SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2024] FAI 45

GLW-B1506-23

DETERMINATION

BY

SUMMARY SHERIFF PATRICIA A PRYCE

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

into the death of

ALEXANDER JAMIESON

GLASGOW, 24 October 2024

The sheriff, having considered 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 (herein after referred to as "the 2016 Act") the following:

(1) In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred) that Alexander Jamieson, born on 10 March 1963, died at Glasgow Royal Infirmary, Glasgow on 21 August 2022 at 1556 hours.

(2) In terms of section 26(2)(c) of the 2016 Act (the cause or causes of death), that the cause of death was metastatic adenocarcinoma (unknown primary site).

(3) In terms of section 26(2)(e) of the 2016 Act that there are no precautions which could reasonably have been taken that might realistically have resulted in the death being avoided.

(4) In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death) that there are no other facts which are relevant to the circumstances of the death.

(5) In terms of section 26(1)(b) of the 2016 Act, there are no recommendations which might realistically prevent other deaths in similar circumstances arising from the information provided.

NOTE:

Introduction

[1] This Inquiry into the death of Mr Jamieson was held on 17 June 2024 and 11 September 2024 by way of an in-person hearing at Glasgow Sheriff Court. Ms Ramage, Procurator Fiscal Depute, represented the Crown. Ms Monaghan, represented the next of kin, Ms MJ, daughter of Mr Jamieson and Mr AJ, brother of Mr Jamieson. Ms Paton of the NHS Central Legal Office, represented the interests of the relevant Health Board. Ms Johnston, Solicitor, for the Scottish Prison Service, represented the interests of the SPS.

[2] The parties entered into three detailed and comprehensive Joint Minutes of Admissions in advance of the hearing dates. I am grateful for the care and attention given to the agreement reached by all concerned.

Purpose of the Inquiry

[3] The 2016 Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 Rules") govern Fatal Accident Inquiries. A Fatal Accident Inquiry is held under section 1 of the 2016 Act and its purpose in terms of section 1(3) is to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. The purpose of the Inquiry is not to establish civil or criminal liability. The process is inquisitorial in character. The procurator fiscal represents the public interest at the Inquiry. The present Inquiry was mandatory in terms of sections 2(1) and (4) of the 2016 Act as Mr Jamieson was in legal custody at the time of his death.

[4] As regards the circumstances, the sheriff must make findings regarding:

(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; and

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

[5] In terms of section 26(4) the sheriff is entitled to make recommendations regarding:

(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 other steps, which might realistically prevent other deaths in similar circumstances.

Witnesses

[6] The court heard evidence from the following witnesses:

1 Ms MJ, daughter of Mr Jamieson.

2 Mr AJ, brother of Mr Jamieson.

3 Mr Robert Luke, Unit Manager at HMP Barlinnie.

4 Melanie Brooks, Business Manager at HMP Barlinnie.

I am grateful to the witnesses who gave evidence to assist the Inquiry. I found them to be credible and reliable.

[7] The Inquiry also considered evidence from numerous witnesses by affidavit, namely, affidavit of MJ, affidavit of AJ, affidavit of ET, mother of Mr Jamieson, affidavit of Jill Clancy, Chaplain at HMP Barlinnie, affidavit of Dr Julia Bell.

Factual circumstances

Events leading to Mr Jamieson's death

[8] On 19 November 2021, Mr Jamieson was convicted, following trial, of assault to injury with a domestic abuse aggravation and a contravention of section 2 of the Sexual Offences (Scotland) Act 2009. On 17 December 2021, Mr Jamieson was sentenced to a period of 18 months' imprisonment in respect of the assault to injury charge and a period of 4 years' imprisonment in respect of the contravention of section 2 of the Sexual Offences (Scotland) Act 2009, both sentences to run concurrently. His earliest date of liberation was calculated as at 16 June 2025.

[9] Mr Jamieson was incarcerated in HMP Barlinnie at the time of his death.

[10] Mr Jamieson was admitted to Glasgow Royal Infirmary on 1 August 2022 with general malaise, weight loss and abdominal pain. Initial investigations raised the possibility of haematological malignancy but further investigations undertaken confirmed a metastatic adenocarcinoma with unknown primary site. Mr Jamieson was fatigued, frail and required oxygen. He was also treated for co-existing sepsis with antibiotics. It was decided that he was not fit for any oncological therapy and he was referred to palliative care who provided input with regards to his pain management. Although a referral to a hospice and investigations into an application for compassionate release had commenced, this was not progressed due to the rapid deterioration of Mr Jamieson's health. Mr Jamieson died at 1556 hours on Sunday, 21 August 2022 within the medical high dependency unit, Ward 44 of Glasgow Royal Infirmary. His family were with him at the time of his death.

