SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE IN PERTH

[2021] FAI 7

PER-B54/20

DETERMINATION

BY

SHERIFF GILLIAN A WADE QC

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

into the death of

MARK ROBERTSON STEPHEN
Born 28 August 1981
Latterly a prisoner at HMP Perth, 3 Edinburgh Road Perth.

Perth, 7 January 2021

The Sheriff, having considered all the evidence adduced and the joint minute of agreement,

Determines

1. In terms of section 26(2)(a) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, that Mark Robertson Stephen, born 28 August 1981 died whist occupying Cell 3/03, C Hall, HMP Perth, 3 Edinburgh Road, Perth on 1 March 2019 at 20.46 hours.

2. In terms of section 26(2)(b) of the said Act, makes no finding.

3. In terms of section 26(2)(c) of the said Act that the cause of his death was:

Part I (a) Prescription Medication Toxicity with Agonal Aspiration of Vomitus. Part II Atherosclerotic Coronary Artery Disease.

4. In terms of section 26(2)(e), that there were no precautions which could reasonably have been taken to prevent the death.

5. Makes no findings in terms of sections 26(2)(d), (f) and (g).

NOTE

Procedural background

[1] The fatal accident inquiry into the death of Mark Robertson Stephen was held on 15 December 2020. The Crown was represented by Mrs Whyte, Procurator Fiscal Depute. Dr Rebello, solicitor, appeared to represent Tayside Health Board. Mr Smith, solicitor, appeared to represent the Scottish Prison Service (hereinafter referred to as "SPS" and Ms Wallace, solicitor, appeared to represent the interests of the Prison Officers' Association of Scotland.

[2] The deceased's sister Ms JR was invited to participate in the proceedings should she wish to do so although she was not represented. Ultimately she did not join the hearing.

[3] A preliminary hearing had taken place on 14 August 2020.

[4] Under reference to a draft joint minute of agreement I was advised that a number of matters had been agreed and a final joint minute would be provided. I was also given sight of the productions upon which the parties sought to rely. It was clear that a

considerable amount of preparation had taken place in advance of the preliminary hearing and this enabled me to consider matters fully and focus the scope of the inquiry.

[5] At the first preliminary hearing the parties indicated that due to the extent of the matters agreed there would be no requirement to hear any oral testimony and that at the conclusion of the proceedings all parties would be inviting me to make formal findings only.

[6] Mindful of the inquisitorial nature of the proceedings I did consider that there were areas upon which I required further investigation and following the first preliminary hearing I issued a note of some further investigations which I wished to have carried out in advance of the full Inquiry. I continued the preliminary hearing to allow these investigations to be undertaken.

[7] When the case called again on 17 November 2020 the court was furnished with the further information requested and the matter was continued to the full Inquiry for the joint minute to be finalised. It was agreed that one day would be sufficient for the hearing as a number of witnesses would provide their evidence by way of affidavits and it was also considered that the hearing could otherwise be conducted using the WebEx platform to reduce the requirement for personal attendance at court.

[8] Prior to the full hearing I therefore had had the benefit of considering the lists of witnesses, the relevant witness statements and affidavits and the productions lodged by the parties including:

1) Intimation from Registrar

2) Post Mortem Examination Report

3) Toxicology Report

4) Death in custody folder

5) Medical records

6) Book of photographs

7) NHS – Local Adverse Event Review – "LAER"

8) SPS – Death in Prison Learning Audit review – "DIPLAR"

9) SPS – Management of an offender at risk due to any Substance Policy – MORS

10) Management of an offender at risk due to any substance (MORS) paperwork relating to 25 December 2018

11) Management of an offender at risk due to any substance (MORS) safety bundle

12 Medical Spot checks protocol

13) SPS and NHS medication checks protocol

14) "In-possession" Medication Contract

Labelled Productions

1) Disc containing calls made by the deceased between 8 February 2019 and 1 March 2019

2) CCTV footage from HMP Perth captured on 1 March 2019.

The evidence

i) KM

[9] The Crown led oral evidence from KM who was the prison officer first on the scene when the alarm was raised. He spoke to his police statement which had been lodged.

[10] In the course of his evidence he confirmed that he had been a prison officer for 12 years and that he had worked in C Hall before the deceased's death. He confirmed the deceased was a quiet man who caused no concerns whatsoever.

[11] He was aware that while in A Hall on remand the deceased had been subject to the Management of Offenders and Risk of a Substance Policy known as MORS but he had seen nothing in the deceased's demeanour to suggest he might have been abusing substances.

[12] On 1 March 2019 the cells had been secured at lock down (17.00 hours). He explained that on a Friday there are no work parties so the prisoners are locked up at 14.00 hours and then given a meal about 16.00 hours. They are locked up again just after 17.00 hours for the staff break and the cells are reopened at about 19.00hours for "open association". During that time security is maintained and the officers also make preparations for the shifts over the weekend.

[13] An officer is stationed in the landing and officers can see down both sides of the landing to ensure there are no issues. During that period between 19.00 hours and 20.00 hours there was no cause for concern about the deceased's presentation

whatsoever. If there had been a concern a nurse would have been contacted to assess the deceased. The witness confirmed that there are nurses available at that time.

[14] On cross examination on behalf of the SPS Mr M confirmed that there are about 655 prisoners in HMP Perth as at today's date. The witness was aware that the majority received some sort of medication. He was also asked in cross examination about random cell searches. He confirmed that such a search would take about half an hour to 45 minutes in relation to a single cell. A double cell would take longer. It would depend on the number of items which the prisoner had in the cell. It was clear that this had potential to be a resource intensive process.

[15] In the event of a nurse being required to attend as a result of concerns over drug misuse the MORS process would be triggered.

[16] The witness was clear that the key responsibility of a prison officer is prisoner safety which is at the forefront of the officer's mind throughout their shifts. Mr M was aware that transfers of illicit substances took place within the prison and accordingly officers would be looking out for evidence of such transfers on a daily basis. He explained that there are means by which they can counter such activity by way of cell search, intelligence entries and MORS if it is suspected that a prisoner is under the influence of any such substance.

[17] In addition affidavit evidence was provided by the following witnesses :-

ii) Staff Nurse EH

[18] This witness has been a staff nurse since 2010 and has worked in NHS Tayside for 5 years. At the time of the deceased's death she had been working in the prison for about 4 years and on 1 March 2019 had started her shift at 07.00 hours administering medication to prisoners. At some point between 07.30 and 08.30hours she administered prescribed methadone to the deceased. She explained the procedures for providing methadone and underlined that if the patient presented as being under the influence of substances the methadone would be withheld and a spot check would be carried out. If so required the patient would then be placed on MORS or Management of Offenders and Risk of a Substance Policy.

[19] That was her only interaction with the deceased until the alarm was raised between 20.05-20.10 hours that day. On attending at the deceased's cell she observed the deceased lying on his back with a great deal of vomit on his face. She could see that he was choking. She turned him onto his side and he continued to vomit but was still breathing at that point. In accordance with procedure she radioed a "Code Blue". She continued to rub the deceased's back to encourage him to vomit and clear his airways but despite this he went into cardiac arrest. Other officers attended and CPR was commenced. An AED was applied by her colleague MH. The ambulance arrived within minutes and is recorded as being there by 20.20 hours. Despite the defibrillator being in place the machine would not allow it to administer a shock. The machine cannot be overridden.

[20] Paramedics continued to work on the deceased who at this time had been removed from his cell to afford more space however the deceased could not be revived and death was declared.

[21] A check of the deceased's medical records confirmed that he had received his weekly medication from the pharmacy on the morning of 1 March 2019. She was aware that there had been concerns about the deceased consuming illicit drugs but the records indicated this had been in December 2018. She also noted that after the reclassification of pregabalin in April 2019 patients who were prescribed this drug on an ongoing basis required to be supervised and would not have it in their possession but at the time of the deceased's death that change had not been implemented.

iii) Dr HB

[22] This witness is a pathologist at the Centre for Forensic and Legal Medicine at the University of Dundee having held that post for 12 years. She undertook the post mortem examination of the deceased and spoke to the content and findings in her report. She had also had sight of the toxicology report. Following my initial note after the preliminary hearing I had asked the Crown to seek clarification as to the extent the Atherosclerotic Coronary Artery Disease contributed to the deceased's death.

[23] In response this witness indicated that the deceased might not have had any awareness that he had underlying heart disease although he could have experienced tightening or pain on exertion. She indicated that it is possible that the level of heart disease present could have lowered the threshold for cardiac arrhythmia and cardiac

arrest but she could not be more precise about the impact. She stated that it was impossible to say whether the narrowing of the deceased's arteries had contributed to his death.

[24] She had considered whether there was anything within the post mortem findings which could explain whether the deceased's death was accidental or deliberate but was unable to offer any opinion. Accordingly this witness was not really able to say anything of assistance beyond what was in her post mortem report.

iv) Detective Constable JS

[25] This witness has been a serving police officer for 28 years and has a secondary role as a Crime Scene Manager. On 1 March 2019 he attended HMP Perth in that capacity to investigate the death of the deceased. Scenes of Crime officer SM photographed the deceased's cell. He drew attention to one photograph (28) which showed the bin and a quantity of empty medication packs. In addition he found an empty black vaping machine, rolled up paper, written notes and rolled up blue material which prison staff believed to be a "swing cord" which is used to move illegal contraband between cell windows. These productions and labels were photographed and produced. Their provenance was agreed in the joint minute.

v) Senior Nurse DW

[26] This witness is the Senior Nurse, Justice Healthcare and she has been in that role for 8 months, having been employed by NHS Tayside at HMP Perth for 6 years. She

qualified as a Registered Nurse in 1996. Her general duties as Senior Nurse, Justice Healthcare, involve line management and professional leadership of the Nursing and Allied Health Professionals across NHS Tayside Prison Healthcare and Custody & Forensic Healthcare Services. She does not deliver direct patient care as part of her role.

