidosis] is a readily treatable condition and can usually be remedied by a few hours of intravenous fluids and insulin in the hospital setting. Death as a result of DKA while in hospital is rare as the condition is typically highly responsive to these simple treatments. Deaths due to DKA therefore typically take place in the community. Those who die in hospital usually present late with very severe and advanced DKA on the brink of cardiorespiratory arrest at the time of admission. Younger, fitter individuals can physiologically 'compensate' for several hours before becoming critically unwell, hence affording time to be admitted to hospital and commence on appropriate treatment. Considering the timeline involved in this case, I am certain that Mr Sweeney's DKA was much less severe in the morning and early afternoon of 14/1/20 and would likely have been amenable to treatment. Had he been assessed by prison healthcare staff prior to 13.00 hours that day and

arrangements made to convey him urgently to hospital, it is my opinion that his deterioration and death could have been avoided. Mr Sweeney's survival would have depended on the following taking place:

- Earlier assessment by prison healthcare staff (at least several hours prior to the time of his death);
- Their detection of high blood glucose and ketone levels leading to a diagnosis of DKA;
- Urgent transfer to hospital for DKA treatment when the condition was less severe and not at risk of causing imminent cardiorespiratory arrest."

[50] Dr Thurtell is the author of Crown Production 9, an email sent by him to the Procurator Fiscal in a Question and Answer format. Said email is to be admitted into evidence and treated as if it were the parole evidence of Dr Thurtell.

[51] William Watt, former Prison Custody Officer, left the employ of Sodexo on 9 October 2020.

[52] The following witnesses were all employed by NHS Lothian Health Board as at 14 January 2020, and working within HMP Addiewell healthcare team on said date:

- Michaela Rennie
- Lindsay Dickson
- Natalie Dyer
- Ruth Smith
- Deborah Hendry
- Allison Forbes
- Fiona McGregor
- Leigh-Ann Robb

[53] The witnesses listed in the preceding paragraph above all state that they were not notified of any health issue or concern in relation to the prisoner Steven Sweeney by any person within HMP Addiewell on 14 January 2020, until the point at which PCOs Paton and Anderson contacted healthcare at a point after 17.00 hours same date.

[54] HM Prison Addiewell is operated by Sodexo Justice Services under contract to The Scottish Ministers acting through the Scottish Prison Service.

Discussion

[55] This was an Inquiry into the circumstances of the death in custody of Steven Sweeney, a 34 year old male prisoner with a lengthy and complex medical history including in particular Diabetes Mellitus, substance abuse and poor self-management of his conditions.

[56] The evidence at the Inquiry was largely uncontroversial and embodied in two extensive joint minutes of agreement. This included the salient points of the reports by the medical expert, Dr Thurtell, and substantial parts of the health history and evidence of prison and healthcare witnesses about the sequence of events on 14 January 2020. Such parole evidence as there was, was in short compass. Only one witness was asked questions in cross examination, and the questions asked were non-challenging and aimed at seeking clarification. This substantial measure of agreement between the parties represented at the Inquiry was reflected in their submissions.

[57] With the exception of the Crown, all parties invited the court to make only formal findings in terms of section 26(2) (a) and (c) as to the place, time and cause of

death. The death was not caused by an accident, and accordingly no findings fall to be made under section 26(2) (b) or (d). The Crown submitted that the court could properly make findings under section 26(2)(g) (any other facts which are relevant to the circumstances of the death) in relation to Mr Sweeney's possible interaction with un-prescribed drugs in the period leading up to his death, the effect of illicit substances on his ability to manage his diabetic condition, and the efforts taken by fellow inmates to conceal Mr Sweeney's state of intoxication from the prison authorities.

[58] Leaving aside the witness William Watt, to whose evidence I will return later, I found that the witnesses were doing their best to assist the Inquiry. I was satisfied that they gave credible and reliable evidence.

[59] I accept on the evidence that until the alarm was raised at a point shortly after 17.00 hours on 14 January 2020, no issues or concerns had been raised by anyone with the prison healthcare team in relation to Mr Sweeney. This pattern of events is in line with the position expressed by the majority of witnesses. SMc, Mr Sweeney's friend and fellow prisoner, first raised the alarm to prison authorities of Mr Sweeney's poor health shortly after 17.00 hours. When healthcare team were alerted by PCOs Paton and Anderson, they attended expeditiously to Mr Sweeney's cell.

[60] The evidence from Dr Thurtell's reports was that Mr Sweeney's condition was not survivable by the time the healthcare team became involved. By that time, his condition was too far advanced for any medical assistance over and above the care he received to have altered the outcome. Given this expert opinion, there is no basis to

make any adverse findings in relation to the adequacy of the response of prison or healthcare staff at this point or thereafter.

