SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT DUNFERMLINE

[2025] FAI 4

DNF-B222-24

DETERMINATION

BY

SUMMARY SHERIFF MARK O'HANLON

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

into the death of

ALEXANDER SALMOND

17 December 2024

Determination

[1] The Sheriff, having considered the evidence presented at the inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 that:-

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

On 26 October 2022, Alexander Salmond, born 25 November 1962, died within Cell 3-61, Abercrombie Hall, His Majesty's Prison Glenochil King O'Muir Road, Tullibody FK10 3AD. His life was formally pronounced extinct at 23.25 by Scottish Ambulance Service Paramedics.

1.2 In terms of section 26(2)(b) of the Act (when and where any accident resulting in the death occurred):

Mr Salmond's death did not result from an accident.

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

1(a) Left Lower Lobar Pneumonia

(2) Previous Cerebrovascular Event (Right).

1.4 In terms of section 26(2)(d) of the Act (the cause of any accident resulting in the death):

Mr Salmond's death did not result from an accident.

1.5 In terms of section 26(2)I of the Act (the taking of precautions):

There were, on the available evidence, no precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death being avoided.

1.6 In terms of section 26(2)(f) of the Act (defects in any system of working):

There were, on the available evidence, no defects in any system of working which contributed to the death.

1.7 In terms of section 26(2)(g) of the Act (any other facts relevant to the circumstances of death):

There were, on the available evidence, no other facts relevant to the circumstances of death.

Recommendations

[2] In terms of section 26(1)(b) of the Act, there are, on the available evidence, no recommendations to be made.

NOTE

Representation:

Procurator Fiscal: Kelly, Procurator Fiscal Depute.

Scottish Ministers for Scottish Prison Service ("the SPS"), Thornton, Solicitor, Anderson Strathern LLP.

Forth Valley Health Board: Waseem, Solicitor, NHS Scotland Central Legal Office

[3] This is an inquiry into the death of Mr Alexander Salmond. Mr Salmond died within Cell 3-61, Abercrombie Hall, His Majesty's Prison Glenochil, King O'Muir Road, Tullibody FK10 3AD on 26 October 2022. At the time of his death Mr Salmond was a serving prisoner at HMP Glenochil. This is, accordingly, a mandatory inquiry in terms of section 2(4)(a) of the Act.

[4] The Procurator Fiscal issued a notice of inquiry on 24 June 2024 and a preliminary Hearing was held on 19 August 2024.

[5] A t the preliminary hearing on 19 August the representatives for the Crown, the Scottish Prison Service and the Forth Valley Health Board all were in agreement that the evidence could be by way of joint minute. The statements of the crown witnesses were agreed in the Joint Minute and the representatives of the Scottish Ministers and the Fort

Valley Health Board indicated that they did not intend to call any witnesses on their behalf.

[6] The inquiry was conducted virtually with participants appearing by video conference on 19 September 2024. All evidence was agreed by way of a Joint Minute of Agreement lodged on 5 September 2024. The sister of Mr Salmond having being intimated upon elected not to observe the inquiry.

[7] I have found that Mr Salmond died of natural causes, and, on the evidence, there are no systemic defects arising or precautions that might have been taken to avoid the death. I also provide a narrative of the facts which I found established.

The Legal Framework

[8] This inquiry was held under section 1 of the 2016 Act. The relevant procedural rules are found in the Act of Sederunt (Fatal Accident inquiries rules 2017) (" the 2017 rules"). The purpose of the inquiry as defined by section 1(3) is to;

(a) establish the circumstances of the death and:

(b) consider what steps, if any, might be taken to prevent other deaths in similar circumstances.

It is not the purpose of the inquiry to establish civil or criminal liability.

