SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2024] FAI 42

GLW-B1797-23

DETERMINATION

BY

SHERIFF DAVID TAYLOR

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

into the death of

GREGG WILLIAM ANDERSON

GLASGOW, 30 September 2024

The Sheriff, having considered all of the evidence and information presented at the Inquiry, Determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (hereinafter referred to as "the Act") that:

(1) In terms of section 26(2)(a) of the Act , Gregg William Anderson, born on 27 January 1991, then a prisoner within HM Prison Glenochil, King O Muir Road, Tullibody, FK10 3AD, died at 11.30 pm on 26 December 2021 within Queen Elizabeth University Hospital, Glasgow.

(2) In terms of section 26(2)(c) of the Act, the cause of death was:

1a: Graft versus host disease

1b: Allogenic stem cell transplant

1c: Bi-phenotic acute leukemia

2: Infection

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

(4) In terms of section 26(2)(f) of the Act, there were no defects in any systems of working which contributed to the death.

(5) In terms of section 26(2)(g) of the Act, there are no other facts which are relevant to the circumstances of the death.

Recommendations

The Sheriff having considered the information presented at the Inquiry, Makes no recommendations in terms of section 26(1)(b) of the Act.

NOTE:

Introduction

[1] This Determination is made following the Fatal Accident Inquiry held under the Act into the circumstances of the death of Gregg William Anderson, born 27 January 1991, who died while a prisoner in HM Prison Glenochil, King O Muir Road, Tullibody, FK10 3AD, on 26 December 2021.

[2] Three parties were represented at the Inquiry: Mr Neilson, procurator fiscal depute, appeared for the Crown, Mr Richmond, solicitor, appeared on behalf of the Scottish Ministers

for the Scottish Prison Service and Mr Nicolson, advocate, appeared on behalf of GeoAmey Limited. Intimation of the Inquiry was made to Mr Anderson's father Mr Billy Anderson who provided a statement to the Crown but who elected not to participate in the Inquiry.

[3] For the purposes of the Inquiry parties tendered a joint minute of agreement which covered all of the necessary evidence which required to be placed before the court except for two matters. These two matters concerned the handcuffing of Mr Anderson prior to his death and the extent to which standard prison rules regarding issues such as a prisoner's access to an iPad applied to a prisoner nearing the end of their life such as Mr Anderson. The court heard evidence in relation to these two issues from Sarah Kelly, a witness cited by GeoAmey Limited. At the conclusion of the Inquiry parties invited me to make only formal findings in terms of section 26(2)(a) and (c) of the Act.

Legal framework

[4] This Inquiry was held in terms of section 1 of the Act. It was a mandatory Inquiry in terms of section 2(4)(a) of the Act as Mr Anderson was in legal custody at the time of his death. Although Mr Anderson died whilst in hospital, he remained a prisoner of HM Prison Glenochil throughout that time, meaning that at the time of his death, he was in legal custody.

[5] In terms of section 1(3) of the Act, the purpose of an Inquiry is to establish the circumstances of the death and to consider what steps, if any, may be taken to prevent any other deaths occurring in similar circumstances. Section 26 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 facts which are relevant to the circumstances of the death.

[6] In terms of sections 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 any 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.

[7] The procurator fiscal represents the public interest. An Inquiry is an inquisitorial process and the manner in which evidence is presented is not restricted. The Determination must be based on the evidence presented at the Inquiry. It is not the purpose of an Inquiry to establish criminal or civil liability (section 1(4) of the Act).

[8] Responsibility for the provision of health care to prisoners transferred from the Scottish Prison Service to the NHS on 1 November 2011. Since then, individual regional NHS health

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

Background to Mr Anderson's medical treatment and death

[9] The background circumstances have been taken from the terms of the joint minute and the agreed productions and statements.

[10] Mr Anderson was remanded in custody in HM Prison Edinburgh on 3 October 2018 in respect of charges of contravening sections 1 and 3ZB of the Road Traffic Act 1988 and of attempting to pervert the course of justice. He was transferred to HM Prison Glenochil on 1 August 2019 before being transferred to HM Prison Castle Huntly on 15 September 2020 and transferred back to HM Prison Glenochil on 30 November 2020.

[11] Mr Anderson first reported feeling unwell on 17 January 2021 and was admitted to hospital. Following tests, he was diagnosed with a rare type of acute leukemia. The prognosis was poor, and he was transferred to the Beatson in Glasgow for further tests. The tests revealed that Mr Anderson had Biphenotypic Acute Leukemia which would be treatable with intensive chemotherapy as an in-patient.

