SHERIFFDOM OF GRAMPIAN HIGHLAND AND ISLANDS AT PETERHEAD

[2023] FAI 4

PHD-B76-21

DETERMINATION

BY

CHRISTINE P McCROSSAN

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

into the death of

ALAN HASTINGS

PETERHEAD, 30 DECEMBER 2022

The Sheriff having considered the information presented at an inquiry into the death of ALAN HASTINGS under the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (the Act) makes no recommendations in terms of section 26(1) of the Act. Formal findings under Section 26(2) are made as follows:

(1) Mr Hastings born on 22 August 1967 died at HMP Grampian, South Road, Peterhead on 21 January 2021, life being pronounced extinct at 0919 hours on that date;

(2) There was no accident which caused or contributed to the death of Mr Hastings;

(3) The cause of Mr Hastings' death , confirmed by the findings of a post mortem carried out on 25th January and 2 March 2021 was 1(a) Coronary artery atheroma and cardiac enlargement;

(4) Following an investigation into the circumstances surrounding the death of Mr Hastings the sheriff finds and determines that there were no precautions which could reasonably have been taken, which if taken, might realistically have resulted in his death being avoided, nor were there any defects in the system of working which contributed to his death.

Procedural background

[1] The Crown issued a Notice of Inquiry on 11 October 2021. This was a mandatory inquiry due to Mr Hastings dying while in legal custody. At that time the Crown anticipated that the issues for the Inquiry would be as follows:

(i) Whether the deceased's medical condition has been adequately managed at HMP Grampian;

(ii) Whether the emergency response provided to the deceased on 21 January 2021 by the prison staff and NHS staff was reasonable and adequate;

(iii) Whether there were any precautions which could reasonably have been taken by Prison Staff and NHS Staff and which might realistically have resulted in the death having been avoided.

[2] The parties represented at the inquiry were (i) he wife of Mr Hastings and the next of kin (hereinafter referred to as Mrs KA) (ii) the Scottish Prison Service (SPS), (iii) the Prison Officers' Association (Scotland) (SPOA) and Grampian Health Board (hereinafter referred to as NHS Grampian).

[3] The Crown lodged the following documents as productions:

1 Autopsy Report

2 Combined Prison Medical Records

3 SPS incident Report and initial witness Statements (these numbered 17 statements taken from SPS and NHS staff plus a statement from Mrs KA the next of kin)

4 Operation Procedure for Referral Forms and Booking Appointments between HMP Grampian and NHS Grampian

5 SPS Revised Locking & Unlocking Procedures

6 Screenshot of VISION

7 Death in Prison Learning Audit Review (DIPLAR)

[4] Witness statements were taken by Police Scotland from 17 individuals during the course of their enquiry into Mr Hastings' death. These included statements from those working for SPS, NHS Grampian, the Scottish Ambulance Service and Mrs KA.

[5] In their original notices of intention to participate SPS and SPOA advised they did not intend to lodge productions, nor raise any issues at the Inquiry. NHS Grampian lodged no productions and raised no issues of their own but sought further specification from the Crown on the issues they had raised. The preliminary hearing which took

place on 1 February 2022 was continued to (i) allow the solicitor acting for Mrs KA to take full instruction from her regarding any issues she wishes the Inquiry to consider and (ii) to allow the Crown to further consider the issues they had raised in light of the evidence disclosed in their productions and in the submissions from the other parties to the inquiry.

[6] Subsequently those acting for Mrs KA lodged a note set out the following as potential issues: (i) the delay in the ECG being carried out, (ii) whether the appointment system VISION was open to human error, (iii) whether Mr Hastings' medical condition(s) had been adequately managed while he was in HMP Grampian, (iv) whether the information passed to a paramedic upon his arrival at prison was sufficient and (v) whether the SPS revised requirements during locking and unlocking periods were met when Mr Hastings was checked on the morning of 21 January 2021.