Medical history and treatment

[11] On admission to HMP Barlinnie on 17 December 2021, Mr Jamieson's prison medical notes were updated to reflect his known health issues and current medical prescription. He reported to NHS staff that he suffered from hearing loss, tinnitus, low vision and required the use of a walking aid. On admission, Mr Jamieson was being prescribed Ramipril and Amlodipine, Sildenafil Citrate, Omeprazole, Baclofen, Pregabalin, Naproxen and Clonazepam (as per Crown production No 4, page 286).

[12] On 18 December 2021, Dr Ahmed, GP, carried out an admission consultation with Mr Jamieson at HMP Barlinnie. The doctor noted that Mr Jamieson had a history of a head injury that led to left-side hemiparesis. It was noted that Mr Jamieson reported no issue with drugs or alcohol.

[13] On 19 January 2022, Mr Jamieson attended an out-patient appointment at the New Victoria Infirmary, Glasgow, where he received a left sacroiliac joint injection. This treatment was in relation to multi-level lumbar spondylosis and pain. This appointment had been made prior to Mr Jamieson's incarceration. A follow-up telephone consultation was arranged with the consultant orthopaedic surgeon, Niall Craig, to take place on 23 February 2022 (as per Crown production No 4 at pages 55, 61, 62, 75, 78, 285 and 286).

[14] On 23 February 2022, the telephone consultation with the consultant orthopaedic surgeon, Mr Craig, was not facilitated due to staff shortages within HMP Barlinnie.

Mr Craig issued a further telephone appointment to take place on 30 March 2022 (as shown at Crown production No 4, pages 47, 50 and 284).

[15] On 30 March 2022, the telephone consultation with Mr Craig did not take place due to the telephone number being engaged and thereafter a GP surgery taking place within the health care centre of HMP Barlinnie. Mr Craig issued a further telephone appointment to take place on 20 April 2022 (as shown as Crown production No 4, pages 47 and 284).

[16] On 20 April 2022, a telephone consultation with consultant orthopaedic surgeon Mr Craig could not take place due to a power cut within HMP Barlinnie. Mr Craig issued an in-person appointment to take place at his clinic at the New Victoria Hospital, Glasgow on 11 July 2022 (as shown at Crown production No 4, pages 41, 42 and 284).

[17] On 19 May 2022, Mr Jamieson attended for medication and stated that he had a dental abscess and was constipated. The consulting nurse noted in the medical records that she would order laxatives already prescribed (as shown at Crown production No 4, page 284).

[18] On 31 May 2022, Mr Jamieson completed a self-referral form requesting to see medical staff in relation to "sometimes severe" stomach pain that had lasted over 2 weeks (as shown in Crown production No 4 at page 34).

[19] On 1 June 2022, Mr Jamieson approached a member of nursing staff during medication round and disclosed ongoing stomach pain and discomfort. Mr Jamieson was listed for the next available GP clinic (as shown at Crown production No 4, page 284).

[20] On 3 June 2022, Mr Jamieson completed a self-referral form requesting to see medical staff in relation to constipation (as shown at Crown production No 4, page 26).

[21] On 6 June 2022, Mr Jamieson was reviewed by a nurse within his cell regarding ongoing abdominal pain. Dr Senthill, GP, consulted with Mr Jamieson and arranged for an ambulance to attend at HMP Barlinnie to transport Mr Jamieson to Glasgow Royal Infirmary Emergency Department (as shown at Crown production No 4, pages 27 and 84).

[22] On 6 June 2022, upon arrival at Glasgow Royal Infirmary Emergency Department, investigations were carried out including a chest and abdomen X-ray. Nothing abnormal was discovered and Mr Jamieson was diagnosed with constipation (as shown at Crown production No 5 at pages 198 - 207, 429 - 430 and 561 - 562).

[23] On 7 June 2022, Mr Jamieson was discharged back to the care of HMP Barlinnie at 0123 hours (as shown at Crown production No 4, page 284 and Crown production No 5 at pages 429 - 430).

[24] On 7 June 2022, Mr Jamieson was seen by a nurse on return from hospital. Medical records reflect that Mr Jamieson advised healthcare staff that all his medication had changed including the laxatives. The Emergency Department discharge letter was not available to the nurse at this time but the assessment undertaken at the hospital was reviewed. The nurse in charge was informed (as shown at Crown production No 4, page 284).