[12] On 17 February 2021, Mr Anderson tested positive for Covid-19. By 18 February 2021, he had commenced chemotherapy. His prognosis remained poor because, generally, patients with haematological vulnerabilities and Covid-19 do not tend to have positive outcomes, regardless of how they are treated. Mr Anderson spent some time in the High Dependency Unit of the Queen Elizabeth University Hospital in Glasgow but on 5 March 2021 was transferred to the Brownlea Ward, the Covid-19 Ward, at Gartnavel Hospital.

[13] Mr Anderson continued to receive chemotherapy and after recovering from Covid-19, returned to HMP Glenochil on 24 March 2021. He took a break from chemotherapy while back in prison but returned to Gartnavel Hospital on 7 April 2021 to receive further chemotherapy. He returned to HMP Glenochil on 12 May 2021.

[14] On 19 May 2021, Mr Anderson had a virtual appointment with Dr Ann Parker of the Queen Elizabeth University Hospital to discuss a possible bone marrow transplant. Mr Anderson received information on what the procedure would involve and the associated risks. Mr Anderson agreed to an appointment with a specialist leukemia nurse and to continue his planned chemotherapy at the Beatson. Following his consultation with the specialist leukemia nurse on 21 May, Mr Anderson's bone marrow transplant was provisionally planned for July 2021. On 11 June 2021, Mr Anderson had a consultation with the transplant coordinator at the Queen Elizabeth University Hospital. The role of the transplant coordinator was explained, and the pros and cons of the transplant were discussed.

[15] Mr Anderson's bone marrow transplant was scheduled for 18 August 2021 but was cancelled by the hospital the day before because of problems with the donor.

[16] Mr Anderson received his bone marrow transplant on 25 October 2021. He became very unwell in the days that followed, suffering from severe anal pain, a sore throat and mouth, and a fever. He was treated with a syringe driver for pain management, and oxygen.

[17] By 7 November 2021, Mr Anderson was on day 13 following the procedure. His health was fragile. Doctors were concerned because he had increased bilirubin and fluid overload. On 12 November 2021, Mr Anderson remained on a syringe pump for pain relief and was being treated with antibiotics. By 16 November, Mr Anderson was still being treated for fluid

overload and remained on antibiotics. He was also being treated with oxygen because he had developed flu.

[18] On 24 November 2021, staff at the Queen Elizabeth University Hospital were making plans to discharge Mr Anderson back to HMP Glenochil and prison healthcare staff devised a care plan to accommodate his return (Crown production No 3, page 11). However, Mr Anderson's return was delayed because of worsening liver function.

[19] By 11 December 2021, Mr Anderson had developed engraftment syndrome, which can be a complication following a bone marrow transplant. He was very unwell. On 13 December 2021, Mr Anderson was on a syringe driver for abdominal pain, but he was still being actively treated in the hope he could return to prison.

[20] Mr Anderson developed possible veno-occlusive disease and definite grade 3/4 acute Graft versus Host Disease (GvHD), well recognised complications of his transplant which prolonged his admission and contributed to progressive debilitation. Mr Anderson had to be fed using total parental nutrition because of intractable diarrhoea and weight loss. He became susceptible to infection. He was treated with multiple immunosuppressive agents without success. Doctors within the transplant unit worked with the palliative care team throughout and supported his symptom burden with anti-sickness medication, anti-diarrhoeals and painkillers.

[21] By 22 December 2021, Mr Anderson's condition had deteriorated, and he was moved to the High Dependency Unit. At this stage, hospital medical staff thought it was unlikely he would survive.

[22] On 23 December 2021, Mr Anderson was being treated for sepsis. He improved slightly but was still extremely unwell (Crown production No 3, page 7). Following discussions between the stem cell transplant team and the critical care consultants, it was felt that his condition was not likely to improve, and, as it was also felt that he would be unlikely to tolerate ventilation, doctors decided to move Mr Anderson from the High Dependency Unit back to Ward 4B.

[23] On 24 December 2021, the consultant, Dr Grant Quaker, signed a Do Not Resuscitate (DNR) for Mr Anderson because it was felt that resuscitation would not be successful in the event of a cardiorespiratory arrest due to progressive multi-organ failure and refractory Grafts versus Host Disease. Mr Anderson and his father agreed with this decision.