[9] Section 26 of the 2016 Act requires the sheriff to make a determination which in terms of section 26 (2) is to set out the factors relevant to the circumstances of the death, in so far as they have been established to his satisfaction. These 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 death;

(d) the cause or causes of any accident resulting in the death;

(e) any precautions which could reasonably have been taken and if they had been taken might realistically have resulted in the death being avoided;

(f) any defect in any system of working which contributed to the death or to the accident; and

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

[10] In terms of section 26 (1) (b) and 26 (4) of the Act, the inquiry is to make such recommendations(if any) as the sheriff considers appropriate as to:

(a) the taking of reasonable precautions;

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

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

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

[11] Responsibility for the provision of health care to prisoners transferred from the Scottish Prison Service to the NHS on the 1 November 2011. Health Board Provision of Healthcare in Prisons (Scotland) Directions 2011. Since that date individual regional NHS health boards have been responsible for the delivery of health care services within prison settings in Scotland which fall within their geographical remit.

Summary

Background

[12] That Alexander Salmond was born on 25 November 1962. At the time of his death, he was 59 years of age and was being held in legal custody at His Majesty's Prison Glenochil, King O'Muir Road, Tullibody FK10 3AD.

[13] That on 5 June 2003, Mr Salmond was convicted and sentenced at Edinburgh High Court for certain offences; he was sentenced to life imprisonment with a punishment part of seven years and six months to run from 14 October 2002. The punishment part of Mr Salmond's sentence expired on 13 April 2010, and he was never released on licence.

[14] That Mr Salmond's death occurred within Cell 3-61 Abercrombie Hall of His Majesty's Prison Glenochil, King O'Muir Road, Tullibody FK10 3AD on 26 October 2022 and his life was pronounced extinct at 23:25hrs.

Medical History, Care and Treatment.

[15] That Mr Salmond had a diagnosis of late onset Schizophrenia and, on 22 October 2003, Scottish Ministers acting under section 71(1) of the Mental Health (Scotland) Act 1984 directed that he be transferred to the State Hospital at Carstairs for treatment of this condition. That Mr Salmond was admitted to the State Hospital at Carstairs on 31 October 2003.

[16] That from around 2011/12, for a period of two to three years, clinicians at the State Hospital trialled Mr Salmond off medication and concluded following this that he did not suffer schizophrenia but rather a complex personality disorder(s).

[17] That on 27 August 2014, Scottish Ministers revoked the transfer of treatment direction and Mr Salmond was thereafter transferred to HMP Glenochil on 28 August 2014.

[18] That at some time before being discharged from the State Hospital Mr Salmond was diagnosed with Type 2 diabetes.

[19] That Mr Salmond had a history of diabetes, dust allergy, leg ulcers and cellulitis; at times these conditions required him to make use of a wheelchair and necessitated attendance and admissions to Forth Valley Royal Hospital (hereinafter referred to as "FVRH").

[20] That on 20 October 2020, Mr Salmond was admitted to FVRH suffering from symptoms of a Stroke. He remained there until 09 November 2020, when he was transferred to the Bellfield Centre, Stirling to undergo rehabilitation.

[21] That on 26 October 2020, a Do Not Attempt Cardiopulmonary Resuscitation (hereinafter referred to as a "DNACPR") was put in place. This indicated that Cardiopulmonary Resuscitation (hereinafter referred to as "CPR") would not be successful for Mr Salmond and was not a treatment option for him. It was deemed that Mr Salmond did not have capacity to be made aware of this decision at the time and it was therefore intimated to his sister.

[22] That on 14 December 2020, Mr Salmond was discharged from hospital and returned to a disabled access cell with a range of supports including a personal alarm and specialist equipment however at this time Mr Salmond was mobile and independent with personal care.

[23] That on 25 January 2021, Mr Salmond was admitted to FVRH as he was seen to have been suffering from left sided weakness. Mr Salmond was treated for a stroke. He was discharged back to HMP Glenochil on 18 March 2021

[24] That on 11 February 2021, there was a review of the DNACPR already in place with the outcome again being that CPR was unlikely to be successful and was not a treatment option for Mr Salmond. This decision was discussed with Mr Salmond on 12 February 2021.

[25] That on 17 March 2021, prior to Mr Salmond's discharge from FVRH a single shared assessment was undertaken which confirmed that Mr Salmond required assistance of two carers for all aspects of personal needs on a minimum of four times per day.

[26] That on 8 November 2021, there was a review and discussion with Mr Salmond about his DNACPR and Mr Salmond agreed that he would not be for CPR.

[27] That between 23 December 2021 and 14 January 2022, Mr Salmond had a further three admissions to FVRH for conditions including cholecystitis, chest pains and concerns regarding further strokes.