[25] On 8 June 2022, Mr Jamieson completed an NHS prison healthcare self-referral form relating to a change in his pain medication. Medical records note this referral was

received and that nursing staff would review and order the alternative painkiller (as shown at Crown production No 4, pages 25 and 284).

[26] On 10 June 2022, Mr Jamieson was seen by a nurse and reported that he had not had a bowel movement for 14 days (as shown at Crown production No 4 at 284).

[27] On 11 June 2022, Mr Jamieson completed an NHS prison healthcare self-referral form stating that the A&E doctor had advised that he wished him to have a stomach scan if no significant bowel movement had taken place.

[28] On 12 June 2022, Mr Jamieson was seen by a nurse following his self-referral dated 11 June 2022. The NHS Portal was consulted and a change in laxative was ordered.

[29] On 22 June 2022, Mr Jamieson completed an NHS prison healthcare self-referral form referring to ongoing severe stomach pains and constipation, requesting this be investigated (as shown as Crown production No 4, pages 21 - 22).

[30] On 24 June 2022, Mr Jamieson was reviewed by the nurse, wherein he described generalised abdominal pain. He was listed to see a GP at the next available clinic (as shown at Crown production No 4, page 284).

[31] On 1 July 2022, Mr Jamieson was reviewed by Dr Akinsamolu, GP, within HMP Barlinnie regarding his ongoing abdominal pain and weight loss. The doctor completed a hospital referral and conducted a medication review (as per Crown production No 4, pages 15 and 284).

[32] On 11 July 2022, Mr Jamieson was escorted to the New Victoria Hospital, Glasgow, Out-patient Department for Orthopaedics for a consultation with Mr Craig.

Mr Craig noted that Mr Jamieson had noticed some improvement in pain for up to 2 weeks after the injection and placed him on a waiting list for a facet injection to see if that helped for a prolonged period (as shown at Crown production No 4, pages 6 and 283).

[33] On 14 July 2022, prison healthcare received confirmation of an out-patient appointment at Stobhill Hospital General Surgery Department, for 3 August 2022 (as shown by Crown production No 4, page 11).

[34] On 1 August 2022, Mr Jamieson was noted by prison medical staff to be in respiratory difficulty. An ambulance was contacted, and Mr Jamieson was taken to Glasgow Royal Infirmary (as shown at Crown production No 4, page 284 and Crown production No 5 at pages 208 - 210).

[35] On 1 August 2022, Mr Jamieson was admitted to the intensive care unit at Glasgow Royal Infirmary. Investigations were undertaken which raised the possibility of a haematological malignancy (as shown at Crown production No 5, pages 211 - 225, and 227 - 232).

[36] On 3 August 2022, a biopsy was performed which, on analysis, revealed that Mr Jamieson was suffering from an inoperable metastatic adenocarcinoma with an unknown primary site (as shown at Crown production No 5, pages 404 - 411, pages 418 - 423 and page 471).

[37] On 10 August 2022, Mr Jamieson was discharged from the intensive care unit to the high dependency unit for palliative care (as shown at Crown production No 5, pages 32 and 399).

[38] On 12 August 2022, Mr Jamieson's biopsy results confirmed a metastatic adenocarcinoma with unknown primary site (as shown at Crown production No 5, page 337).

[39] On 19 August 2022, Mr Jamieson began to deteriorate and was made comfortable by nursing staff.

[40] On 21 August 2022 at 1625 hours, Dr Philip Dunne pronounced Mr Jamieson's life as extinct. Mr Jamieson's family were with him when he died (as shown at Crown production No 5, pages 257 - 268 and page 436).

[41] On 29 August 2022 a post-mortem examination was conducted by Dr Julia Bell, at the Queen Elizabeth University Hospital in Glasgow. Cause of death was confirmed as 1(a) metastatic adenocarcinoma (unknown primary site), (as shown at Crown production No 1. Consideration was given and referred and the affidavit of Dr Julia Bell which is located as Crown production No 12. This was admitted into evidence and agreed by all parties).

Communication with next of kin

[42] On 1 August 2022, after Mr Jamieson was transferred to hospital as an emergency, HMP Barlinnie attempted to contact Mr Jamieson's next of kin, his brother, Mr AJ. The landline telephone number used by HMP Barlinnie was obtained from the next of kin details held on Mr Jamieson's admission records. There was no answer to this number and a message was left asking Mr Jamieson's next of kin to contact HMP Barlinnie (as per Crown production No 6, page 160).