[24] On the morning of 26 December 2021, Mr Anderson's oxygen levels dropped, and he had trouble breathing. A chest x-ray showed widespread consolidation. The registrar attended and a decision was made to stop active care of Mr Anderson as his death was expected.

[25] Around 2215 hours on 26 December 2021, Mr Anderson's breathing changed, with longer gaps between breaths. Staff Nurse Yasmin Fergie explained to the deceased's father and his father's partner that this was normal and confirmed that the deceased was approaching the end of his life.

[26] At 2330 hours on 26 December 2021, witness Yasmin Fergie was advised that Mr Anderson had stopped breathing. The witness Yasmin Fergie attended and confirmed he had passed away. Witness Scott Calvert thereafter attended, and he pronounced life extinct at 2330 hours on 26 December 2021.

[27] Mr Anderson's death was certified by medical practitioner Miriam McKean and recorded as:

1a: Graft versus host disease

1b: Allogeneic stem cell transplant

1c: Bi-phenotypic acute leukaemia

2: Infection.

[28] As at the date of his death on 26 December 2021 Mr Anderson was a prisoner in HM Prison, Glenochil and was accordingly in legal custody at the time of his death.

Other matters which arose in the course of the Inquiry

[29] In paragraph 3 of this Note I referred to two matters which arose in the course of this inquiry. Those matters concerned the handcuffing of Mr Anderson prior to his death and the extent to which standard prison rules regarding issues such as a prisoner's access to an iPad applied to a prisoner nearing the end of their life such as Mr Anderson. Both of these issues arose from the terms of the Death In Prison Learning, Audit and Review ("DIPLAR") dated 8 February 2024 which was lodged by the Scottish Ministers as a production. Specifically paragraph 3.9 of the DIPLAR states:

> **"3.9 Did the family raise any questions or concerns to be discussed at the DIPLAR?**
> **YES ☒ NO ☐**
> If yes, please detail below
> These should be considered throughout the DIPLAR at the relevant points and the responses recorded in Section 12.
>
> Mr Anderson's family were not happy due to Mr Anderson still being in handcuffs until he was unconscious on 25/12/21. GIC N Beal and Chaplain G Bell met with the

> family on 28/04/23 where the family raised concerns claiming their sons treatment was 'barbaric' they claimed GEOAmey staff were watching videos on their phones and laughing when the family were in comforting their son. GEOAmey need to investigate this. The family also made accusations that NHS staff had offered Mr Anderson some hot chocolate by NHS staff and GEOAmey staff would not allow this. Mr Anderson claims the staff responded in an aggressive manner.
>
> Governor Natalie Beal gave the family a sincere apology at the time of their meeting. N Beal made reference to the issue with the handcuffs being confusion on who was responsible for making this decision. GEOAmey stated they carry out a cuffing risk assessment however on this occasion escorting staff wanted the establishment to make the descison. During the DIPLAR GeoAmey manager Sarah Kelly stated she had only come into post in 2022 she checked the records for GEOAmey and unfortunately there was no formal evidence of a complaint being raised by the family in relation to the conduct of those staff member so was unable to comment any further but she made comments on how this should have never happened and if this did in fact happen she sends her apologies to the families.
>
> GEOAmey stated that since Sarah has taken up post GEOAmey now have a process where care plans are drafted in collaboration with SPS establishments for people who are end of life care or their conditions have deteriorated since GEOAmey have taken over the escort. This allows good partnership working and provides clarity and detail around what individuals can have access to i.e. dietary/ fluids and includes a risk assessment around need for handcuffs as well as permitted visitors. The care plan is shared with the escorting staff. They stated this is working really well and all who attended the DIPLAR agreed that this approach going forward would be best practise and will be part of the learning points."

[30] The inventory of productions containing the DIPLAR was lodged shortly prior to a preliminary hearing which took place on 26 March 2024. GeoAmey Limited ("GeoAmey") were represented at the preliminary hearing given the issues raised in the DIPLAR. At the preliminary hearing I was invited by the Crown to consider the issues raised in the DIPLAR in the course of the Inquiry. That request was made by the Crown on the basis that it was in the public interest that the issues raised in the DIPLAR should be investigated in the course of the Inquiry. Subsequent preliminary hearings took place at which these issues were discussed with further investigations being carried out by the parties, particularly by the Crown and

GeoAmey. The Crown lodged a statement taken from Mr Anderson's father Billy Anderson (Mr Anderson senior).

