

**SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE IN FALKIRK**

**[2020] FAI 12**

FAL-B148-19

**DETERMINATION**

**BY**

**SUMMARY SHERIFF DEREK LIVINGSTON**

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

**into the death of**

**TAMMI BRUCE**

Falkirk, 30 January 2020

**DETERMINATION**

The sheriff, having considered the information presented at the inquiry, determines in terms of section 26 of the above Act (hereinafter referred to as “the Act”) that:

1. Tammi Bruce, born 14 January 1979, residing in Auchterarder, died on 10 November 2017 at 12.40pm at Her Majesty’s Prison and Young Offenders Institution Redding Road, Brightons, Polmont in Cell 26, Blair Hall.
2. In terms of section 26(2)(a) of the Act the death occurred at 12.40pm in cell 26, Blair Hall, Her Majesty’s Prison and Young Offenders Institution, Polmont.
3. In terms of section 26(2)(b) no accident took place.

4. In terms of section 26(2)(c) death was due to an unascertained cause or causes.
5. In terms of section 26(2)(d) there was no accident and therefore no finding requires to be made under the subsection.
6. In terms of section 26(2)(e) there were no precautions which could reasonably have been taken and had they been taken might realistically have resulted in the death being avoided.
7. In terms of section 26(2)(f and g) there were no defects in any system of working which contributed to the death and there are no other facts which are relevant to the circumstances of the death.

## **NOTE**

### **Introduction**

[1] On 31 July, 23 September, 1 October, 10 December 2019 and 21 January and 30 January 2020 I presided over various hearings under the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 into the death of Tammi Bruce. Preliminary hearings had previously taken place on 24 June and 15 July 2019. The parties to the inquiry were represented by Ms Rollo, Procurator Fiscal Depute for the Crown; Ms Watts, advocate for the Forth Valley Health Board; Mr Gillies, solicitor for Scottish Prison Officers Association; Mr Khan, solicitor for the family of the deceased and by Mr Fairweather, solicitor for the Scottish Prison Service.

[2] The only day on which I heard oral evidence was on 31 July. Thereafter as a result of further enquiries being made by the deceased's family a further evidential hearing on 23 September was postponed with a view to allowing them a reasonable period of time to make investigations. On 30 January the only further evidence led was from Dr Roger Paterson and that was by way of a statement which was agreed as being his evidence by the various representatives. Oral evidence was given on 31 July by William Bruce, the father of the deceased, Dr Jahangir Khan, the GP who dealt with Tammi's medication upon admission to HMP Cornton Vale, Mrs Sophia Lennon, a prison officer, and Dr Ian Wilson, a forensic pathologist. The evidence of Irene McKirdy, mental health nurse, Catriona Robertson, staff nurse, Karen Clark, prisoner, Elizabeth Forrester, nurse, DC Grant Stronach, Falkirk Police Office and Dr Roger Paterson, Tammi's GP was all agreed by joint minute.

### **The legal framework**

[3] This inquiry was held under section 1 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016. The inquiry is governed by this Act and also the Act of Sederunt (Fatal Accident Inquiry) Rules 2017. The purpose of an inquiry 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.

[4] In making my determination I require in terms of section 26 of the 2016 Act to set out my findings as to the circumstances and any recommendations which I consider appropriate. In setting this out I require to state:

- (a) when and where the death occurred;
- (b) when and where any accident resulting in the death occurred;
- (c) the cause or causes of the death;
- (d) the cause or causes of any accident resulting in the death;
- (e) any precautions which –
  - (i) could reasonably have been taken, and
  - (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided;
- (f) any defects in any system of working which contributed to the death or any accident resulting in the death;
- (g) any other facts which are relevant to the circumstances of the death.

[5] In considering recommendations I require to look at (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.

[6] At the inquiry the procurator fiscal represents the public interest and an inquiry is an inquisitorial process and it is not the purpose of the inquiry to establish civil or criminal liability.

**The evidence**

[1] I heard evidence in person from the following on 31 July. The first witness to give evidence was Mr William Bruce. He is the father of Tammi. Tammi was 38 when she died. He stated she had had a good Christian upbringing and was a happy child. She entered into a relationship which went bad. She had a 4 year old child. She had held problems including a compressed spine when she was 23 and cancerous cells. Tammi then got involved in matters which brought her into trouble with the police. She moved to Auchterarder and Mr Bruce believed that she became involved in a dispute with her next door neighbour which led to her being charged and remanded. Tammi's two children are now aged 18 and 11 and live with Mr Bruce and his wife who themselves live in Auchterarder.

[2] He had last seen Tammi on 1 November. She was very distressed. The police had removed her child. Mr Bruce was frightened she might commit suicide. She had been involved in previous episodes where he had been concerned for her wellbeing. She was cutting herself in these episodes. Social services had said there was to be no contact by Tammi with her child and accordingly the only contact which Mr Bruce was allowed at that stage was for Tammi to phone and speak to her child.

[3] Mr Bruce stated that he had a number of concerns in relation to the circumstances of Tammi's death. The first of these is that she was locked up at 10.00am and unlocked at 11.15am. No one had checked she was okay. He was unhappy with the way the police had told him about the death and in particular they had said, "There's no easy way to tell you this, Tammi's dead." He was also concerned that that was

exacerbated by one of the police officers telling him, "Don't worry you'll just have to get on with it. When my father died I had to." He was also unaware that the doctor had taken the decision to withdraw her antidepressants. He had been told that this should be gradual. She was after all only on remand.