[43] On 3 August 2022, following an enquiry by nursing staff via GeoAmey escort officers, the SPS was asked to contact Mr Jamieson's next of kin. The next of kin confirmed that they did not receive a telephone call (as shown at Crown production No 5, page 287).

[44] On 4 August 2022, the next of kin were alerted to Mr Jamieson's hospital admission by a third party. The next of kin immediately attended Glasgow Royal Infirmary (as per Crown production No 5, page 292).

[45] No request for change of next of kin was completed by Mr Jamieson.

[46] On 17 November 2022, a Governors and Managers Action ("GMA") was issued by the Scottish Prison Service advising of the requirement to provide assurance that next of kin details were properly recorded and that processes were in place to ensure that these are updated appropriately along with consent to contact named next of kin in the event of serious illness or admission to hospital (as shown at Crown production No 10).

Scottish Prison Service

[47] On 8 September 2022, a Death in Prison Learning, Audit and Review or "DIPLAR", was carried out. The DIPLAR report identified no learning points (as per Crown production No 7, pages 2 - 7).

[48] The DIPLAR guidance has been reviewed and revised since Mr Jamieson's death. New DIPLAR guidance was implemented in August 2023 (next of kin's production No 10 - revised Death in Prison Learning, Audit and Review (DIPLAR) guidance). In terms of same, it is now the role of the governor, or deputy governor, to contact the

family within 24 hours of an individual's death (as shown at next of kin production 10, page 4). In terms of this new guidance, the governor appoints a member of the management team to be the main contact with the family along with providing them with the Family Support Booklet which contains the contact details for the chaplaincy and NHS (as shown at next of kin production 10, page 4). The DIPLAR will consider all aspects of the engagement with the family and will ensure all contact with them is recorded including the family being informed of how they may raise any questions or concerns to be discussed at the DIPLAR (as shown at next of kin production 10, page 4). In terms of the reviewed guidance, the chaplain must now attend all DIPLAR meetings (as shown as next of kin production 10, page 4).

Witnesses

First witness - Ms MJ, daughter of Mr Alexander Jamieson

[49] Ms MJ read out her affidavit and confirmed the veracity of the contents of same. Ms MJ gave very clear evidence in a straightforward fashion. She referred to the letter of 30 January 2023 (next of kin production No 1) which she wrote to HMP Barlinnie. She advised that she had sent the letter as she was trying to achieve closure. In terms of her affidavit, she recounted how her father had been in significant pain whilst in HMP Barlinnie together with the fact that various medical appointments had been missed whilst he was in HMP Barlinnie. She raised these issues with HMP Barlinnie's Unit Manager, Mr Jim Beaton, but considered that she had not received adequate responses. In short, she considered that her father had not been treated with respect and dignity.

[50] She submitted that her family was not informed of her father's admission to hospital until 4 August 2022, some 3 days after he had been admitted. She complained about the number which HMP Barlinnie had used to attempt to contact her uncle, Mr TJ, as this number had never belonged to her uncle. She referred to Crown production No 5 at page 161 which showed her father's address history as held by the Scottish Prison Service. The second entry shows an address at Northgate Quadrant in Balornock together with a corresponding telephone number. Ms MJ confirmed that this was an address where her father had lived 20 years previously with his ex-partner. She considered that this meant that the number had been taken from old next of kin records when her father had previously been incarcerated in HMP Barlinnie. She considered that her father would not have provided this number for his brother to the Scottish Prison Service given that her father had not lived in that house for over 20 years. She confirmed that her uncle had never lived at that address.

[51] She complained that the SPS had not provided any record of her father's admission interview in December 2021 and was upset that HMP Barlinnie appeared to be blaming her father for providing an incorrect number for her uncle. She submitted that she and her family were concerned as the incorrect number and the use of same prevented her and her family from seeing her father for 3 days following his admission to hospital. Furthermore she submitted that HMP Barlinnie had a record of her uncle's mobile phone number because that was the number that her father had used to contact her uncle from prison, explaining that prisoners can only make calls to numbers on an

approved list which is held by the prison. However, she submitted that the Scottish Prison Service made no attempts to reach her uncle on his mobile number.

[52] Ms MJ made reference to a letter from the Scottish Prison Service, from Jim Beaton, to her dated 22 February 2023. The third paragraph of that letter confirms that HMP Barlinnie had used the wrong telephone number to attempt to contact Mr Jamieson's next of kin, namely, Ms MJ's uncle. The fourth paragraph of that letter confirms that that same number was used again on 3 August 2022 when Mr Jamieson's health started to deteriorate. Ms MJ confirmed that she found out about her father's admission to hospital through her mother on 4 August 2022. Her mother phoned her and advised her that her father was in hospital. Her mother happened to be in Glasgow that day and had met with Ms MJ's uncle. Ms MJ's uncle had found out from Mr Jamieson's friend, Andy, that he had happened to bump into in the hospital that his brother had been admitted to hospital, all of which appeared to have emanated from Facebook.