[61] The expert opinion of Dr Thurtell (Crown Production 8) about the survivability of Mr Sweeney's condition, is that:

> "I am certain that Mr Sweeney's DKA [diabetic ketoacidosis] was much less severe in the morning and early afternoon of 14/01/20 and would likely have been amenable to treatment. Had he been assessed by prison healthcare staff prior to 13.00 hours that day and arrangements made to convey him urgently to hospital, it is my opinion that his deterioration and death could have been avoided."

[62] In this context, the Crown referred to the evidence of PCO Bell in relation to her early morning interaction with Mr Sweeney on the day of his death. She found that Mr Sweeney was not his usual self. He remained in bed and was tired. The Crown addressed the question of whether the circumstances of this initial morning interaction could give rise to a view that it would have been a reasonable precaution in terms of section 26(2)(e) for Ms Bell to have contacted healthcare about Mr Sweeney at that point. Dr Thurtell's opinion is that assessment by healthcare of a known diabetic patient would likely have identified a state of diabetic ketoacidosis resulting in admission and treatment at hospital which could reasonably have resulted in the death being avoided.

[63] However, PCO Bell was clear that, although Mr Sweeney remained in bed and was tired, she did not consider this something to cause her any great concern. Further, Dr Thurtell's opinion (Crown Production 9) identifies that at that point in the morning "It is likely the clinical signs indicating emergency medical care was needed were NOT present earlier that day [14/01/20]". Dr Thurtell goes on to describe the further

complications of identifying a deterioration, in that young persons may physiologically compensate for the illness for a prolonged period of time. I agree with the Crown that it is not reasonable to criticise PCO Bell for not escalating the situation to healthcare staff at that point.

[64] Mr Sweeney had been diagnosed with Type 1 diabetes at 18 years of age. His medical history revealed a background of poor control of his condition in the community, with numerous admissions to hospital with diabetic ketoacidosis, or other diabetic complications. The agreed evidence of Dr Thurtell (at point 37 of the first joint minute of agreement) noted that:

> "[Mr Sweeney's] lack of engagement with secondary care diabetes services and frequent hospital admissions with diabetes emergencies were strong predictors of adverse morbidity and mortality outcomes."

The general evidence of Advanced Nurse Practitioner Vicky Thomson was to the effect that the care of diabetic prisoners in HMP Addiewell is comparable to the level of care offered in the community. Prisoners manage the condition themselves with their own prescribed insulin, glucose monitors and diabetic packs. Prison healthcare remains available for any additional issues or concerns that such a prisoner might raise – and advice may thereafter be sought from specialists out with the prison. This is illustrated by the fact that all of Mr Sweeney's admissions to hospital with complications related to diabetes, (noted within the Joint Minute at paragraph 25), relate to periods when Mr Sweeney was not incarcerated and was living within the community. Aside from the fatal incident on 14 January 2020, there appear to have been no other issues as

relating to Mr Sweeney's diabetic condition while he was a prisoner within Scotland's prison estate.

[65] The timescale shows that Mr Sweeney's condition deteriorated rapidly from his initial assessment by the staff nurses in his cell to the time he suffered a cardiac arrest in prison reception. Only 35 minutes separated the beginning of the initial assessment and the cardiac arrest. Furthermore, the total length of time from his discovery by the PCOs to the time of his cardiac arrest was only 1 hour.

[66] Two further matters raised in the evidence and submissions call for comment: (1) the evidence of former PCO William Watt about possible interactions with Healthcare staff earlier on the day in question, and (2) whether intoxication from non-prescription drugs was relevant to the circumstances of the death.

The evidence of former PCO William Watt

[67] Former PCO William Watt gave evidence that he recalled someone saying that morning that Mr Sweeney had been unwell, but nothing else about any interaction with him. He could not recall anything specific about Mr Sweeney's condition or presentation. He did not contact healthcare, but thought that PCO Lorraine Bell had. He thought that someone from Healthcare did attend after some delay. Ms Bell gave evidence that she thought it was Mr Watt's intention to contact healthcare but that she did not see or hear any call being made. She did not do so. The significance of Mr Watt's evidence is that, standing the opinion of Dr Thurtell, Mr Sweeney's condition would have likely been amenable to treatment if the prison healthcare staff had assessed

him prior to 13.00. Whether prion or healthcare staff were alerted to Mr Sweeney's condition earlier was therefore a relevant matter for Inquiry as bearing on the question of whether there were precautions which could have been taken that might have resulted in the death being avoided.

[68] All other witnesses were in agreement about the events and timings on the day of Mr Sweeney's death. PCO Bell was on duty with Mr Watt from around 07.00 hours. She did not have any reason to think Mr Sweeney's presentation that morning was worrying. She recalled opening up Mr Sweeney's cell in the morning and finding him in bed – something she described as unusual for him. However, she said that despite him telling her he was feeling tired she thought "nothing more of it" as he looked fine and had a conversation with her. She had no concerns for Mr Sweeney and her reaction on hearing of his death later in the day was one of shock.