[7] Additional preliminary hearings took place to allow parties time to consider these issues in line with the productions which had been lodged by the Crown. In response to issues (iv) and (v) raised by Mrs KA SPS lodged the following documentary productions: (1) SPS Standard Operating Procedure – Reference 402: Call in Ambulance (undated), (ii) SPS Standard Operating Procedure – Reference 402: Call in Ambulance dated 17 March 2021[1] (iii) Copy Email from Residential Unit Manager SPS dated 16 May

[1] First Inventory of Productions for SPS

2022 to all Operational Staff at HMP Grampian attaching SPS Revised Procedure HMS 016A/16.[2]

[8] Parties confirmed, having considered all of the evidence now lodged, that they had no outstanding issues they wished investigated at the Inquiry. The exception to this was a concern Mrs KA continued to have regarding issue (v) set out in paragraph [6] above. She quite properly raised with the Inquiry the fact that the Witness Statements of Officers Rush and Sinclair were inconsistent with the findings in the DIPLAR report. The report recorded that on unlocking his cell the officers had seen Mr Hastings' face and "believed" they had received a verbal response from him; whereas their statements clearly recorded that the response they received was the raising of a hand with no reference to seeing his face. The solicitor acting for SOPA carried out an investigation into this discrepancy. He obtained draft Affidavits from the Prison officers unlocking Mr Hastings' cell that morning. These drafts were circulated between parties and lodged with the Inquiry. The details within the Affidavits were wholly consistent with the version of events each officer had provided to Police Scotland at the time of their investigation. Mrs KA's representative confirmed on her behalf that no further evidence required to be led on this matter. All parties were in a position to agree the terms of a joint minute.

[9] The Joint Minute was signed by all parties and lodged at court. It sets out the relevant circumstances leading up to and following Mr Hastings's death. Mrs KA has a

[2] Second Inventory of Productions for SPS (this being the SPS Unlocking & Locking Procedure).

copy of that document. Parties lodged written submissions. Those acting for Mrs KA attached to their submission a copy of the letter she had sent directly to SPS following the death of her husband. All parties asked that a formal determination be issued in the case. On 26 August 2022 an interlocutor was issued confirming that a formal determination would be issued in due course.[3]

Background circumstances

[10] Mr Hastings was 53 years old at the time of his death. He is survived by his wife, Mrs KA and two adult step-children. As referred to in paragraph [9] above following the death of her husband Mrs KA wrote a detailed letter to the Scottish Prison Service (SPS). It is clear from this letter that Mr Hastings was deeply loved by his family and will be sorely missed. Whilst Mrs KA acknowledges in her letter that her husband was a serving prisoner she conveys movingly how hard it has been for the family that he died while away from them and alone in a prison cell.

[11] On 28 August 2019 Mr Hastings was imprisoned in HMP Barlinnie. He was due to serve a sentence of 5 years and 3 months. He was transferred to HMP Grampian on 5 November 2019. Very sadly Mr Hastings passed away in his cell within the prison in the early morning of 21 January 2021.

[12] Mr Hastings had occasion to consult NHS Grampian within the prison on a number of occasions in the months leading up to his death. There is no indication from

[3] This has been delayed as the sworn Affidavits were not lodged at court until December due to illness.

the VISION appointment records or the medical notes themselves that Mr Hastings' encountered any delay in getting appointments, treatment or medication. There was indeed an issue with a postponed ECG in the weeks leading up to his death. This postponement was due to a staff absence and did not in itself demonstrate any overall inadequacy within the system; in addition the delay was a matter of days. Most significantly when the ECG was carried out it did not show any changes nor alert staff to any problems that required medical attention at that time. This delay did not contribute to Mr Hastings' death.[4]

[13] Each morning on first unlocking a prisoner's cell Prison Officers carry out what is referred to as a "numbers check". This is not a medical check. SPS officers are not qualified to carry out such a check. It is in effect a check to confirm that all prisoners are accounted for. Reference is made in this regard to the SPS Revised Locking & Unlocking procedure[5] which was the system in place at the time. This procedure was revised in March 2016 and provides as follows:

> "When conducting checks staff ensure that they physically account for each prisoner. Appropriate steps must be taken to confirm the presence and identity of each prisoner by seeing the face of and getting a response from each prisoner in their cells/dormitories.

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[4] The DIPLAR review did identify learning points from the circumstances surrounding Mr Hastings' death. These were to the effect : (i) improvements to be made in the record keeping system of NHS Grampian, (ii) that discussions are to take place directly between the GP and a prisoner regarding the outcome of ECG procedures and (iii) improvements are to be made in the communications between SPS and bereaved families.

[5] See Crown Production 5

> To ensure compliance … appropriate steps should be taken to see the face of. and get a verbal response from all prisoners during all lock up and unlock periods."

This procedure has been put in place for a purpose, which is set out in the following terms: "This is a measure to reduce the risk of suicide and also identify someone with a deteriorating health condition."