[53] Ms MJ thereafter made reference to next of kin production 8, Freedom of Information Response by HMP Barlinnie to her request and the response was dated 18 May 2023. She submitted that she had made this Freedom of Information ("FOI") request as HMP Barlinnie had never contacted her family. By the time she and her family visited her father, he was confused and heavily under the influence of medication and could not provide them with any information. She and her family were concerned about some of the things her father had said. She considered that she was not receiving a direct response from Mr Beaton and therefore made the FOI response. She felt fobbed

off by Mr Beaton. She confirmed that she and her family had not been contacted by the Scottish Prison Service between 1 and 4 August. She said that the first contact they had received was from Police Scotland which was after her father's death.

[54] In relation to the DIPLAR guidance, Ms MJ confirmed that she found out about this herself after conducting her own research, in the same way as she had submitted an FOI request. This was an attempt to gain any information which she considered was not forthcoming from the Scottish Prison Service. She confirmed that nobody had contacted her family and the chaplain had not contacted her family during her father's illness or after his death. Had Ms MJ been aware of the DIPLAR guidance, she confirmed that she would have definitely participated in this process. She considered that the DIPLAR report was vague and dishonest in its terms and she would have complained about her father's death and treatment but that she and her family were never approached in relation to this. Ms MJ confirmed within her affidavit that of particular concern to her was that, if a prisoner is admitted to hospital as an emergency, as her father had been, and the SPS fails to contact the next of kin via telephone, the SPS must contact Police Scotland to attend the next of kin's address. She confirmed that Ms Siobhan Ramage informed her that HMP Barlinnie failed to follow their own policies and procedures in this matter and did not contact Police Scotland. She has never received any reason for this. She considered that the SPS have these policies and procedures in place but do not seem to follow them.

[55] Ms MJ complained about the change in her father when she finally saw him in hospital, his weight loss so significant that he was almost unrecognisable. She could not

understand how medical professions in HMP Barlinnie were able to look at her father's appearance and not know that something was seriously wrong.

[56] Ms MJ confirmed that HMP Barlinnie has not contacted her family since her father's death, with any contact being initiated by her alone. She referred to the DIPLAR guidance and submitted that the prison chaplain should have offered her family support following her father's death but this did not happen and she and her family were never contacted by the chaplain, informed of the DIPLAR guidance or indeed given an opportunity to raise any specific concerns or questions about her father's death. She disagreed with some of the DIPLAR review findings carried out by the SPS, in particular, No 7 and No 8, and disagreed that the family had ever made a complaint to the NHS about her father's treatment. She considered that the escort staff were not respectful or mindful of the need for privacy as they remained in the room with her and her father until the day he died.

Second witness - Mr AJ, brother of Mr Alexander Jamieson

[57] Mr AJ read out his affidavit and confirmed his signature on each page of same and adopted it as his principal evidence. He confirmed that he was close to his brother and before his brother was admitted to prison he saw his brother two or three times per week. On his brother's admission to HMP Barlinnie in December 2021, Mr AJ used to go and see his brother once or twice a month for around an hour. He complained that his brother's mobility was worse every time he saw him. He considered that this brother was treated poorly in prison, missing medical appointments and lacking

medication. Mr AJ confirmed that he first noticed that his brother was not well on or about June 2022. He noted that his brother's stomach was swollen and his arms were wasting away together with his face being gaunt. Mr Alexander Jamieson complained to his brother that the pain in his back and stomach was unbelievable and he could not go to the toilet. Mr Alexander Jamieson complained to his brother that he was not being given the appropriate pain relief medication. Mr AJ knew, on looking at his brother, that there was something badly wrong with his brother physically. His brother complained to him that he was constantly in agony. In relation to this brother's admission to hospital on 1 August 2022, Mr AJ confirmed that no-one in the family was advised of this admission. Mr AJ was Mr Alexander Jamieson's next of kin and that his number was on the approved list for Mr Alexander Jamieson but Mr AJ did not receive any phone calls from HMP Barlinnie. Mr AJ confirmed that he found out that his brother was in hospital through his ex-partner, Helen. On discovering his brother had been admitted to the hospital, Mr AJ went directly to the hospital and informed the rest of the family.