[31] Mr Anderson senior refers in his statement to his son becoming unwell and to the initial treatment which he received. His evidence about these matters is consistent with the other Crown statements and the medical records. On page 2 of his statement Mr Anderson senior refers to the concerns he had during the initial 6 weeks of his son's treatment (in or around February 2021) that his son was handcuffed to a GeoAmey security guard at all times when receiving treatment. He states that he called GeoAmey every day for 2 weeks to ask that the handcuffs be removed. According to Mr Anderson senior his son's handcuffs were removed at some point in April. Contrary to what is stated in the DIPLAR at paragraph 3.9 Mr Anderson senior states in his statement that his son remained uncuffed from April 2021 until his death in December 2022. Mr Anderson senior also refers in his statement to his concerns that he was unable to bring in a Rubik's cube and an iPad to his son, to put up photos in his son's room and take photos of him and his son in his final months, weeks and days. He describes the refusal to allow these things to someone who was receiving end of life care as "unbelievably barbaric".

[32] Finally Mr Anderson senior criticises the behaviour of the GeoAmey staff guarding his son as unprofessional and disrespectful, particularly in the last few days of his son's life.

[33] For their part GeoAmey lodged a number of productions along with statements taken from their employees Candace Hart and John Brown.

[34] Candace Hart is a prison custody officer with GeoAmey having been employed by them for approximately 3 years. She recalls being the prison custody officer for Mr Anderson on two occasions which she believes were likely to be 25 and 26 December 2021 based on the GeoAmey

rota. On both of those dates Ms Hart was working with one of her more senior colleagues John Brown. She is clear in her recollection that Mr Anderson was not handcuffed on either of those dates. She states that she and Mr Brown sat inside Mr Anderson's room on the first date, ie 25 December and outside his room on 26 December. She recalls discussions taking place about Mr Anderson being near the end of his life and of the decision being taken to give his family time and space with him. The information about Mr Anderson nearing the end of his life would have been relayed by the hospital staff to the GeoAmey prison custody officers who would in turn have passed that information to what is referred to as the control room at GeoAmey. Ms Hart is clear that the decision about whether to make any change in the custody arrangements for Mr Anderson, ie for the prison custody officers to sit outside his room, would have been made by the GeoAmey control room. Ms Hart also refers in her statement to training - as well as being a prison custody officer she is also a part time support trainer for new recruits. She explains that the training given to new starts about on-site risk assessments is that the situation can and does change and that they should look out for simple risks and dangers to GeoAmey staff, the prisoner, the medical staff and members of the public. She describes the process as one of continual risk assessment. The training given to officers is that at the end of life stage all prisoners should be immediately uncuffed.

[35] Finally Ms Hart speaks about the access of prisoners to iPads and the like. She states that she would not allow a prisoner access to an iPad as that would not be permitted under prison rules. However she would allow a prisoner access to an iPad if that was sanctioned by the GeoAmey control room or by the prison governor.

[36] GeoAmey also lodged a statement taken from John Brown. Mr Brown is a detain officer with GeoAmey having been employed by them for approximately 5 years. As a detain officer he is involved in the care and security of prisoners in custody in medical facilities.

[37] His evidence is that he only worked one shift guarding Mr Anderson, with Candace Hart. That was most probably the day shift of 25 December 2021. He recalls Mr Anderson being uncuffed and states that he and Candace Hart remained outside Mr Anderson's room for the duration of the shift. Mr Brown recalls being told that Mr Anderson was nearing the end of his life and that he and Ms Hart should sit outside Mr Anderson's room to give him privacy. He states that the procedure in such circumstances was that if medical staff asked GeoAmey staff to leave a prisoner's room the GeoAmey staff would ask for permission to leave from the GeoAmey control room.

[38] Mr Brown goes on to refer to the training he received on carrying out a handcuffing risk assessment during his 6 week induction. In relation to a prisoner nearing the end of their life Mr Brown states that medical staff will advise GeoAmey staff when a prisoner is at the end of life stage. The GeoAmey prison custody officer will then report that information to GeoAmey control and seek control's confirmation that they can remove the prisoner's handcuffs. Mr Brown also speaks to the application of prison rules to prisoners at end of life stage. The general position is that prison rules continue to apply to such prisoners. At paragraphs 62 and 63 of his statement Mr Brown refers to what prisoners are allowed and not allowed to do when in hospital. For example, Mr Brown would allow prisoners to see photos but they could not hold them. They could make phone calls but would not be allowed to touch the phone if it enabled access to the internet. A prisoner could watch a film on an iPad but that would have to

be approved by GeoAmey and the prisoner would not be able to touch or access the iPad. Mr Brown refers to there often being confusion between GeoAmey rules and Scottish Prison Service rules. He does not refer to any particular procedure for disapplying prison rules on, for example allowing prisoners to have access to iPads, when a prisoner is nearing the end of their life.