Events on morning of 21 January 2021

[14] Mr Hastings' cell was unlocked on 21 January 2021 by two officers. They will be referred to as Officers S and R. Officer S said "Good morning". Mr Hastings responded by lifting a hand. A carton of milk was left inside his door. The light was off. When Officer S returned to unlock Mr Hastings for work at approximately 0840 he found him lying on his bed. When he was unable to rouse him he initiated a Code Blue. Thereafter procedures were followed as set out in the Joint Minute. Members of the ambulance service attended but all attempts at resuscitation by prison staff, NHS Grampian and the ambulance staff were unsuccessful. Mr Hastings was pronounced dead at 09.19am. It is now accepted by all parties that procedures for the calling in of the emergency services were followed and that the ambulance personnel were in possession of all relevant information to enable them to provide what assistance they could to Mr Hastings when they arrived at the hall. What is also clear is that the specific requirements of the Unlocking/Locking procedure were not followed; in particular the Officers did not see Mr Hastings' face not did they receive a verbal response from him.

[15] Mrs KA has voiced concern about the possibility that her husband was lying ill and unattended in his cell for some hours when his condition could have been detected earlier. As set out in paragraph [8] *supra,* she highlighted inconsistencies in the police statements and DIPLAR report; this led to Affidavits being obtained from the officers. I accept the Officers' version of events that morning as both credible and reliable. The version of events contained within each Affidavit is wholly consistent with the earlier statements they gave to Police Scotland. [6] There is no attempt by either officer to retrospectively suggest that he did comply with the specific requirements of the Unlocking procedure. I did not find that the failure to comply with the procedure was due to any shirking or incompetence on their part. Evidently both officers appreciated the importance of getting a response from the prisoners. The Affidavits confirm that it was always two officers who carried out the morning checks. It was a joint effort and in each cell they made sure they got some response. A lot of prisoners will say "good morning" to them whereas with others it was the lifting of a hand or the shaking of a foot. Officer S explained that if no response was obtained they would resort to knocking the door, shouting or on occasion shaking the prisoner. It was clear from their respective Affidavits that they would never move on from a cell without getting a response which satisfied them that the prisoner was safe and well. Officer S stated:

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[6] It is a matter of concern that there is a discrepancy between the DIPLAR report and what is contained in the police statements of the officers waking Mr Hastings up that morning. I have not conducted further investigations in relation to why this is so. This is a matter for SPS. I am satisfied that the Affidavits provide clarity on what happened that morning when Mr Hastings' cell was unlocked.

> "There have been times when I have had to rouse prisoners from sleep to get a response from them and they haven't been happy. I have done it though, where I have given a prisoner a shake to get a response."

Officer R :

> "Alan Hastings raised a hand to us in acknowledgement of Chris saying good morning. It is not uncommon for prisoners to not say morning or hello. Personally for me through my experience as an officer if I say good morning and I don't get a verbal response or a physical movement of an arm or a leg to suggest that the prisoner is alive and well I will continually say good morning and use their name until I get a response. As an officer I would never leave prisoner after any numbers check without having received a response. There is a fine line though between getting a response and rousing a prisoner. I have known prisoners who have been in deep sleeps – then they have been roused by a PO and the PO has been assaulted."

It is my view these officers moved on only once they were assured Mr Hastings had responded to their call and were satisfied there was no issue of concern.

[16] That being said, the Unlocking Procedure of course requires the officers to do more than they did that morning, recognising that it is possible for someone whose health is deteriorating still to raise a hand. Therefore, whilst there was a wholly adequate system in place to mitigate against such an eventuality it appears at the time of Mr Hastings' death it was not being followed scrupulously.

[17] In Mr Hastings' case it cannot be said that his death might realistically have been avoided had these steps been taken.

[18] The likelihood, based on the evidence before the Inquiry is that Mr Hastings succumbed to illness in the period between his cell being first unlocked that morning and the return of Officer S some time later. This was a time when prisoners would be on their own in the cell. It was the time when officers were attending to medication and

breakfast. Prior to COVID prisoners would be out of their cells having breakfast, but since the restrictions imposed in 2020 this has not been the case. It was standard for Mr Hastings to be in his cell getting himself ready for his work party during this time; this would involve him having breakfast, showering and dressing. There is every indication that he had started that process on the morning of 21 January after the officers had left his cell.