[27] She explained that Prison Healthcare use a computerised medical records system called Vision. People, on admission to prison, are asked by a nurse to sign an In-possession Medication Contract. On 8 November 2018 it is recorded that the deceased completed such a form. Once completed the contract should be placed in a tray for the administrative staff to be scanned and a copy saved on the Docman records. Unfortunately the witness could not see a scanned copy in Docman for the deceased, and could only assume it was completed.

[28] The purpose of getting the patient to sign the In-possession Medication Contract is to inform them of what is expected of them to take their medication as prescribed, on how to store their medication and to make them aware that if they do not comply then their prescription will be reviewed and potentially their medication could be changed or discontinued. The In-possession Medication Contract also makes the prisoner aware that medication checks may be carried out.

[29] She went on to explain that a patient can decline to sign an In-possession Medication Contract. If a contract is not completed the patient can still be prescribed medication to have in possession, as this is a clinical decision made by the prescriber. The prisoner could still be subject to medication checks. From this perspective it would not matter that a contract had not been signed.

[30] The witness could not recall when the medication check procedures were first introduced, but they have been in place in HMP Perth for many years. The decision on whether a medication check is to be carried out on a patient is a matter for the Scottish Prison Service (SPS) staff. SPS staff send requests for medication checks to the health centre. A medication check is separate from cell searches. Only SPS staff can carry out a cell search. When a medication check is carried out, the role of the NHS nursing staff at that time is only to carry out a cross check of the medication produced by the patient, against what is recorded on the patient's drug Kardex. The patient can refuse to produce their medication when asked. The results of the medication check would be recorded on the Vision record as a pass or fail, and if the patient had refused to cooperate this would be recorded as a fail. This process is described in Crown Production 13.

[31] There are no entries in the Vision record (Crown Production 5, Pages 145-149) that relate to a medication check in respect of the deceased. It therefore seems that during the deceased's time in HMP Perth the SPS did not request a medication check on him.

[32] The witness also explained that the purpose of the SPS Management of an Offender at Risk due to any Substance (MORS) policy (Crown Production 9) is to ensure the safety of a person in prison who is observed to be under the influence of a substance. MORS can be instigated by anyone who has concerns which includes nurses or prison officers. It would normally be instigated by SPS staff as they have more interaction with

inmates. The MORS policy is used as a short term measure and usually no longer than a couple of days.

[33] The witness continued to say that it is the expectation of the service that when an individual is placed on MORS, the SPS will advise the nurse of this. The nurse would then assess the patient to determine whether they are under the influence of a substance, whether any intervention or treatment is required, and the frequency of observations that are necessary to monitor the individual for signs of deterioration. These visual and verbal observations are carried out by SPS staff.

[34] A nurse would then review the patient after 24 hours to determine whether they need to remain on MORS or are safe to be removed from MORS. When the patient is taken off MORS Policy, they are discussed at a Substance Misuse Allocations Meeting, which is a meeting of the Substance Misuse Team. The patient would then either see their allocated Substance Misuse Nurse, if they were on opiate substitution therapy (OST), or a Case Worker to see if they will engage with the Substance Misuse Team. This was the procedure at the time of the deceased being in HMP Perth and is still the procedure. Decisions are made from there as to further appropriate management, for example if it was felt to be necessary the patient could be referred to the weekly Multidisciplinary Team (MDT) meeting for a review of their medication.

[35] The MORS policy is a reactive policy to deal with a situation where someone is found to be under the influence of drugs. It is not a proactive policy to prevent substance misuse. The proactive management of patients who misuse drugs is through

the Substance Misuse Team. Patients can self-refer to the Substance Misuse Team, or a referral can be made by any healthcare practitioner.

[36] The deceased had engaged with the Substance Misuse Team. The records clearly show that the deceased was placed on MORS on 25 December 2018 and then removed from MORS on 26 December 2018. He was reviewed by the Substance Misuse Team on 7 January 2019, when he was seen by a Substance Misuse Nurse, and also on 24 January 2019, when he was seen by a Consultant Psychiatrist (Crown Production 5, Page 145).

[37] This witness was also able to discuss and explain the operation of the procedures which SPS have in place to manage the risk of suicide or self-harm. She described in detail the Talk to Me (TTM) procedures. On admission to prison all people are assessed for the need for TTM. The initial TTM booklet would be completed on admission and that record is held by the SPS.

[38] The Vision record disclosed that on 8 November 2018 that the deceased had no thoughts of self-harm and there was no apparent risk of suicide (Crown Production 5, Page 145). It is the expectation of the service that if there were any concerns about an individual being at risk of suicide Talk to Me procedures would be implemented and as no entry to this effect has been made in the records it would appear there were no concerns. At the time of the deceased's death no health care referrals for mental health intervention had been received by the service.

[39] At some point in 2019, the healthcare team implemented a checklist to support managing patients on MORS (Crown Production 11). This amendment introduced a medication check to be carried for those managed on MORS, where feasible. If a

medication check is completed then the patient would be referred to the weekly MDT Meeting, which is chaired by a prescriber, for a review of their medication. This is in addition to being reviewed by the Substance Misuse Team as described above.

[40] The witness made clear that it is common for people in prison to misuse prescription medications and illicit substances. That is why the SPS have devised the MORS policy. In addition there is the Joint Medication Check procedure. The healthcare team have invested in the Substance Misuse Team resource within Prison Healthcare to counter what is a known problem.

[41] The medication and the frequency that it is to be provided to people in prison is a clinical decision made by a prescriber, such as one of the doctors, who will have access to the full Vision record. None of the nursing staff are prescribers.

[42] She confirmed the evidence of Nurse EH that pregabalin was reclassified as a Schedule 3 controlled drug on 1 April 2019. This meant that all patients who remained on pregabalin or gabapentin after this date went onto supervised administration.

[43] I found this witness's evidence to be particularly helpful in explaining both the MORS policy and the TTM policy and how they were applied in this case.

vi) Prison Officer ER

[44] This witness spoke to his role as a residential prison officer whose day to day responsibility was to ensure that the prisoner's needs were met and to ensure prisoner safety.

[45] He explained that the deceased was a quiet individual who had only been on the landing for 3 or 4 weeks before his death. He explained that, in common with a number of prisoners, the deceased was not someone who liked to engage with the prison staff and he respected that. However the deceased appeared to have interacted with other inmates and appeared to have settled in. He was not aware of any issues such as bullying and the deceased did not appear in any way anxious. He had given the prison staff no cause for concern and thus there was a degree of shock when he had died.

vii) Prison Officer KS

[46] This officer also provided a full affidavit outlining his role in the hall and his interactions with the deceased. Again he described him as new to the hall and a very quiet man who liked to keep himself to himself. He indicated that it could be daunting moving to C Hall as it was much larger than A Hall where the deceased would have been on remand but he saw nothing to indicate any anxiety. He was sure that in his role as a residential officer he would have picked up any issues of concern and described how these could have been addressed if they had been brought to the attention of prison staff. So far as this witness was concerned there was nothing of that nature affecting the deceased and he too was shocked that the deceased had passed away.

viii) Deputy Governor (Acting) RWC

[47] The SPS lodged and relied upon a helpful affidavit from the acting deputy governor of HMP Perth. This witness has been working with the Scottish Prison Service

(SPS) for almost 28 years. He started as a residential officer in January 1993. He has been in his current role for around two months having held a number of senior management roles within SPS.

[48] In his current role he is in charge of all residential halls, the Segregation and Reintegration Unit (SRU) and the OLR (Order of Lifelong Restriction) prisoners. He also assists the Governor with all aspects of the day-to-day running of HMP Perth.

[49] He had no direct involvement with the deceased but was able to speak to the policies and procedures operated by SPS. His evidence was approached in chapters which I found particularly helpful.

Prescription medication

[50] In relation to prescription medication he explained that the NHS are responsible for prescribing medication to prisoners. Medication can be prescribed on an "in possession" or "supervised" basis. If "in possession", the prisoner is provided with a week's supply of their prescribed medication once a week. They are trusted and responsible for taking it as directed and storing it appropriately. All cells have a medication safe for prisoners to store their medication. If they do not store it in their safe, they should keep it on their person. If the prisoner receives their medication on a "supervised" basis, they are brought to the NHS dispensary by SPS officers as and when required. They then consume the drugs under the supervision of the healthcare staff. This would be done in accordance with Governors & Managers: ACTION (GMA) *"010A/15 – Witnessing the Administration of a Controlled Drug"* (SPS Production 2) and

HMP Perth's Standard Operating Procedure (SoP) *"PM003(b) – Issuing of Medication"* (SPS Production 5).

[51] The healthcare staff decide whether a prisoner receives their medication on an "in possession "or "supervised" basis. This decision is made by the healthcare staff. The SPS do not make this decision nor would they be aware, due to reasons of patient confidentiality, what medication each prisoner is prescribed.

