SHERIFFDOM OF GLASGOW AND STRATHCLYDE AT GLASGOW

[2022] FAI 31

GLW-B661-21

DETERMINATION

BY

SHERIFF PAUL ANTHONY REID

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

into the death of

JOHN HANLEY HARRISON

Glasgow, 25 August

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

(a) in terms of section 26(2)(a) of the Act, John Hanley Harrison, born 18 April 1946, then a prisoner within HM Prison, Barlinnie, Lee Avenue, Glasgow, died at 0022 hours on 10 April 2020 within Glasgow Royal Infirmary, Castle Street, Glasgow.

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

1.A subarachnoid haemorrhage

due to

1.B ruptured basilar artery aneurysm

(c) in terms of section 26(2)(b) of the Act no accident took place and accordingly no finding requires to be made under section 26(2)(d) of the Act.

(d) 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.

(e) in terms of section 26(2)(f) of the Act there were no defects in any system of working which contributed to the death.

(f) 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 John Hanley Harrison, born 18 April 1946, who died whilst a prisoner of HMP Barlinnie, Glasgow on 10 April 2020.

Procedural history

[2] A Notice of the Inquiry was given by the Procurator Fiscal under section 15(1) of the Act on 12 July 2021. The Sheriff at Glasgow pronounced a First Order on 8 July 2021 assigning a preliminary hearing for the Inquiry to be held on 20 August 2021 at 10.00am within the Sheriff Courthouse, Glasgow Sheriff Court, 1 Carlton Place, Glasgow G5 9DA. Amanda Allan, Procurator Fiscal Depute represented the Procurator Fiscal, Mr J Devlin, Solicitor, represented the Scottish Prison Service, Ms B Baxter, represented the NHS Central Legal Office. Mrs C Harrison, the wife of the deceased attended personally. She advised that it was her intention to meet with and instruct solicitors to represent her at the hearing. As a consequence a further preliminary hearing was fixed for 5 October 2021 at 10.30 am for Mrs Harrison to appoint a solicitor. The matter called again on 5 October 2021 as a further preliminary hearing. A Mr McAllister, Solicitor, appeared on behalf of Mrs Harrison. A further preliminary hearing was fixed to allow the solicitor to obtain full instructions from, in particular, to ascertain what factual circumstances could be agreed and for full disclosure. The further procedural hearing of 16 November 2021 was continued until 3 February 2022 to allow the solicitor on behalf of the wife of the deceased to make further enquiries. The Inquiry was assigned for 3 February 2022 at 10.00 am. On 6 January 2022, on the motion of the solicitor for the wife of the deceased, the Inquiry of 3 February 2022 was adjourned. A further date of 15 August 2022 was identified as the date for the Inquiry.

[3] All parties entered into a joint minute agreeing the Inquiry's evidence in its entirety. In addition, the following productions were lodged:

(a) Crown production number 1, is a true and accurate copy of the intimation of death form relating to the deceased;

(b) Crown production number 2, is a true and accurate copy of the post-mortem report prepared by Dr Julia Bell, dated 28 May 2020;

(c) Crown Production number 3, is a true and accurate copy of the death in prison learning, audit and review (DIPLAR) which took place on 17 August 2020 in relation to the death of the deceased. This contained true and accurate information in relation to the deceased's time within HM Prison, Barlinnie and Glasgow Royal Infirmary.

(d) Crown production number 4 is a true and accurate copy of prison records relating to the deceased. These records contain true and accurate information in relation to the deceased's time within HM Prison, Barlinnie.

(e) Crown production number 5 is a true and accurate copy of prison medical records relating to the deceased. The information contained therein is a true and accurate record of the deceased's medical history and treatment during his time within HM Prison, Barlinnie.

(f) Crown production number 6 is a true and accurate copy of GP medical records in relation to the deceased. The information contained therein is a true and accurate record of the deceased's medical history and treatment whilst in the community.

(g) Crown production number 7 is a true and accurate copy of medical records in relation to the deceased's admission and treatment at Glasgow Royal Infirmary.

[4] In light of the joint minute of agreement and the productions lodged, which were agreed, both of which I reviewed, I agreed with parties that the Inquiry could proceed without the requirement of witnesses to attend.

[5] The Inquiry was set down to take place on 15 August 2022 within Glasgow Sheriff Court. A joint minute of agreement was tendered. The said joint minute was agreed by Ms Allan, Mr Devlin, Mr Mackenzie and Ms Baxter. Written submissions were provided to the court by each representative in advance of the Inquiry by all parties. I was asked by all parties to make formal findings only.

Legal framework

[6] The Inquiry was held under section 1 of the Act and the procedure was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. The Inquiry was a mandatory Inquiry. It was held in accordance with section 2(4)(a) of the Act because, although Mr Harrison died whilst in hospital, he remained a prisoner of HM Prison, Barlinnie throughout that time, meaning that at the time of his death, he was in legal custody.