[69] Neither PCO William Johnson, the senior custody officer that day, nor any of the other prison or healthcare staff appear to have had any information earlier in the day that Mr Sweeney was unwell and needed medical attention. He attended the cell with healthcare staff at 5pm. He had no involvement with Mr Sweeney that day, and no information was passed to him at any time earlier in the day.

[70] PCO Paton called healthcare staff to attend by radio when he was alerted by SMc to Mr Sweeney's condition at around 5pm. They attended in minutes. Mr Sweeney was moved to reception in a wheelchair, his condition having apparently improved. PCO Anderson gave evidence to similar effect.

[71] Each of these three witnesses gave evidence that there was no indication when they began their shifts at 1pm that Mr Sweeney had been unwell, or that NHS staff had been advised.

[72] Mr Logue gave evidence that he was one of the two Staff Nurses who attended Mr Sweeney, which he says he did at around 1645 – 1700. He had not been notified of any concern prior to that. Had any member of the healthcare team been notified that a diabetic prisoner was unwell, they would have attended the wing, and a note would have been made in the prisoner's medical records. Mr Logue estimates that he attended within five or six minutes, despite not being called as an emergency, and despite having a number of locked doors to pass through before reaching the wing. Mr Logue gave clear evidence of the treatment he administered to Mr Sweeney. Mr Logue caused Mr Sweeney to administer a dose of fast-acting insulin to himself, and arranged for him to be transported to hospital.

[73] I agree with the submissions to the effect that Mr Watt was vague and evasive at times in giving his evidence. His recollection that NHS staff attended Mr Watt earlier is not supported by any of his former colleagues, or by Mr Sweeney's medical records. The first entry made in Mr Sweeney' medical record on the day of his death is the attendance of Mr Logue and his colleague at the request of Mr Anderson. In terms of the supplementary Joint Minute, each of the other members of NHS staff who was working on the day of Mr Sweeney's death has confirmed that they received no notification of Mr Sweeney's condition prior to the call that prompted the attendance of Mr Logue and his colleague shortly before 17.00.

[74] For these reasons, I prefer the evidence of the other witness to that of Mr Watt. Having regard to the totality of the evidence which I accept, it does not appear that any phone call was made to alert Healthcare staff to any problem with Mr Sweeney that morning.

Was intoxication from unprescribed drugs relevant to the circumstances of the death?

[75] The Crown suggested that it was open to the court to find in terms of section 26(2)(g) that (i) Mr Sweeney took illicit and non-prescribed drugs in the period leading up to his death; (ii) that the effect of the illicit and non-prescribed drugs on Mr Sweeney is likely to have impacted upon his ability to effectively manage his diabetic condition; and (iii) that fellow prisoners and friends of Mr Sweeney took efforts to conceal Mr Sweeney from prison authorities due to his intoxication during this period, and that this may have led to missed opportunities to detect any deterioration in his health.

[76] The Crown accepted that illicit drugs did not have a direct causative effect on death, but submitted that they may have played a part in Mr Sweeney's management of his diabetic condition so that the court could properly find that these are facts relevant to the circumstances of the death. Lothian Health Board advanced no submissions of their own in support of section 26(2)(g) findings but indicated a position of neutrality on the Crown's argument. Neither Sodexo nor SPS supported a finding under this subsection in relation to the drugs issue.

[77] The basis for the Crown submission is that SMc, a former prisoner and friend of Mr Sweeney, indicated that Mr Sweeney had taken illicit substances the day prior to his death and that he, along with other prisoners, actively took steps to hide Mr Sweeney's intoxicated state from prison authorities. The post mortem toxicology results confirmed the presence of illicit and non-prescribed drugs within Mr Sweeney's blood. SMc raised the prospect of Mr Sweeney not having taken his required doses of insulin, although the evidence of prison staff was that Mr Sweeney appeared to deny this. This confused picture, coupled with the very high blood glucose levels taken at that time, might well strengthen the narrative that Mr Sweeney's management of his condition at this period was unstable. They referred me to Dr Thurtell's opinion, within Crown Production 7 (paragraph 42 of the Joint Minute), that:

> "Whilst none of these substances were present in concentrations sufficient to have caused death through direct drug toxicity, I would argue that the sedative effect of these substances effectively rendered him incapable of managing his diabetes thus provoking DKA [diabetic ketoacidosis]"
>
> and
>
> "I think it is extremely unlikely that Mr Sweeney would have been capable of either checking his blood glucose levels or administering insulin during this time."