[52] At the time of the deceased's death, a large number of prisoners received medication "in possession". However, as has been made clear by other witnesses on or around April 2019, there was a reclassification exercise involving certain medications. This meant that some medications were no longer allowed to be prescribed "in possession" and required to be "supervised". This included medication such as pregabalin and gabapentin.

[53] Paracetamol and antacids can be given out by officers. The reason being that these are medications which are available over the counter in the community. This should be done by officers in accordance with GMA "*032A/18 – Policy on Issuing of Paracetamol & Antacid Tablets to Prisoners by Operational Staff*" (SPS Production 1)

Measures for monitoring consumption and circulation of prescribed medication

Spot checks

[54] The SPS take a number of steps to monitor the consumption and circulation of prescribed medication with the establishment. This includes medication spot checks which are carried out within each hall each week. Around 10 individuals are spot

checked per week on the smaller halls. More are carried out on the bigger halls such as C Hall. The spot checks are usually targeted and intelligence led. If any concerns are noticed, officers or nurses can identify individuals whose medication should be spot checked. For example, if they suspect an individual was stealing medication or selling it they can arrange for his cell to be searched.

[55] This witness explained that the spot checks are carried out jointly by the SPS and NHS. The SPS facilitate the opening etc. of the cell and the nurse would check the medication found in the cell against the prisoner's prescription. The SPS do not have access to prisoners' medical records and therefore NHS staff are required to carry out the spot checks. This evidence was in slight contrast to the evidence of DW who did not seem to consider that the NHS had a role to play in the spot checks.

[56] If a prisoner fails the medication spot check (i.e. they do not have all of their prescription), they will be subject to a medication review by the NHS. This will be to ensure the prisoner actually requires the medication he has been prescribed. The SPS have no involvement in this process. They may also be placed on a Governor's Report by the SPS.

[57] The witness had checked the available records and confirmed that the deceased did not feature within the medication spot check database. This means he was not subjected to a medication spot check during his time at HMP Perth. However, the witness made reference to the incident from 25 December 2018 where the deceased was found under the influence and nursing staff attended (Crown Production 4, page 107).

At this point, it was suspected that he had consumed his weekly prescription medication as a check was carried out and he had none of his weekly medications on his possession.

Cell searches

[58] As part of the measures to counteract misuse of drugs in the prison the SPS carry out cell searches. These are carried out in three ways: (1) randomly; (2) intelligence focussed; and (3) at changeover.

[59] Firstly, all cells are randomly searched at least once every quarter. This is done by the FLM in each hall giving the residential officers a searching sheet – usually handed out on a Sunday. The staff then search the cells noted, fill in the search sheets, record any findings on PR2 (the SPS Prisoner Records system) and then return the sheets to their FLM. The FLM is responsible for allocating the cells for searching to ensure the quarterly quotas are met.

[60] Records to which this witness spoke confirmed that the deceased's cells were subject to random searches on 5 December 2018 (Cell 1/04, A Hall) and 22 February 2019 (Cell 3/03, C Hall). No illicit items were found during either search.

[61] Secondly, cell searches may be intelligence focussed. If the Intelligence Unit receives information that a cell requires to be searched then this will be done. For example, a member of staff may raise a concern that a prisoner is stockpiling prescribed medication or one prisoner may make an officer aware that another prisoner is in possession of an illicit item.

[62] Finally, cells are searched and cleaned every time a prisoner is moved from a cell (prior to the new occupant being assigned).

[63] When a cell search is carried out, this should be done in accordance with HMP Perth's SoP *"PM011 – Routine Cell Searches"* (SPS Production 6). Everything that is in the cell would be searched including the prisoner. The medication safe would also be checked to ensure there are no prescribed medications which do not belong to the prisoner. All prescribed medications will be in a clear bag and have a label with the prisoner's details – a label similar to those on prescriptions in the community. If any prescribed medication is not identified as the occupant's, it will be removed and the NHS will be asked to check whether this medication is included within that prisoner's prescription. The NHS can only provide a yes or no answer as they cannot provide any further detail due to reasons of patient confidentiality.

[64] A prisoner will also be searched during the cell search. This should be done in accordance with HMP Perth's SoP *"OPS 302 – Searching Prisoners"* (SPS Production 7).

[65] If a prisoner fails a cell search, he may be placed on a Governor's Report If a prisoner is found to have an excess of prescribed medication, the NHS are informed and they carry out a medication review.

Prescription medication consumed by the deceased and the toxicology report

[66] Addressing the issue of prescription medication found in the deceased's system this witness was asked which substances had a prison currency value and confirmed

that both pregabalin and amitriptyline could be used as currency. Other witnesses provided more specialist evidence in this regard.

Management of an Offender at Risk due to any Substance (MORS)

[67] Finally turning to the Management of an Offender at Risk due to any Substance (MORS) the witness explained that MORS provides staff with guidance on how to manage someone who is either suspected of: (1) being under the influence of a substance; (2) ingesting a package containing a substance; or (3) internally secreting a package contained a substance. A substance could be an illicit drug, new psychoactive substance, prescribed medication, alcohol or chemical. A copy of the MORS Policy and Guidance is lodged as SPS Production Number 4.

[68] If an officer suspects a prisoner is under the influence, has ingested or internally secreted a substance, they should initiate the MORS policy. This involves the officer filling out some questions and a healthcare clinical assessment taking place. The healthcare professional will then decide the care plan – for example, the type (visual/ verbal)/ frequency of observations and whether the prisoner should be placed in a safer cell. The officers will then carry out the observations.

[69] If there is a change, the prisoner officer should immediately alert the healthcare professional who will come and reassess the prisoner. The healthcare professional will then decide what action to take. This may include, for example, changing the type or frequency of observations or arranging for a transfer to hospital.

[70] If an officer finds a prisoner unresponsive he would initiate a Code Blue radio call. A Code Blue is a radio call for immediate assistance for a medical emergency. During working hours, the healthcare team would attend with emergency equipment (e.g. oxygen, defibrillator, etc.).

[71] A person will only be on MORS for around 24-48 hours. This is because the effects of the substance will likely have worn off by this point. However, if there is a suspicion that they are internally secreting the substances, they may remain on MORS for slightly longer as they may have been able to top up.

[72] On being specifically questioned as to why the deceased was not on MORS at the time of his death given the previous known incidents of drug use on 6 and 25 December 2018 he said that a prisoner would not remain on MORS for a number of months simply due to previous drug use. It is a short term process to manage the immediate risk whilst the prisoner is under the influence. When the effects wear off, they are removed from the process.

Additional drug prevention measures

[73] Finally the witness explained that there are a whole range of further drug prevention measures to assist SPS in dealing with illicit substances. These cover every aspect of the prison regime from the external walls, searching of incoming deliveries and mail to searching of visitors. However, the focus of these measures are the prevention of illicit substances coming in from outside the prison rather than prescribed medication.

[74] He added that HMP Perth is the only prison in Scotland that has a Recovery Hub which is run in partnership with the NHS addictions team. The Recovery Hub is a place where prisoners can go to try and find alternative ways to deal with their addiction issues.

Bullying

[75] Turning to the issue of alleged bullying the witness said the SPS hold no information or intelligence to suggest that the deceased was being bullied whilst at HMP Perth.

[76] If a prisoner is suspected of being bullied, there are various measures which can be deployed including putting them on protection, relocating the prisoners involved or taking action against the bullies. Staff are also aware if prisoners have previously been bullied due to markers (i.e. notices) which are clearly displayed on the PR2 system. These markers will encourage officers to speak with certain prisoners or keep an eye on them.

[77] The system relies on ingathering intelligence about bullying activity. This may come from a member of staff, be reported by another prisoner or identified in some other way. Bullying is something the officers will look out for. If a prisoner is placed on protection, they are kept separate from the offenders and appropriately protected. Markers can also be placed on PR2 noting that certain prisoners are "enemies" or "must be separate". This ensures the identified prisoners do not mix with each other.

[78] Finally, the SPS also directly target bullies. There is a "Think Twice" policy in place which means they can be brought in, spoken to and punished if they are found to be bullying other inmates. This is designed to discourage bullying. This policy is lodged as SPS production 8.

[79] Again I found this evidence to be helpful both in explaining the detail of the polices which are in existence and the application of the policies in the case of the deceased.

Joint Minute of Agreement

[80] In addition to the oral and affidavit evidence I was also furnished with a very extensive joint minute of agreement as a result of which I was able to make the majority of the findings upon which my final determination is based.

[81] Mark Robertson Stephen ("the deceased") was born on 28 August 1981.

[82] The deceased's death occurred within Cell 3/03, C Hall, HMP Perth, 3 Edinburgh Road, Perth on 1 March 2019 at 20.46 hours.

[83] At the time of his death, the deceased was an inmate at HMP Perth, 3 Edinburgh Road, Perth where he occupied a single cell on the third floor/flat of C Hall.

[84] On 1 October 2018 the deceased was remanded in custody and accommodated at HMP Grampian.