[28] That on 12 January 2022, Mr Salmond was made subject to section 47 of the Adults with Incapacity (Scotland) Act 2000 whilst in FVRH as it was considered that he

did not have capacity to consent to investigation for possible underlying malignancy due to cognitive impairment.

[29] That on 16 January 2022, Mr Salmond was admitted to FVRH as Prison Staff were concerned about his level of consciousness and a cough, querying possible sepsis. An examination by the hospital doctors indicated that there was no acute issues and Mr Salmond was discharged back to HMP Glenochil on the same date.

[30] That on 18 January 2022, Mr Salmond's DNACPR was reviewed by Dr Jack Kildare and the outcome remained as previous versions.

[31] That on 27 January 2022, the Certificate of Incapacity under section 47 of the Adults with Incapacity (Scotland) Act 2000 was reviewed and renewed until 27 January 2025 as it was considered that Mr Salmond's cognitive impairment was likely to be permanent and this was required to allow fundamental medical, nursing and personal care.

[32] That an Anticipatory Care Plan (hereinafter referred to as "ACP") was put in place in January 2022. The most recent ACP available is dated 26 July 2022

[33] That the ACP acknowledged that Mr Salmond's condition was likely to continue to deteriorate and recommended that all current medications were discontinued as appropriate. It would be in his best interest to remain within HMP Glenochil for comfort and palliative care only and "Just in Case" Medications would be prescribed It was further stated that Mr Salmond's condition had deteriorated with each hospital admission, and he was now receiving assistance for all personal and comfort needs on a two hourly basis.

[34] That Mr Salmond had previously expressed a desire to be considered for compassionate release. This application was refused by the Parole Board on 21 March 2022.

Circumstances of Death

[35] That on 23 October 2022, NHS Medical Staff were asked to review Mr Salmond in his cell as carers reported concerns. It is noted that Mr Salmond had a temperature of 39.0 and was hot to touch. Mr Salmond was thereafter reviewed by medical staff on 4 further occasions prior to his death.

[36] That at around 22:00hrs on 26 October 2022, Medical Staff attended at the cell of Mr Salmond to undertake their two hourly check in accordance with his care plan. They were allowed into the cell by Prison Officers. Upon entering they believed Mr Salmond may have died and they attempted to locate a pulse without success. Mr Salmond was warm to touch but there was no sign of chest movements to indicate breathing. As Mr Salmond had a DNACPR in place no CPR was undertaken.

[37] That an ambulance was summoned, and a crew arrived at 23:15hrs. A Paramedic checked for a pulse and heart signs, but both were absent. She pronounced life extinct at 23:25hrs on 26 October 2022.

[38] That on 16 November 2022 a post-mortem examination was carried out by Dr Amanda Paton; Mr Salmond's cause of death was attributed to (1a) Left Lower Lobar Pneumonia and (2) Previous Cerebrovascular Event (Right).

[39] As at the date of his death on 26 October 2022 Mr Salmond was a prisoner in HM Prison Glenochil and was accordingly in legal custody at the time of his death.

[40] That on 10 March 2023, a DIPLAR was undertaken in relation to Mr Salmond's death. This report identified good practice including joint partnership to provide medical care, nightshift protocols, organisation of regular phone calls between Mr Salmond and his sister, more than two hourly checks by staff and that compassionate leave had been discussed. It also identified that there were learning points including review of nightshift order and confirmation of death process.

Matter that arose during the inquiry

[41] At the inquiry I raised the issue of any processes that existed to reconsider the decision of the Parole Board of 16 March 2022 to refuse compassionate leave and have a further review in 9 months in circumstances where his health deteriorated prior to the review date. I was concerned as to position that if Mr Salmond's health deteriorated further to the extent that the risk could be managed there existed no mechanism to bring the matter back within that 9-month period. I accordingly ordered the Scottish Ministers on 19 September to lodge in process, within 3 weeks, written submissions or an affidavit to advise on internal processes, if any, to reconsider a decision to refuse compassionate leave if health deteriorates further. This was further extended to 7 November 2024 and written submissions; a supporting affidavit and various productions were lodged on 31 October 2024 A further Joint minute covering this evidence and documents was submitted on 12 December 2024.