[4] The next witness to give evidence was Dr Jahangir Khan, age 51. He was referred to various productions. In essence however his evidence was to the effect that he had not, contrary to perhaps what had been understood by Mr Bruce, withdrawn Tammi from all her drugs. He did however have concerns that she should not be on Tramadol, Diazepam and Pregabalin. They are very potent. In particular Tramadol is an opioid, Diazepam is used for sleeping and Pregabalin should only be used by a pain specialist and is usually used for epilepsy, neurological problems and nerve pains or similar. He spoke to her doctor, Dr Paterson, and they both believed that she should be off these drugs. He continued to leave her on other drugs including Citalopram for depression and the various other drugs listed in the production lodged on behalf of the prison service. He did also have concerns that these items had a sale value in the prison. Dr Paterson had stated to him that he had been trying to start reducing or stopping these items. He was concerned that Tammi had been self-harming and there was a view that she was doing so in order that she could be prescribed these drugs. The thigh wound which Tammi had looked self-inflicted. He stated that the effects of coming off these drugs were quite limited. There could be a little bit of diarrhoea from coming off Tramadol which could be treated by paracetamol and anti-diarrhoea tablets, with the Diazepam she was on other drugs and there might be a small amount of heightened

anxiety but he pointed out that the dose of Diazepam was not that high and the stopping of it could actually enhance the Citalopram. He had no concerns about the side effects in stopping.

[5] The next person to give evidence was Mrs Sophie Lennon, a prison officer. On the day in question she had been working on level two at Blair Hall. Levels two and three are for prisoners over 21 and are connected. On 10 November she was working from 6.30am to 12.30pm. She gave details of her various duties that day. She saw Tammi when she gave her her medication. She had a brief introductory chat and had to ask her name to make sure she was the person that was due to get the drugs. She had no concerns about Tammi in any way. She could not recall any conversation. She thought she had seen Tammi at association that day which took place before 10.00am. She was directed to her statement and confirmed that Tammi had been inquiring regarding phone numbers and paracetamol. After 11.00am there should have been at least three staff but only two were available. She was working on level one and Officer Hamilton was stationed at level three. She recalled standing at the pantry. She did not recall whether she had looked in the cells. After lunch she was alerted by shouts from a prisoner shouting, "She's dead". The emergency alert went and nursing staff came. She stated that she would normally look in when getting a prisoner out their cell at 11.15am but there was no compulsion to come out at that time, although she would expect somebody to be present at lunchtime.

[6] The final witness of the day to give evidence was Dr Ian Wilkinson who is a consultant forensic pathologist and who examined Tammi's body. He referred to the

fact that she was a tall lady with a few injuries and puncture marks. He thought that a number of her injuries were self-inflicted on her arms and right thigh. He could not identify the cause of death. There was some fibrosis but he did not consider there was a heart attack. There were no indications of chronic or sudden heart problems and the fibrosis was at the lower end. As far as he is concerned the cause of death is unascertained. There was no evidence of trauma. He did say that it was always possible a substance had been taken that was not one of which they were aware and had not been found. He did state that withdrawal from drugs can cause side effects.

[11] His examination was jointly carried out with Dr Ralph Bou Haidar on 15 November 2017. Their joint report was lodged and they were both of the view that Tammi's death should be regarded as having been unascertained.

[12] A joint minute had been lodged which agreed that the statements of Irene McKirdy, mental health nurse, Catriona Robertson, staff nurse, Karen Clark, prisoner and Elizabeth Forrester, nurse, all of HMP Polmont could be treated as their parole evidence. There was similar agreement regarding the statements of DC Grant Stronach and that of her GP, Dr Paterson. None of this evidence shed any light on the causes of Tammi's death but I was satisfied from it that everything possible was done for her at the time of her death. Dr Paterson's evidence spoke to his care of Ms Bruce as her GP when she was living in Auchterarder but there was nothing in either his evidence or that of Dr Khan's to indicate that the withdrawal of Diazepam, Tramadol or Pregabalin was linked to Tammi's death.



**Submissions and Decision**

[13] All parties to the enquiry invited me to simply make formal findings.

[14] Standing the evidence I am satisfied that following upon Tammi Bruce being remanded to Cornton Vale Prison on 6 November 2017 she was moved to Polmont Prison on 8 November 2017 and to a single occupancy cell. On 10 November 2017 she indicated that she felt unwell at about 06.30am. She spoke with another prisoner at 09.05am that day. At about 10.00am she was locked in her cell to allow for cleaning and at 11.00am her cell was unlocked. Another prisoner attended at her cell at 11.50am and found her unresponsive in bed. She called for assistance immediately and prisoners, prison and nursing staff attended at Tammi's cell where chest compressions were administered and thereafter ambulance personnel attended. Her life was pronounced extinct at 12.40pm on that date. Toxicology samples were also examined but there was nothing in these to provide a likely cause of death.

[15] On the basis of the evidence I heard in this case along with the joint minute I do not consider that there is anything entitling me to make anything other than formal findings. The cause of Tammi's death remains unascertained.

[16] Once again on behalf of the Court and everyone who took part in the inquiry I extend my condolences to Mr Bruce and to all of Tammi's family and friends.