[85] On 3 October 2018 at 12.00 hours the deceased was found lying on the pantry floor at HMP Grampian, appearing concussed with a 2cm cut to his forehead, consistent

with his head having struck a cabinet with force. Nurses cleaned and dressed said wound applying 6-7 steri-strips. The identified assailant was placed on a "Rule 95(1)". These are the powers which the Scottish Government give to SPS to restrict the rights of prisoners in certain ways. It is otherwise referred to as a Governor's report. The deceased could not recall how his injury was sustained. Motivation for the attack appeared to the SPS to be linked to pending Court proceedings. Whilst en-route to Aberdeen Royal Infirmary for medical assessment, a weapon was found in the foot well close to the deceased who was placed on report. Crown Production number 4 pages 107 and 108 provides detail of both events. Notes of the medical treatment provided by nursing staff at HMP Grampian are detailed in Crown Production Number 5 page 146.

[86] On 9 October 2018 at around 1530 hours, whilst accommodated at HMP Grampian, the deceased was observed to have fresh injuries consistent with being assaulted. A CCTV review showed that the injuries were sustained within another inmate's cell between 14.48 and 14.53 hours same date. The deceased was assessed by medical staff but did not require any treatment. Intelligence entries relating to these incidents are detailed in Crown Production number 4 page 106.

[87] The deceased was placed on protection from 12 October 2018 to the date of his transfer out of HMP Grampian (8 November 2018). A protection prisoner's regime is restricted for their own safety. For example, they would have separate times for their daily exercise, telephone access and their meals would be brought to their cells.

[88] On 8 November 2018 the deceased was transferred from HMP Grampian to HMP Perth where he was initially accommodated in B Hall whilst on remand.

[89] On 13, 18 and 20 December 2018, 8 February 2019 and 16 February 2019 the deceased self-referred requesting a GP appointment for pain in his foot and ankle. On 21 February 2019 the deceased had a consultation with Dr Wallace, this related to ongoing difficulties with his left ankle and foot. A referral was sent to the Orthopaedic Department of Perth Royal Infirmary and the deceased was marked as not fit for work and the relevant form was completed. The entries relating to these self-referral requests and consultations are detailed in Crown Production number 5 pages 145 and 146.

[90] On 21 January 2019 the deceased was sentenced at the High Court of Justiciary to 6 years imprisonment. Said sentence was imposed in relation to assault to severe injury, permanent disfigurement, danger of life, attempted murder and intent to rob and a further charge of attempting to defeat the ends of justice. Crown Production number 4 is the death in custody folder pertaining to the deceased produced by SPS staff. Page 68 of that production is the copy Warrant relating to this sentence.

[91] Following his appearance in court for sentencing, the deceased was returned to HMP Perth to serve his sentence. He arrived at the reception area of said establishment on 21 January 2019 at 20.10 hours. Crown Production number 4 page 96 shows the arrival time at HMP Perth. As he was now serving a sentence, the deceased was moved to Cell 3/03 of C Hall on that date.

[92] As part of the standard admissions process, all prisoners are assessed by a Reception Officer and a nurse under the 'Talk to Me' strategy. 'Talk to Me' is the Scottish Prison Service's suicide prevention policy. The role of the Reception Officer is to book in a prisoner and carry out an initial interview before the prisoner meets with

the nursing staff. The initial interview usually lasts around 10 minutes and covers any issues the prisoner may have, for example mental health and self-harming issues. The nurse then separately assesses the prisoner to determine whether she has any concerns that they may harm themselves. In both instances, account will be taken of the prisoner's history and how they are presenting at the time. If either the Reception Officer or nurse have any concerns, they can mark the prisoner as "At Risk" and an appropriate care plan is put in place (e.g. placed under observations/in an anti-ligature cell/in anti-ligature clothing). If they have no concerns, the prisoner would be marked as "No Apparent Risk".

[93] On 21 January 2019 at 20.10 hours, the deceased was seen by Reception Officer IC. The said officer entered the standard descriptive details of the deceased onto the system. He then carried out a 'Talk to Me' assessment and noted that the deceased "presented well- good eye contact- a little apprehensive about going to C Hall. No thoughts of self-harm at this time" and assessed him as "No Apparent Risk". Crown Production number 4 pages 96 and 97 is a record of the assessment by Officer IC.

[94] At 20.50 hours on 21 January 2019, the deceased was seen by Nurse GB. Page 98 of Crown Production number 4 contains a record of the healthcare risk assessment carried out by Nurse B. During said assessment the deceased would have been asked a number of questions about his physical and mental health; the VISION notes recorded during said assessment are detailed in Crown Production number 5 page 145. The deceased was assessed as no apparent risk.

[95] On 6 December 2018 and 25 December 2018, the deceased was thought to be

under the influence of some substance. Crown Production 4 page 130 details the Governor's reports and findings. Further entries relating to said incidents are detailed in Crown Production number 4 page 107. HMP Perth did not retain the MORS documentation from 6 December 2018.

[96] On 25 December 2018, Nurse F was called to deceased's cell following concerns raised by prison staff. Deceased was found slumped in a chair unable to be roused, slurred speech, bloodshot eyes. He was not in possession of his dispensed medication but refused to be examined. A treatment refusal form was completed and he was placed on SPS Management of an Offender at Risk due to any Substance (MORS) policy with 30 minute observations. Crown Production number 10 is the MORS paperwork completed by NHS and SPS staff whilst the deceased was considered at risk.

[97] Crown Label number 1 is a copy of telephone calls made by the deceased to his fiancé between 8 February 2019 and 14 February 2019. Crown Production number 4 page 104 is a list of said calls and shows the date and duration of each call.

[98] SS is a Pharmacy Assistant based at HMP Perth. She had previously dispensed medication to the deceased. On Friday 1 March 2019 at around 09.30 hours she dispensed weekly medication to the deceased. At that time, he was given the following medication:

- 7 Lodine SR 600 mg tablets (anti-inflammatory), one to be taken daily.
- 42 Nefopam 30mg tablets (pain killer), 2 tablets to be taken 3 times a day,
- 14 Pregabalin 300mgs (pain killer), one tablet twice a day.
- A prescribed daily dose of 65mls of Methadone issued daily had been

administered at an earlier point.

Prisoners' prescriptions are prepared at Lloyds Pharmacy offsite, then delivered to HMP Perth and handed out by Pharmacy staff. For this reason, the stickered dates can be different to the date they are handed out.

[99] Crown Production number 5 pages 138 to 142 is the Kardex relating to the deceased providing details of his prescribed medication and the date dispensed. At the time of his death the deceased was not prescribed Amitriptyline. Paracetamol can be given to prisoners by Prison Staff; the deceased was not prescribed paracetamol at the time of his death. Prison staff keep a record of any paracetamol which is dispensed. However, given the passage of time, the SPS no longer has any record of whether the deceased was provided paracetamol prior to his death.

[100] On 1 March 2019 the deceased was seen by AM, an inmate at lunchtime. During evening recreation time he socialised with the deceased and other prisoners around the pool table. He did not notice anything unusual about the deceased's presentation. At approximately 19.45 hours the deceased left to make a cup of tea in his cell and he did not see the deceased again.

[101] FW is an inmate who occupied the cell next to the deceased. He did not know the deceased well as he spent a lot of time in his cell but would say hello to him in passing. He reported never seeing the deceased under the influence of any substance. At about 20.00 hours on 1 March 2019 FW returned to his cell to tidy and mop. Once finished he entered the deceased's cell to offer him the mop and found the deceased lying on his bed with his head closest to the door, partially slumped off the bed and

believed something was wrong. He saw vomit and mucus on the deceased's face and heard him making a deep snoring noise, he immediately shouted to SM to help as he was close by. The deceased was moved onto his side as he appeared to be choking.

[102] On 1 March 2019 around 20.00 hours SM, an inmate, was speaking to other prisoners when he saw FW mopping his cell. He heard FW call for help from cell 3/03 and went there immediately where he found FW trying to move the deceased who was lying fully clothed, on his back in bed, onto his side. He could see that the deceased had vomit or white foam on his face and was gasping for air. He shouted to the nearby prison officers for help who responded immediately.

[103] The Scottish Ambulance Service responded to an emergency call with the first ambulance arriving at HMP Perth at 20.20 hours on 1 March 2019. During efforts to resuscitate the deceased he was given naloxone (antidotal narcotic) and adrenaline, CPR was continued but life saving measures were unsuccessful and life was pronounced extinct at 20.46 hours on 1 March 2019.

[104] AL has been a paramedic with the Scottish Ambulance Service for 20 years. On 1 March 2019 he answered an emergency call arriving at HMP Perth at 20.25 hours, he was informed by Nursing staff that the deceased had been found choking or vomiting when nursing staff first attended however at some point he had suffered a cardiac arrest, approximately 5 minutes before his arrival and a defibrillator machine indicated that there was no shockable rhythm. The deceased was moved outside the cell to create space to work on him whilst CPR continued. The deceased was unconscious and in cardiac arrest, the LUCAS (mechanical chest compression device) was attached which

took over the chest compressions and allowed those present to focus on ventilation. Maintaining the deceased's airway was difficult due to the presence of vomit, an i-gel had been inserted into the deceased's throat but this was removed and an endotracheal tube inserted. There was a lot of vomit which required suctioning on numerous occasions. During CPR, the endotracheal tube became displaced. After 20 minutes the deceased being asystole throughout, without being able to contain the airway a decision was taken to stop and life was pronounced extinct at 20.46 hours.

[105] Crown Production number 4 pages 107 and 108 are a record of intelligence entries received and created in respect of the deceased.