[58] Mr AJ confirmed that by the time he got to see his brother for the first time on 4 August 2022, his brother did not really know what day of the week it was and that was the way his brother remained until he death. He complained that his brother was very agitated and did not seem to understand what was happening to him. Mr AJ considered that the family did not get to say a proper goodbye because, by the time the family got to visit him, Mr Alexander Jamieson was not aware of what was going on.

[59] Mr AJ, referring to Crown production No 6 at page 160, confirmed that the telephone details of the purported next of kin was a telephone number that had never belonged to him. On page 161 of the same document, he confirmed that Mr Alexander Jamieson's address in Balornock, Northgate Quadrant, was where Alexander Jamieson had lived with his ex-partner some 25 years previously and that his brother had been in Barlinnie around that time as well. Mr AJ confirmed that he never received a telephone call from HMP Barlinnie confirming that his brother had been admitted as an emergency to hospital. Mr AJ confirmed his telephone number and that he had had the same number for around 35 years. In relation to Crown production No 5 at page 147 (page 196 of the physical document) the telephone number noted is wrong as it has too many digits. This was the contact number that the NHS confirmed they had received from HMP Barlinnie.

[60] Mr AJ could not understand why he had not been contacted by HMP Barlinnie as he was on his brother's approved list of contacts. He confirmed that his brother knew Mr AJ's mobile number by heart.

[61] In relation to the DIPLAR process, Mr AJ confirmed that he had never heard from anyone. He had never received any contact from the prison after his brother's death. Mr AJ himself contacted HMP Barlinnie in order to uplift his brother's belongings. However, he arranged an appointment to go and uplift the belongings and when he went up to HMP Barlinnie he waited for an hour and was told that they were too busy and he had to come back the following day. Mr AJ left the prison and phoned the procurator fiscal who advised him to ask to speak to a manager or indeed

the ombudsman. Mr AJ went up to the prison again and sat for another hour but was told they were too busy to come out and hand over his brother's belongings. Mr AJ contacted the procurator fiscal again who said that Mr AJ should speak to a manager. Mr AJ managed to speak to a manager, arranged an appointment and the manager took him upstairs to hand over his brother's belongings. There was no mention made of the DIPLAR process and the only comment that was made was that they were sorry for his loss.

Third witness - Mr Robert Luke, Unit Manager, HMP Barlinnie

[62] Mr Robert Luke was referred to his statement which had been lodged. Mr Robert Luke adopted this as his evidence in chief. In relation to the recording of next of kin details, he was referred to paragraph 4 of his statement and confirmed that a contact telephone number could be both a mobile and landline number or either. When referred to paragraph 9 of his statement, Mr Luke confirmed that although it was not a requirement to look at the visitor list and extract a relevant number it was something that the officer could do. Mr Luke confirmed that there were two occasions when the Scottish Prison Service would speak to a prisoner and confirm the next of kin details, namely, at reception and thereafter at induction. These were general comments and did not refer specifically to Mr Alexander Jamieson's admission to the prison. He confirmed that if a prisoner were detained in hospital then an effort would be made to contact the next of kin. He confirmed that the process should be that where a prisoner is kept in hospital then the next of kin should be contacted irrespective of the serious nature of

any such admission to hospital. When asked what other steps HMP Barlinnie could have taken when contact could not be successfully initiated with the family after Mr Jamieson's admission to hospital on 1 August 2022, Mr Luke confirmed that contact details would be looked at first but, if that were not fruitful, then the option would be there for the duty manager to check, for example, visitor records etc but he cited that the Data Protection Act would limit them to contacting next of kin only. Mr Luke confirmed that there was no requirement to contact Police Scotland to attend the next of kin's address where the establishment could not contact the next of kin and that they would only contact the police to inform the next of kin on the event of the death of a prisoner in custody. Mr Luke was referred to next of kin production 8, letter dated 18 May 2023 by HMP Barlinnie's business manager to Ms MJ, Alexander Jamieson's daughter. He was referred to the third heading of that letter which referred to contacting the family if he was admitted to hospital and procedures when family could not be contacted. The final paragraph of the letter comments as follows:

> "If we failed to gain contact with the next of kin via the telephone number provided then we would contact Police Scotland to attend the address provided, dependant on the severity of the circumstances".

With reference to this quote, Mr Luke confirmed that he had no knowledge of any policy that would require the SPS to contact Police Scotland in these circumstances.