[42] In terms of those productions and the further submissions from the SPS I was able to determine that there is guidance relating to compassionate release which is set out in production GMA039A-21 In Annexe A, there are four grounds which must be considered when determining whether someone is eligible for compassionate release on medical grounds. Of particular relevance is that "the risk of re- offending or public harm is low and can be managed" and "there are appropriate arrangements for the prisoner's supervision, care and treatment in the community". Compassionate release was never applied for by the SPS in relation to Mr Salmond. Mr Salmond attended a Tribunal hearing before the Parole Board on 21 March 2022. Mr Salmond was assessed as high level of risk and needs using LS/CMI, medium risk of serious harm with high risk of re-conviction for both sexual and violent offending using the RM2000, and moderate risk of sexual re- offending under SA07. At the time of this Tribunal hearing, Mr Salmond was receiving end-of-life care and bedridden. The Parole Board was satisfied that it was necessary for the protection of the public that Mr Salmond should be confined. The Board acknowledged that Mr Salmond was end-of-life care but noted that he did not at that point meet the criteria for compassionate release. They were entitled to make that decision and had the benefit of a full submission from Mr Salmond, s solicitor who sought his release and submitted that he could be managed in the community. Mr Salmond situation was also discussed during Risk Management Team "RMT" Meetings on 16 March 2022 and 13 July 2022. At the meeting on 16 March 2022, it was reported that there was also nowhere in the community able or willing to accept Mr Salmond even if he were to be considered for compassionate release. It was noted at

the RMT Meeting on 13 July 2022 that should Mr Salmond's updated risk assessments score as low, he should be considered again for compassionate release. Libby Banyard, Prison Based Social Work Team Manager, confirmed in an email dated 27 September 2024, that Mr Salmond's LS/CMI score of "high" was still relevant at the time of his death. and further stated that there had been no significant changes to Mr Salmond's circumstances that were relevant to or that would have impacted on his risk assessment outcome.

[43] In the circumstances given the terms of the decision of 21 March 2022 the Risk Management team minute of 16 March 2022 and 13 July 2022 and the email of 27 September 2024 I agree with the supplementary submissions made on behalf of the Scottish Ministers that Mr Salmond was not eligible for compassionate leave at any time subsequent to the Parole Board decision of 21 March 2022 as his level of risk was never scored as low. Further even if he did score low in terms of risk there was no place available for him to be managed in a community suiting. The matter was constantly under review and dealt with appropriately in terms of their guidance and processes. Accordingly, there is no basis for any formal findings in terms of section 26 of the act in relation to this issue.

Conclusion

[44] On the evidence I have no difficulty in making the formal findings in terms of section 26 (2)(a) to (c) with no findings in relation to section 26 (2)(d) to (g) as submitted by all parties. These findings are set out above.

[45] Mr Salmond suffered from various health issues that had been long standing and required assistance of two carers for all aspects of his personal needs. In light of his deteriorating health and that CPR was unlikely to be successful for him a DNACPR had been put in place on 26 October 2020 that was regularly reviewed with no changes required.

[46] Mr Salmond was bed bound incontinent and lacked capacity. He required assistance with all aspects of daily living. There was an appropriate package in place to deliver the high level of care that he required. The evidence discloses that Mr Salmond received the appropriate case and treatment and that only in a custodial setting could that level of care be provided in a safe manner.

[47] I have not identified any issues that would merit a finding in terms of section 26(1)(b) and section 26(4) of the Act. I had no locus to revisit the decision of the Parole Board of 16 March 2022 a matter solely within their prerogative. In relation to matters after that date as identified at para [41] to [43], I am satisfied that appropriate procedures were in place and were adhered to in respect of Mr Salmond who received the high level of care that he required.

[48] I am grateful to the parties for their preparation for this inquiry, including the additional evidence and submissions provided by parties in this case re the additional matter raised by me, as a result of which all the evidence was agreed without the necessity of any witness having to give oral evidence.

[49] In conclusion along with all other parties to the inquiry I offer my personal sympathies and condolences to the family, friends and next of kin of Mr Salmond for their loss.