[106] Had the deceased been suspected of being under the influence of illegal substances at any point other than 6 and 25 December 2018, any member of staff who was in contact with him could have placed him on the SPS Management of an Offender at Risk due to any Substance (MORS) policy. The healthcare staff would then have put an appropriate care plan in place (e.g. observations). Crown Production number 9 is GMA079A/14 - Management of an Offender at Risk due to any Substance (MORS) - Policy and Guidance.

[107] On 1 March 2019, CCTV footage from 1 March 2019 was reviewed by CJ, Detective Constable of the Police Service of Scotland and was found to have captured the following:

- At approximately 17.30 hours, officers KM and MS lock all prisoners within their cells.
- At approximately 18.50 hours, officers KM and MS unlock all the cells

and prisoners begin to emerge into the hall area.

- At approximately 19.02 hours, the deceased is seen walking out of his cell and up to the pool table at the top of the hall. He can be seen drinking from a mug and puffs of smoke come from his mouth indicating he was vaping. He speaks to other prisoners near the pool table, namely RC, MO'R, KMcN, AM and BY. The deceased does not appear to be under the influence of any substance. The deceased leans against one of the cell doors near the pool table and talks to someone within for a short time.
- At approximately 19.24 hours, deceased walks back to his cell and goes inside.
- At approximately 19.45 hours, KS approaches the deceased's cell, appears to glance within then walks away.
- At approximately 20.07 hours, FW enters the deceased's cell (C3/03) and emerges seconds later. He signals to SM and both enter the cell, they emerge seconds later. SM raises his hands towards the officer's station and appears to be shouting. Seconds later residential officers KS and ER enter the cell. Residential officers MS and KM then enter the cell along with nurse, EH.

[108] Crown Production number 1 is the Intimation of Death from the Registrar, dated 7 March 2019.

[109] Crown Production number 6 is a book of 27 photographs taken on 1 March 2019 at HMP Perth, Edinburgh Road, Perth.

[110] On 1 March 2019, the deceased's cell was searched and the following items were

recovered by Officers of the Police Service of Scotland: From the bin :- A quantity of prescribed medication – empty packets, all in the deceased's name; Nefopam 30mg; Lodine SR 600mg, paperwork prescribing these drugs to the deceased. The following empty blister packets: Sumatriptan 50mg, blister packet was empty (capable of containing 6 tablets) Nefopam Hydrochloride 30mg, blister packet was empty (capable of containing 30 tablets) Paracetamol, blister packet was empty (capable of containing 2 tablets) Amitriptyline 25mg, blister packet was empty (capable of containing 14 tablets) Lodine 600mg, blister packet was empty (capable of containing 8 tablets) Nefopam 30mg, blister packet was empty (capable of containing 50 tablets) Pregabalin 300mg, blister packet contained 1 tablet, the remaining 10/11 compartments were empty. This was the only tablet found within the cell.

[111] The following labelled productions were also recovered :-rolled up paper, written notes (telephone numbers), rolled up material which prison staff believe is used to move illegal contraband between cell windows known as a "swing cord", a black and a silver vapour machine, and a vapour capsule. Some of the recovered items are shown in the book of photographs (Crown Production number 6).

[112] On 2 March 2019 whilst Police officers noted a statement from the deceased's sister JR she stated that the deceased had access to drugs within prison as he told her on several occasions that he was "scoring drugs."

[113] Crown Production number 2 is a Post Mortem Examination Report containing the findings of a post mortem examination of the deceased which was carried out on 5 March 2019 by Doctors HB and DS. The deceased's cause of death was established as

Part I (a) Prescription Medication Toxicity with Agonal Aspiration of Vomitus. Part II Atherosclerotic Coronary Artery Disease.

[114] Crown Production number 3 is a Toxicology Report which contains the findings following analysis of samples of the deceased's blood, which were taken on 5 March 2019 during said post mortem examination. Methadone, Nefopam, Pregabalin, Paracetamol and Amitriptyline were present in said samples.

[115] I have had sight of Crown Production number 4, the Death in Custody Folder prepared by the SPS. Crown Production number 5 is the medical records kept by NHS Tayside pertaining to the deceased. Parties have agreed that the contents of these are true and accurate.

[116] After any death in custody reviews are carried out by SPS and NHS. Crown Production number 8 is the Death in Prison Learning Audit review carried out by SPS referred to as a DIPLAR. Crown Production number 7 is the Local Adverse Event review carried out by Tayside Health Board referred to as a LAER.

[117] NHS Tayside do not have a written protocol to determine how medicine will be prescribed to inmates. A clinical decision is made by the prescriber who takes a number of factors into account such as whether the drug is a controlled drug; whether the patient is at risk from themselves or others; community practices; whether it is a drug of currency in prison; and whether it is clinically suitable for the patient. When making this decision the prescriber will have access to the VISION records for the patient which will include whether they have previously abused drugs and whether they have been on MORS.

[118] On 1 April 2019 Pregabalin was reclassified and all patients were reviewed to assess their clinical need and those who remained prescribed pregabalin were changed to supervised administration.

[119] On 21 February 2019, the deceased had a consultation with Dr MW. At that time the deceased did not request an increase in pain relief, but shortly after the consultation one of the prison nursing staff asked that the deceased's pain relief be reviewed. The deceased suffered from chronic pain in his left ankle and foot. The deceased's Nefopam was increased from one 30 mg tablet three times daily to two 30 mg tablets three times daily. The usual dose range for Nefopam is 30-90mg three times daily. Nefopam is not a medication that is generally abused in the prison population.

[120] Prescribed medication was subject to regular reviews and the date of review is recorded on the Kardex.

[121] NHS Tayside and the Scottish Prison Service have agreed a joint process to support safe and secure handling of medication within SPS establishments. Said process confirms that on entering the establishment offenders sign an In-possession Medication Contract accepting unannounced medication checks and details that their medication will be reviewed in the event of discrepancies. Crown Production number 13 is a copy of the Medication Checks Protocol dated January 2019 and includes an example of the said contract. The deceased completed an In-possession Medication Contract on 8 November 2018 as recorded in Crown Production number 5 at page 146.

[122] As at December 2018 when an individual was placed on MORS, they would be reviewed by the Substance Misuse Team if the individual is prepared to engage with

them. The deceased had engaged with the Substance Misuse Team and was reviewed by a Substance Misuse Nurse on 7 January 2019 and by Dr TE, Consultant Psychiatrist in Addictions, on 24 January 2019 (Crown Production number 5 at page 145). Consideration was given to the deceased's medication at the consultation with Dr TE (Crown production 18). At some point in 2019 the procedure was amended whereby an individual placed on MORS would also have a medication review in addition to being reviewed by the Substance Misuse Team. This amendment was not in place in December 2018. Crown Production number 11 is the MORS safety bundle checklist detailing said amended procedure.

[123] The SPS have lodged a number of policies and procedures relevant to the circumstances of this death. The contents of these policies were referred to by witnesses in their affidavits and in oral evidence. I had the benefit of considering these policies both in relation to their fitness for purpose and in relation to their application in relation to the deceased's death.

- SPS production 1 is Governors & Managers ACTION (GMA) "032A/18 – Policy on Issuing Paracetamol & Antacid Tablets to Prisoners by Operational Staff" dated 8 May 2018 SPS
- SPS Production 2 is GMA "001A/15 – Witnessing the Administration of a Controlled Drug" dated 5 March 2015 SPS
- SPS Production 4 is GMA *"079A/14 – Management of an Offender at Risk due to any Substance (MORS) – Policy and Guidance"* dated 30 December 2014
- SPS Production 5 is HMP Perth's Standard Operating Procedure (SoP)

"PM003(B) – Issuing of Medication"

- SPS Production 6 is HMP Perth's SoP *"PM011 – Routine Cell Searches"*
- SPS Production 7 is HMP Perth's SoP *"OPS 302 – Searching Prisoners"'*
- SPS Production 8 is *"Think Twice - Strategic Approach to Encouraging Respectful Behaviour in Prison"* dated April 2018.

[124] A GMA is a national SPS policy. Each establishment also puts in place its own SoPs (Standard Operating Procedure) specific to that establishment.

[125] SPS Production 9 is a Prisoner Record System (PR2) extract for the deceased relating to "Prisoner Search History". PR2 is the SPS' prisoner record's system. The extract confirms that the deceased's cells were randomly searched on 5 December 2018 (Cell 1/04, A Hall) and 22 February 2019 (Cell 3/03, C Hall). The extract states "N" under item found. This confirms that nothing unexpected was found during said searches.

Statement of Opinion of Detective Constable BY

[126] Crown Production number 19 is the statement of opinion of BY, Detective Constable, the Police Service of Scotland. Although it was not a formal affidavit it was agreed by parties that this should be treated as equivalent to the parole evidence of the officer.

[127] This witness is currently attached to the Statement of Opinion or STOP Unit and has 24 years' service as a police officer, 16 years of which were in covert operations in relation to the acquisition and distribution of drugs. He noted that he was currently involved in an ongoing project with SPS and Dundee University to collect and analyse

attributable drug recoveries from prison establishments in order to better understand the illicit drug market and identify new substances. In this role he liaises directly with prison staff to obtain up to date intelligence on current drug trends within the prison regime.