[63] When referred to paragraph 15 of his statement, Mr Luke confirmed that in relation to the recording of next of kin details and consent to contact, he could only presume that there had been issues identified regarding this but confirmed at HMP Barlinnie these should always have been checked at reception and induction.

Paragraph 15 of his statement refers to a Governor and Manager's Action (GMA). Mr Luke confirmed that this was a notice from headquarters requiring governors to take action in respect of processes they were using at the time and he confirmed that this was sent to the whole prison estate.

[64] When asked about the actual physical process of checking next of kin details, Mr Luke confirmed that when a prisoner is admitted to the prison, at reception, a prison officer is at a computer and, at induction, there would also be a computer but the officer would also take notes. He confirmed that both officers at these two different points would be able to amend PR2 which is the prisoner records system. He confirmed that there were therefore two occasions where the telephone contact details in Mr Jamieson's next of kin contact details could have been amended. He further confirmed that if a person had previously been in custody and then re-entered the estate both the reception and inductions processes would still take place. Each prisoner has a unique prisoner identifier number which remains with them for life so the information would already have been on the system in respect of Mr Alexander Jamieson. Given this, he presumed that the telephone number had not been updated in respect of Mr Jamieson's contact details. In light of the content of the next of kin details, he conceded that this had not been updated, though could not confirm why.

[65] Mr Luke confirmed that Mr Jamieson received a small mobile telephone device with pre-authorised telephone numbers on it as this would have been issued to every prisoner on admission. This was to allow them to keep in contact with family. Mr Luke

confirmed that in terms of next of kin production 8 he had never come across the policy of contacting Police Scotland for prisoners who had been admitted to hospital.

Fourth witness - Ms Melanie Brooks, Project Manager employed at HMP Barlinnie

[66] Ms Brooks referred to Crown production 11 and confirmed that this was her operational witness statement. She confirmed that at the time of Mr Jamieson's death she was employed as the Business Manager at HMP Barlinnie. Crown production 11, pages 2 - 4 comprise her witness statement to the police in relation to Mr Jamieson's death. She confirmed the details of the statement.

[67] Ms Brooks confirmed that in her role as Business Manager for HMP Barlinnie she was responsible for the management and information services at that date. She would have been advised of any prisoner being detained in hospital. She confirmed that where a prisoner is detained in hospital, the duty manager will attempt to contact the next of kin if the prisoner wishes this. She confirmed that she was aware that consent had been given by Mr Jamieson as it appeared on the PR2 system. She could not confirm what steps were taken but said that it would be in the duty report in relation to what had happened when Mr Jamieson was detained in hospital on 1 August 2022.

[68] Where the next of kin could not be contacted, she confirmed that they would continue to try and contact the next of kin as they appear on file and telephone calls would be made along with a voice message. When asked to confirm whether or not one telephone call between 1 and 3 August was enough she submitted that it would depend on the circumstances. Furthermore, Ms Brooks confirmed that she would not have been

made aware of Mr Jamieson's deterioration in health on 3 August. She had no role in contacting the next of kin but could talk about the policy.

[69] If there had been a deterioration in the health of the prisoner Ms Brooks confirmed that the SPS would not contact Police Scotland to help contact the next of kin.

[70] Ms Brooks was referred to next of kin production 8 which is the FOI response letter by Ms Brooks to Mr Jamieson's daughter dated 18 May 2023. She confirmed this was her signature as business manager on the letter. When referred to the paragraph detailing the contacting of family of those admitted to hospital, Ms Brooks submitted that it was conflicting as there is a difference between a prisoner being detained in hospital and a death in custody. In short, if there were a death in custody then Police Scotland would be informed. However, Ms Brooks accepted that it read as if next of kin would be contacted through the police if they could not be traced by SPS.

[71] When referred to next of kin production 4, which was the letter by Mr Jamieson's daughter which constituted a request under the freedom of information legislation, Ms Brooks accepted that this was asking for details on procedures when prisoners were detained in hospital and did not refer to a death in custody. Ms Brooks stated that she had covered the detention in hospital and further provided information regarding death in custody but she accepted that the phrase "depending on severity of circumstances" conflicted wither own oral evidence at the hearing.