[39] Given the terms of the statements taken from Mr Anderson senior and the two GeoAmey employees, and the terms of the productions lodged, it was agreed that it was only necessary to take oral evidence from one witness at the Inquiry, Sarah Kelly, who is mentioned in paragraph 3.9 of the DIPLAR referred to above.

[40] Ms Kelly is the detain manager for GeoAmey. She started working for GeoAmey in 2018 as a prison custody officer before moving to an administrative role and being appointed as detain manager in 2022. It follows that she was not detain manager at the time of Mr Anderson's treatment and death. She explained that when a prisoner is brought out of prison for a medical appointment or treatment at hospital GeoAmey take over from the Scottish Prison Service in terms of looking after the custody arrangements for the prisoner. GeoAmey's responsibility for custody arrangements is subject to a contractual provision limiting the extent of their responsibility to 14 prisoners in hospitals or hospices. The Scottish Prison Service retain responsibility for any prisoners over and above the 14 prisoner limit. Ms Kelly explained that in general GeoAmey work under Scottish Prison Service rules. That is on the basis that prisoners are still in custody even though they may be in hospital. When a prisoner is transferred to a hospital for treatment the prison in question will prepare a risk assessment in respect of the prisoner concerned. The risk assessment will be sent to GeoAmey and considered by them in

light of the conditions on the ground. The GeoAmey prison custody officers will update the risk assessment if there is a particular risk which needs to be assessed in the hospital concerned. The updated risk assessment will be phoned in by the GeoAmey staff to the GeoAmey control room who will decide whether the risk assessment should be amended. In relation to the handcuffing of prisoners Ms Kelly testified that it would be up to GeoAmey to decide whether a prisoner should be cuffed or uncuffed. She stated that the hospital staff would not have the risk assessment carried out by GeoAmey and would not therefore necessarily be aware of the extent of the risk posed by a particular prisoner. Ms Kelly stated that standard prison rules would still apply to a prisoner who was at end of life stage. However the rules could be relaxed. For example the family of a patient at end of life stage might be allowed to take in a particular type of food, photos or an iPad for the prisoner's use. A relaxation in the rules to eg permit a prisoner to have access to an iPad would be risk dependent. Ms Kelly was asked why there might be a change in procedure at end of life stage. She answered in straightforward terms that a change would be permitted because the prisoner is dying. As an example, she queried the risk of giving an iPad to a prisoner who was nearing the end of their life. Ms Kelly explained that GeoAmey have devised standard operating procedures for custody arrangements for prisoners who are receiving treatment in hospital (see GeoAmey production number 3). Where though there is a deviation from standard operating procedures in relation to a prisoner a separate document - referred to as a care plan - is prepared. Ms Kelly devised the system of care plan documents herself. She was referred to GeoAmey production number 8 which is a sample care plan for a prisoner receiving treatment in hospital. GeoAmey production number 9 is a similar type of sample care plan for a prisoner receiving treatment in a hospice. GeoAmey,

the Scottish Prison Service and the NHS all have input to the terms of the care plan. A care plan might be prepared as a result of information provided by hospital staff or by GeoAmey staff on the ground. A care plan would be prepared for an end of life prisoner if there was any deviation from the standard operating procedure for that prisoner eg if a prisoner was to be allowed access to an iPad. Ms Kelly was also asked about the guarding arrangements for prisoners in hospital. She explained that the general position is that two GeoAmey members of staff would be present in the room of a prisoner. However, as with other matters, that rule could be relaxed and the GeoAmey staff could be directed by the control room to sit outside the prisoner's room particularly at end of life stage. Finally Ms Kelly testified that GeoAmey is in the process of devising a Dignity and Death policy. The intention is that Ms Kelly will devise the Dignity and Death policy along with GeoAmey's compliance department and custody team. There is no date for the implementation of this policy yet. In response to a question from the court Ms Kelly stated that the aim is that the Dignity and Death policy will provide a timeline in relation to a prisoner's ongoing treatment and care at end of life stage and make it clearer to the Scottish Prison Service that a prisoner at end of life stage will not be returning to prison.