[128] He had been provided with the toxicology report in relation to the deceased and was asked to comment on the illicit drugs market within the prison regime. He made clear that the market in prison establishments operates in a similar manner as it does in the community with organised networks arranging methods of introducing the commodity into the prison and then controlling its distribution. Due to the unpredictable nature of drugs entering prison most dealers will supply whatever commodity they can obtain including drugs which would have limited value in the open market.

[129] Given the limits on availability and the risks associated with storing illicit substances within the prison environment the price of drugs increases dramatically and is often 3 to 5 times what would be paid outside the prison system. Information about pricing is intelligence led.

[130] While opiates are most sought after commodity in the prison all of the substances, with the exception of paracetamol, would have a potential prison value. The witness assessed that although Amitriptyline and Nefopam would not normally be recovered in the open market they would have a potential prison value of £3 per tablet.

[131] Pregabalin would have a value of about £6 to £9 per tablet and is commonly recovered in prisons. Similarly methadone is bought and sold in the open drugs market

for about £10 per 100 ml but given that it is an opioid it could have a prison value of £50 per 100 ml.

[132] Those in the prison system often will not have funds to finance this and may run up a drugs debt to a dealer or may require to make repayment by carrying out tasks for the dealer.

[133] The officer went on to confirm that the sharing of illicit prescribed drugs is common both in the community and the prison. He opined that giving drugs under supervision would greatly reduce the risk of particular drugs being sold on but accepted that this was logistically difficult.

[134] Finally and importantly he stated that in his experience most controlled drugs enter the prison system through clandestine means such as being thrown over the walls, coming in via mail or concealed by prisoners. Whilst he accepted that many prescribed drugs could be sold on those drugs do not account for a large part of the commodity within the prisons.

CCTV footage

[135] In the course of the hearing the Crown played part of the CCTV footage (Crown label 2) which clearly shows the deceased captured on a number of cameras within the prison. While the content of the footage was agreed in the joint minute I found it helpful to view as it allowed me to consider for myself whether the witnesses' assessment of the deceased's presentation in the hours and minutes immediately before his death were credible and reliable. I was satisfied that far from showing anything untoward in his

demeanour the deceased looks calm and relaxed at all times and appears to be interacting well with others playing pool not far from his cell door.

Submissions

[136] All parties have very helpfully prepared written submissions which they have now lodged. I am grateful to them for this assistance. The position of all parties was that I should make formal findings only and no specific recommendations but each party made submissions in relation to their respective positions.

The Crown

[137] The Crown commenced by offering condolences to the family and friends of the deceased.

[138] In terms of the legal framework it was submitted that this is a mandatory inquiry as set out by section 2(4)(a) of the 2016 Act as the deceased was in legal custody at the time of his death. It was submitted that the purpose of the Inquiry is to establish the circumstances of death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances.

[139] The Crown invited me to make formal findings in terms of section 26(2)(a) and (c) 2016 Act only and in relation to section 26(2)(b), (d), (f) and (g) to make no finding. I was also invited to find in terms of section 26(2)(e)(i) that there were no precautions which could reasonably have been taken which might realistically have avoided the deceased's death.

[140] The Crown submissions went on to focus on whether I should or could make findings about the source of the drugs. It was submitted that it was a matter of agreement that the deceased received methadone (supervised) and his "in possession" weekly medication on the morning of his death. His weekly medication contained Nefopam, Pregabalin and Lodine (Etodolac).

[141] Those representing Tayside Health Board and the SPS provided further information of the clinical decisions, reviews, processes and policies governing dispensing and possession of prescribed medication and the safeguarding searches and spot checks which were carried out in respect of the deceased. On examination of the available evidence there is nothing to suggest these were not properly applied in respect of deceased.

[142] In relation to the toxicology results it was submitted that although the methadone found on in the deceased's blood was higher than seen in methadone maintenance subjects and within the fatal range, it can redistribute in the body resulting in artificially elevated drug concentration. Methadone was and remains provided on a supervised basis only and it was submitted that it is therefore less likely that this could be shared with other prisoners and less likely that the deceased took more than he was prescribed.

[143] In relation to the level of Nefopam which was found in the deceased's system it was submitted that this was markedly in excess of the expected therapeutic range, although below the level seen in fatalities. However empty packaging was found in the deceased's cell.

[144] The level of Pregabalin was found to be in excess of the expected therapeutic range. Empty packaging was recovered along with a single Pregabalin tablet, this was the only tablet found in the deceased's cell, and all of his other weekly medication was gone. Pregabalin was reclassified a month after the deceased's death on 1 April 2019, (JM paragraph 38) – and is now only dispensed on a supervised basis.

[145] The level of Lodine (Etodolac) cannot be ascertained as the University of Glasgow does not have capacity to analyse for this substance. Nevertheless, empty packaging was recovered from the deceased's cell.

[146] The only substance found in the deceased's system which had not been prescribed to him was Amitriptyline. It has not been possible to establish where this was sourced from. The level of Amitriptyline was found to be markedly in excess of the expected therapeutic range.

[147] The statement of opinion from DC BY (production 19) confirms what is believed to be within judicial knowledge: "The sharing of prescribed drugs is commonplace on the illicit drug market and the prison is no different".

[148] Whilst it could be suggested that a precaution may be that all prescribed drugs should be dispensed on a supervised basis, such a precaution would not be reasonable or realistic as whilst it may reduce the risk of misusing these substances it would not eliminate it altogether, would undoubtedly be very labour intensive, and may result in a loss of competence in managing one's own medication once released. DC BY opines that prescribed drugs do not account for a large part of the commodity within the prisons.

Accordingly, it was submitted that all reasonable precautions were taken, and the Crown sought no findings in respect of subsection (e)(i) or (ii).

[149] Similarly, no defects in the policies and procedures were identified and no findings were sought in respect of subsection (f).

[150] In respect of any other facts which are relevant to the circumstances of the death, it was submitted that it was a matter of agreement in paragraph 15 of the joint minute that on 6 and 25 December 2018 the deceased was suspected of being under the influence of substances. On both occasions he was safely managed on the MORS policy. The Crown considered whether being found in this condition twice in a relatively short space of time should have triggered a review of how medication was dispensed. However further enquiries with Tayside Health Board confirmed that at some point in 2019 the process was altered so that a medication review now takes place automatically. This was agreed at paragraph 42 of the joint minute and this finding is based on the evidence of DW and accordingly, no findings were sought in this regard.

[151] The Crown did not seek a finding as to whether the death was accidental or a deliberate attempt by the deceased to end his life.

Tayside Health Board

[152] On behalf of the Tayside Health Board it was submitted that the Crown submissions should be adopted. The Health Board did not seek findings as to whether the deceased's death was accidental or deliberate. It was submitted that there was no evidence that he was at risk of suicide but it was clear he had a long history of substance

abuse. Whether this is sufficient to support a finding of accidental overdose it was submitted was a matter for the court. However, no submission was made in respect of sections 26(2)(b) and (d).

[153] In relation to sections 26(2)(e) and (f), it was submitted there is no evidence before the Inquiry which suggests that there were any reasonable precautions which could have been taken and which, had they been taken, might realistically have resulted in the deceased's death being avoided. There is also no evidence before the Inquiry that there was any defect in any system of working which contributed to the deceased's death.

[154] Specific reliance was placed on the joint minute paragraphs 12, 37, 40 and 43 and the affidavit of DW.

The Scottish Prison Service

[155] The SPS also adopted the submissions made on behalf of the Crown and invited me to make formal findings only and not to make any recommendations.

[156] The submissions for the SPS were split into three broad chapters – (1) five points of context; (2) summary of measures in place to prevent or restrict prisoners from accessing unprescribed and prescription medication; and (3) discussion of potential findings which may be considered.

[157] In summary, it was submitted that the measures in place to prevent prisoners from accessing prescribed prescription medication are robust and effective. Whilst certain precautions or defects may potentially be considered, these were neither

reasonable nor causally linked to the deceased's death.

[158] I may say that I found the structure of the SPS submissions to be helpful and have divided the evidence into similar chapters in my own consideration of the circumstances pertaining to the deceased.

[159] I found the submissions from the SPS to fairly and comprehensively identify the issues which are at large for the Inquiry and then to assess those against the appropriate test of reasonableness and causation.

Scottish Prison Officers' Association

[160] Finally the submissions from the Scottish Prison Officers Association echoed those of the other parties in inviting me to make formal findings only and no recommendations.

[161] In relation to the question of whether the overdose of prescription medication was an accident or an intentional attempt to take his own life the Association made no formal submission but as with the other parties did tend to suggest that the evidence pointed to an accidental overdose.

[162] The Association made clear that as there were no indicators for invoking Talk to Me and no observed causes for concern there should be no recommendations or findings in terms of section 26(2)(e).

Discussion and determination

[163] At the outset of the Inquiry I was advised that this was a case in which the

parties would be inviting me to make formal findings only and in relation to which they did not intend to adduce any oral evidence as the facts would be agreed in a joint minute.

[164] It should be remembered that while many Inquiries result in formal findings being made this is an inquisitorial process and the Sheriff requires to be satisfied on the basis of the evidence that the statutory criteria have been addressed.

[165] Ultimately it transpired that there were a number of issues pertinent to this particular death which merited investigation and assessment, particularly in relation to the way in which prescription medication was provided to prisoners.

[166] There was a considerable amount of evidence adduced or agreed which allowed me to form a comprehensive picture of the policies and procedures which had been in place at the time of the deceased's death and how they were applied in these particular circumstances.