[19] I arrive at this conclusion as I am satisfied from the evidence that Mr Hastings got himself up that morning after the unlocking of his cell to get himself ready for the day. Officer S is clear in his evidence that when he found Mr Hastings unconscious the light was on in his cell. He is in no doubt that the light had been off when they left the cell after unlock. The light is at the cell door so Mr Hastings must have got out of bed to put the light on. Officer R was also very clear that when he returned to the cell to respond to the Code Blue the milk carton had been moved from where he and his colleague had left it at the door. This was unlikely to have been moved by anyone other than Mr Hastings. There is also reference in Officer R's affidavit to a paramedic turning off Mr Hastings' TV before leaving his cell. Whilst this is hearsay evidence it is admissible. I accept it as credible. It is an important factor and not likely to be misremembered by the emergency worker or Officer R.

Consideration of recommendations

[20] Nonetheless the Unlocking & Locking Policy requires officers unlocking a prisoners' cell to do more than was done that morning. It is in place for a reason. It is an

acknowledgement that someone's health may be deteriorating even in circumstances where they can still raise a hand:[7] thus the requirement on officers to obtain a verbal response or see a prisoner's face.

[21] The obligation imposed on the sheriff under the Act is broader than the obligations set down in Section 26(1) (a). It extends to a consideration of recommendations which might realistically prevent "other deaths in **similar circumstances**." I therefore gave consideration to whether recommendations required to be made under section 26(1) (b). I was satisfied this was not necessary due to steps which had been taken by SPS following the death of Mr Hastings. At the time of Mr Hastings death a wholly adequate Policy for unlocking cells was in place; it did not need improvement. However steps needed to be taken to ensure strict adherence not only to the spirt but also the letter of this policy. I am satisfied that SPS have taken the necessary steps to that end. In particular, by way of email dated 16 May 2022 the Residential Unit Manager (Acting) of HMP Grampian circulated to all Operational Staff at HMP Grampian a copy of the Revised Unlocking and Locking Procedure with the following instruction:

> "Please find attached GMA[8] as a reminder in relation to requirements during locking and unlocking periods. When carrying out checks staff are required to see the face of, and get a verbal response from all prisoners during all lock up

[7] The Policy was revised in 2016 to include these requirements, following observations by a sheriff in a previous fatal accident inquiry, to the effect that SPS should review the policy (albeit the finding in that case was that the lack of a verbal response had not contributed to the death) . A satisfactory system was thus put in place.

[8] Document : Governors and Managers : Action, Revised requirements during Locking & Unlocking Periods, March 2016, Reference 016A/16; this is Crown Production 5

> and unlocking periods. This is a measure to reduce the risk of suicide and also identify someone with a deteriorating health condition. Can all residential staff ensure they fully comply with the attached."

Included in this email trail was an email from the Governor of HMP Grampian advising recipients that "This issue has also been discussed at residential handover meetings in recent weeks".

Given that these steps have now been taken by SPS it is neither necessary nor appropriate for this Inquiry to make any statutory recommendations under the Act. I would simply make the observation that it is expected such reinforcement will be a core element of regular training.

Observations

[22] Officer S spoke in very positive terms about Mr Hastings. He had spent a lot of time with him on programmatic work and had a very high regard for him. In paragraph [2] of his Affidavit he says : "He was a very well-liked prisoner and caused no bother at all. He was quiet but I would say he knew how and when to speak up." He also makes the following observation in paragraph [2]: "I had a really good relationship with Alan and had a lot of time for him. I knew a lot about him and his family." He goes on to explain that he found the events of that morning difficult.

[23] These observations of Officer S serve to remind us of the important work carried out every day by prison officers. Work that largely goes unrecognized and unappreciated in the wider society. The words also demonstrate that in addition to the distress felt by family members when an individual dies in custody, staff are also

impacted. This is an inquiry into the death of Mr Hastings and I have no intent to shift focus from that with these observations. To the contrary - I sincerely hope that the sentiments expressed by Officer S about the high regard in which her husband was held will offer some level of comfort to Mrs KA and her family in their loss.

[24] In conclusion , having examined all the relevant circumstance surrounding Mr Hastings' tragic death, including taking into account the steps SPS have taken since, regarding reinforcing the specific requirements of the unlocking procedure the Inquiry has no recommendations to make which might realistically prevent other deaths in similar circumstances.

Finally I add my sincere condolences to Mrs KA and her family.