Submissions

[72] A hearing on submissions took place on 11 September 2024. I was helpfully provided with written submissions by all interested parties in this process. In short, the main difference between the submissions for the next of kin and the other parties to this process was that I was invited by the next of kin to make determinations in terms of section 26(2)(g) in relation to any other facts which are relevant to the circumstances of the death. Helpfully, the next of kin's lawyer confirmed that the next of kin were no longer insisting on point 3 of the written submission in relation to the DIPLAR guidance. However, the next of kin wished findings to be made in relation, firstly, to the SPS' failure to accurately record Mr Jamieson's next of kin details when he was detained in HMP Barlinnie on 17 December 2021 and secondly, the SPS failed to make reasonable and proper attempts to contact Mr Jamieson's next of kin upon his admission to the Glasgow Royal Infirmary. All other determinations in relation to section 22(2)(a)(c) and (e) were matters of agreement between parties and are as noted at the start of this determination.

[73] It was a matter of agreement between parties that the Inquiry had heard evidence of the profound effect that the failure to be notified of Mr Alexander Jamieson's illness had on the next of kin. This was not a matter of dispute. Furthermore, there was no dispute regarding the fact that prison records contained old or an inaccurate number. Mr Luke gave clear evidence of the processes involved at induction and admission, the two points when next of kin details are updated. There was no evidence directly about what happened in the case of Mr Jamieson. The process is clear, namely, that at both

admission and induction a prison officer should ask questions of a prisoner and ensure that next of kin details are updated. There was no direct evidence about what happened in the case of Mr Jamieson and as such, I can reach no conclusion in relation to this. It was unfortunate that the inaccurate records or lack of up to date records led to the next of kin discovering Mr Jamieson's admission to hospital so late in the day. Again, it was a matter of agreement that the SPS had issued a GMA which was implemented in November 2022 and circulated to all establishments to require next of kin details to be properly recorded and that processes should be in place to ensure that these were updated. This was issued to mitigate the risk of similar circumstances in the future arising.

[74] In relation to the next of kin, it was submitted that there had been a failure to record the next of kin details when Mr Jamieson was admitted to HMP Barlinnie in December 2021. Furthermore, it was submitted that the SPS could have done more to try and contact the next of kin once Mr Jamieson had been admitted to hospital and as a result there had been a failure to make reasonable and proper attempts to contact his next of kin upon his admission to Glasgow Royal Infirmary. In essence, I was asked to make a determination in both these points as it was considered that both these points were of public interest and were relevant to the circumstances of the death of Mr Jamieson.

[75] As stated above, there was no direct evidence in relation to what had actually happened in Mr Jamieson's case as regards the recording or updating of the next of kin details. As such, I cannot reach a conclusion in relation to that point. Regarding the

issue of the attempts to contact the next of kin, it was accepted by the SPS that further steps could have been taken to cross-reference the telephone numbers held on Mr Jamieson's prison issued mobile phone. In light of all of the evidence led at the Inquiry and provided to the Inquiry, I do not consider that a finding should be made that the SPS had failed to make reasonable and proper attempts to contact Mr Jamieson's next of kin. A telephone call had been made, albeit to a telephone number which turned out to be historical in nature.

Conclusion

[76] There was no direct evidence in relation to any failure on behalf of the SPS to record the next of kin details or update them when Mr Jamieson was admitted to HMP Barlinnie on 17 December 2021. In addition, the SPS did attempt to contact Mr Jamieson's next of kin when Mr Jamieson was admitted to hospital on 1 August 2022, albeit a historical number had been used.

[77] I was asked to consider the issue of public interest and relevance to the circumstances relevant to the death of Mr Jamieson and I did so in reaching my conclusions as noted above.

Recommendations

[78] Given that I have not required to make a determination in terms of section 26(2)(g), I have no recommendations to make.

Observations

[79] While I make no formal findings in terms of section 26(2)(g), I consider it appropriate to make the following observations. It is unfortunate that, for whatever reason, the next of kin details were not up to date in respect of Mr Jamieson. This in turn led to a delay in the family learning about Mr Jamieson's admission to hospital. No conclusion can be drawn as to why the next of kin details were not up to date and did not reflect Mr AJ's current contact details. However, the lack of currency of those details led to the family being unaware that Mr Jamieson had been admitted to hospital for some 4 days. I note that a GMA as referred to above was issued and, if properly implemented, situations such as this should be avoided in the future.

[80] The second and final issue for the family related to the DIPLAR process. Once again, I observe that it is unfortunate the way the family was treated by the SPS. It was clear that the family had not been contacted by the SPS following Mr Jamieson's death. In addition, Mr AJ was poorly treated by the SPS in having to attend on three occasions simply to uplift his brother's belongings. However, I note that the DIPLAR guidance was reviewed and reissued after Mr Jamieson's death and that it is now the role of the governor or deputy governor to contact the family within 24 hours of an individual in custody's death.

[81] I make the above observations as I note the distress that was caused to the family as a result of these two particular matters.