[167] It is important to remember that while the SPS and NHS policies applicable to prisons are being constantly reviewed and are generally considered robust and fit for purpose it must be established that in the case of any death in custody the policies were enforced and followed and that the circumstances of any particular death do not expose gaps or identify weaknesses in the existing systems.

[168] For that reason no Inquiry should be treated as a formality and in this particular case I am satisfied that following the directions provided in my preliminary note, all parties have attended to their duties diligently in laying before me the factual matrix against which I am bound to make my determination.

The Legal framework

[169] The legal framework against which I am constrained to make my determination is found in section 26(1) of the 2016 Act, in terms of which I am required to make a determination setting out:

a) my findings as to the circumstances mentioned in section 26(2); and

b) such recommendations (if any) as to any of the matters referred to in section 26(4) as considered appropriate.

[170] The circumstances mentioned in *section 26(2) of the 2016 Act* are as follows:

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.

With regard to any recommendations, the matters referred to in section 26(4) are as follows:

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 have prevented other deaths in similar circumstances.

[171] In terms of section 26(2)(a) and (c), namely where and when the death occurred and the cause of death, parties are in agreement and I have no difficulty in making the findings suggested in paragraphs 2 and 32 of the joint minute.

[172] However sections 26(2)(b) and (d) and section 26(2)(e) merit further consideration of the evidence.

Suicide or Unintentional overdose

[173] I have considered in detail whether there is sufficient evidence for me to determine whether the deceased consumed the drugs with the intention of taking his own life or whether his death was an unintended consequence of consuming his prescription and some non-prescription drugs against an underlying heart condition about which he may not even have been aware.

[174] Having reviewed the evidence in detail it does not appear that there is any evidence to support the conclusion that this was a deliberate suicide. The deceased's demeanour in the hours immediately preceding his death do not suggest any such

disposition and the staff and inmates with whom he had had recent contact did not have any cause for concern. The CCTV which I have had the opportunity to review would strongly support the evidence of the witnesses in this regard. There was no evidence that any bullying or difficulties which the deceased may have experienced elsewhere in the prison estate were continuing and he appeared to interact well with other prisoners who were shocked by his death.

[175] On the contrary he had in the past consumed all of his prescribed medication at one time and had been made subject to MORS. He had a long standing history of drug misuse and there is evidence in Crown Production number 5 page 294 that he would save all of his prescription medication and take it at the end of the week in order to get a "buzz".

[176] Furthermore there is some evidence of deliberate acquisition of non-prescription medication as the Amitriptyline found in the toxicology report was not prescribed to him and is most likely to have been sourced from within the prison. The finding of a swing cord indicates a knowledge of how to transfer contraband between cells.

[177] While I am of the view that the consumption of the drugs by the deceased was not accidental in the sense that he intended to consume an amount of drugs far in excess of the therapeutic levels he knew to be appropriate the consequences were not intentional.

[178] The post mortem reveals an underlying heart condition about which he may not even have been aware and it is clear that he suffered a heart attack as a result of the drugs which he had consumed.

[179] Accordingly while the consumption and acquisition of the drugs was intentional and not an accident in that sense the outcome was most likely not intentional and a tragic consequence of his actions.

[180] Having regard to my assessment of the evidence above I am therefore of the view that while the ingestion of the overdose of prescribed and non-prescribed medication was not a deliberate attempt by the deceased to take his own life, the act of acquiring and consuming them was deliberate albeit the consequences of that action, namely the fatal intoxication, the cardiac arrest and subsequent death were not the intended outcome.

[181] On that analysis I do not consider it appropriate to characterise the death as an accident as such but consider it more as the tragic and unintended consequence of a deliberate act of consuming excessive amounts of prescribed and non-prescribed drugs. For that reason I have made no finding in terms of section 26(2)(b) and (d).

Consideration of the reasonableness of potential measures which could have been invoked and causal connection with the deceased's death

[182] Having decided that the deceased's death was due to his consumption of his prescribed and non-prescription medication which may well have been acquired from within the prison it is important to consider whether in terms of section 26(2)(e) there are any precautions which could reasonably have been taken and had they been taken might realistically have resulted in the death of the deceased being avoided.

[183] I have approached this in chapters

i) The provision and use of prescription medication within the prison setting

ii) Measures for monitoring consumption and circulation of prescribed medication

iii) The relevance and application of the suicide prevention strategy "Talk to Me".

i) The provision and use of prescription medication within the prison setting

[184] On the basis that the evidence would strongly suggest that the deceased took all of his prescription medication at one time along with Amitriptyline and paracetamol, which had not been prescribed to him, the immediate question to be answered is whether he and indeed other prisoners should be given all of their medication at one time.

[185] No doubt it could be said that if all medication prescribed within the prison were to be given on a supervised basis then the opportunities to overdose on the weekly amount or indeed to allow the medication to be used as currency would be mitigated.

[186] Accordingly the focus of the Inquiry was on whether such measures would be reasonable and had they been taken would they have resulted in the deceased's death being avoided.

[187] The issue of "in possession" medication is dealt with paragraph 41 of the joint minute of agreement. It was also dealt with in detail by Mr RWC and Nurse DW.

[188] The responsibility for prescribing medication to prisoners in the custodial setting lies with the NHS. At any given time a large proportion of the prison population receive some form of medication.

[189] Medication can be prescribed on an "in possession" or "supervised" basis. If "in possession", the prisoner is provided with a week's supply of their prescribed medication once a week.

[190] It should be borne in mind that the prison is a micro community and reflects what happens out with the custodial setting where most individuals receiving medication also receive their prescription in bulk doses and are trusted to take it appropriately whether or not they have substance abuse issues.

[191] Similarly within the custodial setting prisoners are trusted and responsible for taking and storing their "in possession" medication appropriately. All cells have a medication safe for prisoners to store their medication. If they do not store it in their safe, they should keep it on their person.

[192] Unlike the patient within the community the patient in the custodial setting is asked by a nurse to sign an In-possession Medication Contract on admission to prison. On the 8 November 2018 it is recorded that the deceased completed such a form. Unfortunately, a scanned copy of the completed contract could not be found and DW could only assume it was completed.

[193] The purpose of getting the patient to sign the In-possession Medication Contract is to inform them of what is expected of them to take their medication as prescribed, on how to store their medication and to make them aware that if they do not comply then

their prescription will be reviewed and potentially their medication could be changed or discontinued. The In-possession Medication Contract also makes the prisoner aware that medication checks may be carried out.

[194] If a contract is not completed the patient can still be prescribed medication to have in possession, as this is a clinical decision made by the prescriber and the prisoner could still be subject to medication checks. From this perspective it would not matter that a contract had not been signed. Accordingly although I have made certain observations about record keeping I do not consider that in this case there was any causative link between the contract going astray and the deceased's death. This is evidence when one comes to consider the fact further measures of spot checks in relation to cells occupied by the deceased.

[195] The evidence confirms that medication check procedures have been in place in HMP Perth for many years. The decision on whether a medication check is to be carried out on a patient is a matter for the Scottish Prison Service (SPS) staff. SPS staff send requests for medication checks to the health centre. It should be made clear that a medication check is separate from cell searches which are dealt with in the next chapter.

[196] There is a division of responsibility in relation to medication and cell searches where issues of medication are live. Only SPS staff can carry out a cell searches.

[197] When a medication check is carried out, the role of the NHS nursing staff at that time is only to carry out a cross check of the medication produced by the patient, against what is recorded on the patient's drug Kardex. The patient can refuse to produce their medication when asked. The results of the medication check would be recorded on the

Vision record as a pass or fail, and if the patient had refused to cooperate this would be recorded as a fail.

[198] Of significance to the operation of this procedure in relation to the deceased is that fact that there are no entries in the Vision record that relate to a medication check in respect of the deceased which would indicate that during the deceased's time in HMP Perth the SPS did not request a medication check on him. This would in turn suggest that but for the incidents in December 2018, to which I will return, there were no concerns about the deceased's compliance.

[199] In this case the deceased also received methadone, which was prescribed on a "supervised" basis. Methadone being an opiate has a higher value in the prison setting and there is therefore a greater risk that it will be used as currency if its administration is not controlled.

[200] The prisoner receiving drugs on a supervised basis is brought to the NHS dispensary by SPS officers as and when required. They then consume the drugs under the supervision of the healthcare staff. This would be done in accordance with Governors & Managers: ACTION (GMA) *"010A/15 – Witnessing the Administration of a Controlled Drug"* (SPS Production 2) and HMP Perth's Standard Operating Procedure (SoP) *"PM003(b) – Issuing of Medication"* (SPS Production 5).

[201] The healthcare staff decide whether a prisoner receives their medication on an "in possession "or "supervised" basis. SPS have no input into this decision nor would they be aware, due to reasons of patient confidentiality, what medication each prisoner is prescribed.

[202] At the time of the deceased's death, a large number of prisoners received medication "in possession". However, on or around April 2019, there was a reclassification exercise involving certain medications. This meant that some medications were no longer allowed to be prescribed "in possession" and required to be "supervised". This included medication such as pregabalin and gabapentin.