Conclusions

[41] Gregg William Anderson was a 30 year old man who became unwell in January 2021 while serving a custodial sentence at HMP Glenochil. He was diagnosed with an acute form of leukemia and received chemotherapy. In October 2021 he received a bone marrow transplant at Queen Elizabeth University Hospital, Glasgow. The hope was that he would recover from the transplant and return to HMP Glenochil. Unfortunately, he developed engraftment syndrome,

possible veno-occlusive disease and definite grade 3/4 acute Graft versus Host Disease. These are all well recognised complications of a bone marrow transplant. As a result of these complications Mr Anderson's condition deteriorated and he continued to receive treatment as an in-patient at Queen Elizabeth University Hospital. As a result of a further deterioration in his condition Mr Anderson was moved to the High Dependency Unit at the hospital on 23 December 2021. Sadly Mr Anderson's condition did not improve and he passed away on 26 December 2021. Having considered the treatment provided to Mr Anderson at HM Prison Glenochil and at Queen Elizabeth University Hospital, I am satisfied that he was well cared for throughout and that there is nothing more that could have been done for him. Given the circumstances of his death I am satisfied, as submitted by all parties that only findings in terms of paragraphs (a) and (c) of section 26(2) of the Act should be made in this case.

[42] In relation to the handcuffing of Mr Anderson it is clear from Mr Anderson senior's statement that, contrary to what is stated in the DIPLAR, Mr Anderson was not handcuffed between about April 2021 and the date of his death in December 2021. I did have some concern about the comment made in the DIPLAR that there was confusion about who was responsible for making the decision about whether handcuffs should be applied to Mr Anderson. However I accepted the evidence of Sarah Kelly about changes made in GeoAmey's procedures since she took up post in 2022. The sample GeoAmey care plan, GeoAmey production number 3, (which I understand was not in use at the time of Mr Anderson's death) states in the second paragraph that:

> "All GeoAmey staff tasked to this specific Hospital detain will as per standard operating procedures conduct an HRA at the commencement of their shift. Where end of life is imminent all handcuffs MUST be removed".

In the circumstances, given the terms of the care plan documents and the evidence of Mr Anderson senior, Candace Hart, John Brown and Sarah Kelly I agree with the submission made by the Crown that the issue of the handcuffing of Mr Anderson has been adequately ventilated in the course of the Inquiry. No submission to the contrary was made by either of the other two parties appearing at the Inquiry. Accordingly there is no basis for any formal findings being made in terms of section 26 of the Act in relation to the handcuffing issue.

[43] Mr Anderson senior also expressed concerns that he was not able to bring in an iPad to his son, put up photographs in his hospital room or take photographs. He alleged that GeoAmey staff were unprofessional and disrespectful when guarding his son. The Crown submitted that while these issues were relevant to Mr Anderson's experience in the care and custody of GeoAmey during his stay in hospital they were not directly relevant to the cause of his death. No contrary submission was made by any of the other parties and I agree with it. In any event as with the handcuffing issue I consider that the other issues raised by Mr Anderson senior were adequately ventilated in the course of the Inquiry. In that respect I accepted Sarah Kelly's evidence about the changes in GeoAmey's procedures since Mr Anderson's death. In particular I accepted that in end of life situations it is possible to relax normal prison rules to allow a prisoner privileges which they would not otherwise be entitled to receive. Such a deviation from GeoAmey's standard operating procedures would, as I understand it, be recorded in the prisoner's care plan. Sarah Kelly concluded her evidence by stating that GeoAmey are in the process of devising a Death and Dignity policy. No doubt the concerns expressed by Mr Anderson senior about the care of his son are matters that GeoAmey will

consider in the course of drafting their Death and Dignity policy. On the basis of the evidence I heard in this Inquiry however I do not consider that there is any basis for making any formal findings in terms of section 26 of the Act in relation to the concerns raised by Mr Anderson senior.

[44] I am grateful to parties for their preparation for this Inquiry as a result of which the majority of the evidence was agreed with only one witness requiring to give evidence.

[45] I wish to conclude this Determination by expressing my sympathies and condolences, along with the parties who appeared at the Inquiry, to the family and friends of Mr Anderson and to his next of kin.