[7] Section 1(3) of the Act sets out that the purpose of the Fatal Accident Inquiry is to establish the circumstances of the death and consider what steps if any might be taken to prevent other deaths in similar circumstances. The Inquiry itself is an inquisitorial process. It is not the purpose of having an Inquiry to establish civil or criminal liability. The matters

which should be considered in a determination are contained within section 26 of the Act and they have been set out above. Section 1 also sets out the requirement that the Procurator Fiscal, who represents the public interest at an Inquiry, must investigate the circumstances of death and arrange for the Inquiry to be held.

Summary

Circumstances of the deceased

[8] On 14 May 2019, John Hanley Harrison, born 18 April 1946, was convicted following trial at the High Court of Justiciary in respect of a number of historic offences. Sentence was deferred for the preparation of a Criminal Justice Social Work Report. On 11 June 2019, Mr Harrison was sentenced to a period of eight years' imprisonment which was back dated to 14 May 2019, the date on which he had first been remanded in custody. The earliest date of liberation was calculated as 13 December 2026. The sentence expiry date was 13 May 2027. At the time of his conviction and sentence the deceased had several previous convictions but had not served any periods of imprisonment. At the date of his death on 10 April 2020, the deceased was a prisoner of HM Prison, Barlinnie. He was accordingly in legal custody at the date of his death.

[9] On his arrival at HM Prison, Barlinnie on 14 May 2019, the deceased was subject to an assessment by health care staff as part of the prison admission process. During this assessment the deceased was noted by staff to have a history of epilepsy, cerebral aneurysm and a slipped disc causing on and off back pain. He also had a history of chronic obstructive pulmonary disease, hypertension and was prone to frequent chest infection. At

the time of his admission the deceased was already prescribed a number of different medications by his general practitioner. He was unable to inform staff what medication he was prescribed. He advised that his wife normally took charge of his medication at home telling him what to take and when. As a result it was decided that it would be safer to have the deceased's medication dispensed, supervised or in a dosette box. It was also decided that one of the deceased's prescribed medication, temazepam, which he had been prescribed to assist with sleep since January 2019 should not be continued as this was unsuitable to be used long term. The deceased was also prescribed with an inhaler which he kept with him at all times. The deceased advised staff he had no addiction issues nor had he consumed alcohol for many years.

[10] The deceased was subject to a Talk to Me Risk Assessment on 14 May 2019 as part of the Scottish Prison Services Suicide Prevention strategy. At this time he was recorded as having no thoughts of deliberate self-harm or suicide. He was recorded as being "no apparent risk". During the deceased's time in HM Prison, Barlinnie, there was no requirement for the prison's Talk to Me strategy to be initiated in relation to the deceased.

Events of 7 and 8 April 2020

[11] On 7 April 2020, the deceased was seen by Nurse Trevor Lines to discuss his medication regime. It was agreed there would be a discussion with the pharmacy in relation to the deceased potentially being provided with a dosette box or continuing with supervised medication dispensing. During the morning of 8 April 2020, the deceased was seen again by Nurse Trevor Lines during medication dispensing. It was noted that the

deceased had been complaining of headaches for the last two days which had not been relieved by analgesia. The nurse arranged for the deceased to be seen by one of the prison's general practitioners. Later that day, the general practitioner, Dr Raheel Ahmed attended at the cell of the deceased for a consultation. The GP described the deceased as clinically well at that time, with observations within normal limits, and the deceased was prescribed co-codamol.

[12] At approximately 1715 hours on 8 April 2020 the call bell was activated in the deceased's cell by the deceased's cellmate. The call was answered by Prison Officer Brian Nicol who was informed by the cellmate that the deceased was unwell within his cell. Officer Nicol immediately attended at the deceased's cell where he found the deceased to be lying on his bed. At this time the deceased described his head as being in great pain, pins and needles in his arms and everything was spinning. Officer Nicol attended at the nurses' station and informed Nurse Trevor Lines of the condition of the deceased. Nurse Lines, who was providing other prisoners with their medication at this time, asked if the deceased would manage going to the nurses' station in order that he could check his observations. Officer Nicol returned to the cell to speak to the deceased. The deceased indicated he would not manage. Officer Nicol re-attended at the nurses' station to advise Nurse Lines of this and Nurse Lines thereafter accompanied Officer Nicol back to the cell of the deceased at or about 1730 hours.

[13] On arrival at the cell, Nurse Lines found the deceased still to be lying in bed. The deceased was assisted into a chair within the cell in order for observations to be carried out. The deceased was unable to maintain his balance, and so his mattress was placed on the

floor of the cell. The deceased moved onto the mattress and was placed in the recovery position. Nurse Lines recorded the deceased as having no handgrip on his right side and some slurred speech which was incomprehensible. Nurse Lines carried out basic observations. Nurse Lines requested of Officer Nicol to call the Health Centre to request assistance and to organise an emergency ambulance. Nurse Lines also asked Officer Nicol to fetch the oxygen cylinder from the front desk.