[78] The Crown submitted that the actions of his fellow prisoners, in concealing him from prison authorities, may have resulted in lost early opportunities to detect a deterioration in Mr Sweeney's condition and/or abnormal glucose or ketone levels. However, the Crown conceded that Mr Sweeney's exact condition on the day prior to

his death was unknown. Neither was it known whether any deterioration might have come to light even if he was not being actively concealed.

[79] The Crown did not suggest that there was any defect in the system of work regarding drug surveillance and prevention by the authorities at HMP Addiewell. Nor was it suggested that there were any further reasonable precautions which the authorities could have taken. The Crown lodged an affidavit from John Morrison, Head of Operations at HMP Addiewell, setting out the extensive measures employed to prevent, detect and disrupt the circulation of illicit drugs within the prison estate. Although the circulation of illicit drugs within the prison population is a matter of serious public concern, I accept that extensive efforts are made by prison authorities to address the problem and I do not find any basis to criticise the arrangements at Addiewell.

[80] In addressing this issue, Sodexo reminded me that, firstly, PCO Bell, on speaking with the deceased just after 7am on January 14, had no cause for concern for his welfare, and while Mr Sweeney stated to her that he was tired, she observed him to be "normal, fine" and "his normal self." No evidence was led to suggest that the deceased was at any time from that point apparently sedated or otherwise impaired. It was submitted therefore that any ingestion of any un-prescribed medication or illicit substance could not, in all these circumstances, be regarded as causative of, or contributory to, the death.

[81] In any event, I was reminded of the efforts made by Sodexo to tackle these known issues. The evidence of Mr Morrison was commended to me. The use of X-ray and Rapiscan equipment, drug detection dogs, staff training and the use of searches are

substantial measures to address the problem. To assist in the prevention of drugs getting into prison, visitors are searched. Items thrown over the perimeter fence is another route for illicit items to enter the prison and measures are in place to mitigate against that practice. Security measures are also in place to mitigate against the possibility of illicit substances entering the prison via staff. Incoming mail to prisoners is searched also.

[82] The agreed evidence of the pathologists was that Mr Sweeney's death was as a result of diabetic ketoacidosis arising from diabetes mellitus, and that it was unlikely that the toxicological findings would have played a significant role in the death. Furthermore there was no evidence led as to the provenance of any un-prescribed medication or illicit substances the deceased may have ingested. Nor was there any direct evidence led that Mr Sweeney's ability to manage his condition was in fact impaired as a consequence of any substance. In any event it appears that other prisoners actively took part in concealing Mr Sweeney from officials, and such consideration of the drug surveillance and detection measures as there was does not disclose any reason to criticise the arrangements in place at HMP Addiewell.

[83] For these reasons, I have come to the view that the potential relevance of drug ingestion to the circumstances of the death is somewhat speculative, remote and tenuous. In my view, it is insufficiently supported by any evidence capable of allowing a useful or meaningful inference to be drawn which would assist the Inquiry. Potential questions about the effectiveness of the drug regime have been answered in evidence, and further consideration of this line seems to me to be beyond the scope of this Inquiry.

I do not therefore make any finding under section 26(2)(g) in relation to the drugs matter which has been raised.

Conclusion

[84] The formal findings I am required to make in terms of the Act are set out at the beginning of this determination. I have not made any findings under section 26(2)(b) or (d) because the death did not result from an accident. I have come to the view on the largely undisputed evidence that in terms of section 26(2)(e) that there were no precautions which could reasonably have been taken which might realistically have resulted in the death being avoided. Nor did the evidence point to any defects in any system of working at HMP Addiewell or in the Healthcare unit there which contributed to the death. For the reasons given above, I have concluded that in terms of section 26(2)(g) there are no other facts relevant to the circumstances of the Inquiry.

[85] The unfortunate facts are that Mr Sweeney suffered long term and serious poor health due to poorly managed diabetes and drugs issues. Adequate healthcare facilities were available to him in prison to address his condition but he had a history of non-engagement with health services in the community. On the day of Mr Sweeney's death, his presentation to prison staff in the morning did not give rise to any concerns for his wellbeing. Although earlier intervention might have altered his survivability, it is clear that healthcare staff were not alerted to his deteriorating condition until many hours later, at about 5pm. By that time it was too late to save him. Efforts to resuscitate him were unsuccessful and his demise was inevitable. Dr Thurtell does not criticise the

response of prison healthcare staff once they were alerted to the issue. He comments in his report that PCO's attended his cell immediately when alerted to the situation (by SMc), they in turn appropriately summoned medical assistance from staff nurses on duty, the staff nurses attended without delay and that the actions of prison staff were "sufficiently expedient".

[86] In closing this Determination, may I join the representatives of the parties at this Inquiry in expressing my condolences to the family of Mr Sweeney for their loss.