[14] Officer Nicol attended at the front desk where he retrieved the oxygen cylinder and asked for the Health Centre to be called and for another nurse to attend. He requested that an emergency ambulance be organised. Officer Nicol returned to the cell of the deceased. Nurse Grant Morrison arrived at the cell of the deceased where he assisted and stabilised the deceased before returning to the Health Centre. There was a delay in an ambulance being requested due to confusion in relation to the original request. The front desk mistakenly thought that the Health Centre had contacted the ambulance. The call was finally placed to the Scottish Ambulance Service at 1916 hours. Nurse Lines had initially asked Officer Nicol to request an ambulance at around 1730 hours.

[15] Paramedics from the Scottish Ambulance Service arrived at the prison at approximately 1946 hours. By this time the deceased was showing some signs of improvement in his condition, with improvement in his speech and appearing to regain strength on his right side. It was assessed that the deceased required to be admitted to hospital. The deceased was able to stand and walk to the ambulance gurney and spoke to paramedics during this time. The deceased was conveyed to Glasgow Royal Infirmary, Castle Street, Glasgow, with a depart from the prison at approximately 2005 hours.

[16] The deceased arrived at Glasgow Royal Infirmary at approximately 2024 hours on 8 April 2020. During the journey to the hospital the deceased was making conversation and appeared to be fine and in good spirits, although he did continue to complain of a sore head. Upon arrival at Glasgow Royal Infirmary the deceased was subject to assessment and a decision was made that he would remain in hospital for further tests. The prison officer arranged for GEOAmey staff to take over the escort of the deceased, with the change occurring at 2240 hours.

[17] The deceased was admitted to Ward 53 of Glasgow Royal Infirmary where he underwent a CT brain scan and CT angiography being an examination by x-ray of blood or lymph vessels. These showed that the deceased's pre-existing aneurysm had slightly increased in size but there was no suggestion of an acute intracranial infarct or haemorrhage. The deceased was diagnosed with a transient right hemiparesis which is a weakness or inability to move on one side of the body and occipital headache.

[18] The deceased was seen by a stroke consultant on the morning of 9 April 2020 and consideration was given to moving the deceased to the stroke ward if a bed became available. The deceased was relatively well and settled throughout the day, he was eating and drinking although he continued to complain of headaches, for which he was provided with regular analgesia. At approximately 2330 hours the condition of the deceased deteriorated suddenly and an emergency was raised. He suffered a sudden of loss of consciousness and impaired respiration. The deceased was suspected to have a suffered an aneurysmal bleed from his basilar artery. This was described as a catastrophic intracerebral event and health care staff concluded that there was no further treatment that could be

provided to the deceased and that the deceased would not survive. The deceased's life was pronounced extinct at 0022 hours on 10 April 2020.

[19] A post-mortem examination was conducted on 27 April 2020 at the Queen Elizabeth University Hospital, Glasgow by Consultant Forensic Pathologist, Dr Julia Baird. The cause of death was recorded as:

1.A a subarachnoid haemorrhage

Due to

1.B rupture bacillary artery aneurysm.

[20] The conclusions of the post-mortem report stated as follows:

> "Post-mortem examination confirmed the presence of a large aneurysm involving one of the main arteries at the base of the brain (bacillary artery) and this had ruptured causing significant subarachnoid haemorrhage and this would account for this man's death.
>
> Saccular aneurysm such as this form when there is a weakness in the wall of the blood vessel. The development is thought to be multifactorial with congenital and environmental factors, for example, (Atherosclerosis, hypertension) playing a role. The aneurysm could have ruptured at any time.
>
> In addition to the aneurysm this man also had significant heart disease. The heart was enlarged with concentric left ventricular hypertrophy and microscopic examination showed moderate scaring of the heart muscle and there was moderate atheromatous narrowing of the three main coronary arteries. This man had a history of hypertension which is a known risk factor for cardiac disease such as this. The lungs also showed a degree of emphysematous change in scarring consistent with the history of chronic obstructive pulmonary disease.
>
> This man had no significant injuries and there were no other significant findings."

Submissions

[21] Written submissions were lodged on behalf of all parties. All parties agreed that only formal findings should be made in this Inquiry.

Discussion and conclusion

[22] In light of the evidence before the Inquiry and the submissions made I am satisfied that the medical care provided to Mr Harrison within both hospital and prison as is relevant to the remit of this Inquiry, was entirely appropriate. There was no evidence to suggest that any alternative form of medical treatment, supervision or intervention would have prevented his illness or changed the outcome of it. I agree, therefore, with the submissions made by all the participants that only formal findings should be made.

[23] I am grateful to parties for their preparation for this Inquiry as a result of which all the evidence was agreed and no witnesses were required to attend.

[24] I wish to conclude this Determination by expressing my sympathies and condolences to Mr Harrison's next of kin.