[203] Paracetamol and antacids can be given out by officers. The reason being that these are medications which are available over the counter in the community. This should be done by officers in accordance with GMA "*032A/18 – Policy on Issuing of Paracetamol & Antacid Tablets to Prisoners by Operational Staff*" (SPS Production 1)

ii) Measures for monitoring consumption and circulation of prescribed medication

[204] It is clear as with many aspects of prison life that there is an operational partnership between agencies and the SPS and NHS have defined roles and responsibilities to enable each to perform specific tasks within their particular areas of expertise. However the relationship involves cooperation and understanding of their respective functions.

[205] There is an acute awareness that prescription drugs have a value within the prison setting and drugs which might not have a street value out with the custodial setting can be used as currency within the prison. In addition the value of such drugs is amplified due to the availability of the commodity.

[206] Despite the fact that there are many thousands of prisoners across the prison estate who receive prescription medication while in custody on an "in possession basis"

DC BY in his evidence confirmed that prescription medication does not account for a large proportion of the commodity within the prison and there is far greater concern in relation to drugs “coming over the prison wall” or being brought in to the prison by other means.

[207] The officer was able to confirm that the supply of drugs within the prison system operated much the same as within the wider community with the supply being primarily operated by organised crime gangs.

[208] The SPS take a number of steps to monitor the consumption and circulation of prescribed medication with the establishment. This includes medication spot checks which are carried out within each hall each week. Around 10 individuals are spot checked per week on the smaller halls. More are carried out on the bigger halls such as C Hall. The spot checks are usually targeted and intelligence led. If any concerns are noticed, officers or nurses can identify individuals whose medication should be spot checked.

[209] There was perhaps some discrepancy between the evidence of Nurse DW and Mr RWC, the latter being of the view that the spot checks are carried out jointly by the SPS and NHS. The SPS facilitate the opening and searching of the cell and the nurse would check the medication found in the cell against the prisoner’s prescription. The SPS do not have access to prisoners’ medical records and therefore NHS staff are required to reconcile the medication found with the prescription. I accepted the evidence of Mr RWC that while the NHS did not actually search the cell they did perform a role in the process.

[210] Mr RWC also confirmed if a prisoner fails the medication spot check (i.e. they do not have all of their prescription), they will be subject to a medication review by the NHS. The deceased did not feature within the medication spot check database. This means he was not subjected to a medication spot check during his time at HMP Perth.

[211] In addition to spot checks the prisoners can be subject to cell searches at any time during their period of incarceration. This can be random, intelligence led or when there is a changeover in the occupant of a cell.

[212] Records disclose that the deceased's cell was searched on 5 December and 22 February 2019. It is of interest that nothing untoward was found and this is despite a cell search being carried out one day before the deceased was found to be under the influence of substances on 6 December 2018.

[213] There was no intelligence to suggest that the deceased had otherwise been misusing substances and indeed the only concrete evidence that he was doing so during his period in custody came from his sister who he appears to have told that he was accessing drugs within the prison. This information was not imparted to the prison authorities but even if it had been would have been unlikely to alter the outcome of events as there was no observed cause for concern that the deceased was regularly under the influence and in any event by the time of his death he was engaging with the substance misuse team which would have been the course of action adopted if a more acute problem had been detected.

[214] However, there remains the relevance of the incidents on 6 and 25 December 2018 where the deceased was found under the influence of substances and nursing staff

attended. At this point, it was suspected that he had consumed his weekly prescription medication as a check was carried out and he had none of his weekly medications on his possession. This appears to have been similar to the circumstances which prevailed at the time of his death.

[215] At that time the deceased was made subject to the MORS policy which was described in the evidence. This is a short term policy as a result of which the patient is then referred on the substance misuse team for ongoing care. It is of note that HMP Perth has a hub for treatment of those with addiction issues and is unique in this respect. The deceased, who obviously had insight into his addiction issues, did engage with the team for long term care and had a consultation shortly prior to his death.

[216] It is disappointing that the MORS paperwork for the incident on 6 December 2018 could not be found but again this did not have any causative effect in relation to the deceased's death and the fact remains that in relation to cell searches he had been subject to a search only the day before.

[217] Helpfully the submissions of the SPS identified a variety of potential or theoretical precautions which could be implemented and offered a discussion on the reasonableness of these measures.

[218] In particular the following options were offered for my consideration.

[219] The first proposition was the removal of prescription medication altogether. Clearly this would not be reasonable given the needs of the prisoners within the estate. Accordingly what is required is a robust system of administering the required medication which mitigates the possibility of abuse as far as is reasonably practicable

having regard to resources and realities of the custodial setting.

[220] Consideration was then given to all medication being provided on supervised basis. This possibility was also addressed fully in the Crown submissions and discounted because of the resource and logistical implications. I also accepted that this approach could result in a loss of competence in managing one's own medication once released. Standing the evidence of DC BY that prescribed drugs do not account for a large part of the commodity within the prisons it would not appear that this would be an economically viable or sensible option and would not withstand any cost/benefit analysis constituting a disproportionate response to what does not appear to be as significant a problem as the introduction of drugs from out with the estate.

[221] Furthermore the impact on the autonomy of the majority of prisoners who comply with the contractual and disciplinary obligations imposed upon them would be disproportionate.

[222] When viewed in conjunction with the other measures in place dispensing all medication under supervision would not in my opinion be a reasonably practical measure.

[223] A question then arises as to whether the Amitriptyline should be prescribed on a supervised basis. Apart from paracetamol this was the only drug identified on toxicology examination which had not been prescribed to the deceased. However I was not provided with any evidence about the particular dangers of amitriptyline and whether it would merit such treatment. Furthermore there was no pathological evidence to support a conclusion that, in the absence of amitriptyline, the deceased

would not have died. Therefore, this is not a precaution which it can be said would realistically have prevented the death.

[224] I am satisfied that the question of which drugs should be provided on a supervised basis only is regularly and appropriately reviewed by the NHS and do not intend to make any finding or recommendation in this regard.

[225] Turning then to the frequency of cell searches it was submitted that the deceased received his medication about 10.00 hours and life was pronounced extinct at about 20.00 hours – a 10 hour period. Therefore, to have any preventative effect bearing on the deceased's death the precaution or system would have to require cells to be searched on a daily basis. This is neither reasonable not practical given the resource implications.

[226] Mr KM gave evidence that there are currently around 655 prisoners at HMP Perth and it takes around 45 minutes to properly search a cell. Even assuming the majority are double occupancy that still leaves around 350 cells and accordingly it would still take well over a week to search every cell. That would be on the basis of a nurse and officer searching cells 24/7, which of course would be impossible.

[227] On the basis that the deceased's cell was searched on 5 December 2018 and he was found under the influence on 6 December 2018 it is impossible to say that daily searching would have prevented his death. I have no evidence to suggest when or indeed how the deceased came into possession of the amitriptyline which could have been shortly before he consumed it. In any event the deceased's cell was searched twice in the three months prior to his death.

[228] Looking at the evidence in its totality I am satisfied that the measures in place to

prevent prisoners from accessing unprescribed prescription medication are robust and effective. Whilst certain precautions or defects may potentially be considered, these are neither reasonable nor causally linked to the deceased's death.

[229] The policies and procedures had identified the deceased as at risk and he had been placed on MORS as a short term measure to address the incidents in 2018. He seemed to be taking advantage of the therapeutic regime offered by the Substance Misuse Team which is the long term regime available to those with addiction issues. There were no intelligence or observational reasons to suspect he was regularly under the influence of illicit substances and he did not request an increase in his pain medication which he could readily have done again leaving no marker that he was inclined to take the course of action he took.

Suicide prevention strategy

[230] Finally and for the sake of completeness it is important to note that the deceased had been reviewed on admission to the prison and subsequently and was not assessed as being at risk.

[231] None of the witnesses who had interacted with the deceased had any cause for concern in relation to self-harm or suicidal ideation and the deceased's death was all the more of a shock as a result.

[232] I heard evidence in relation to the operation of the Talk to Me strategy and am satisfied that had there been a concern in relation to the deceased it would have been picked up.

[233] However for the reasons I have already given I do not think this was a case of deliberate suicide and accordingly there is no need to explore the operation of the suicide prevention measures further in the context of this determination.

[234] I would observe that in the course of examining the evidence there have been a number of discrepancies in record keeping which did not have any causative effect in relation to the deceased's death but highlight the importance of ensuring meticulous systems.

[235] I noted that the MORS records from 6 December 2018 had not been retained although there was clear evidence that the deceased had been placed on MORS at that time. It would have been helpful to note the circumstances of that particular incident in more detail.

[236] Furthermore although the In-Possession Medication Contract appears to have been signed by the deceased there was no record of it. Prescription medication can still be provided to a patient without this contract being completed thus there was no causative link but it would have been helpful to evidence the fact that the deceased knew his obligations and that he was jeopardising his prescription by his conduct.

Conclusion

[237] Sadly there will always be those who are successful in circumventing the most robust of measures and it is for this reason that it is essential that the SPS and NHS continually review the policies in place to ensure that all that can be done to prioritise the safety of prisoners is being done.

[238] However in the circumstances of this particular death I am not of the view that there were any reasonable measures which the SPS and NHS could have taken which, if they had been taken, would have prevented the deceased's death.

[239] The SPS and NHS are aware of the potential for prescription drugs to be used as currency within the prison and have taken steps to ensure that the drugs which would present the greatest risk or which would command the highest value are prescribed on a supervised basis. Otherwise there has to be an element of trust in the individuals within the estate to abide by the prescribing rules set forth in the In-possession Medication Contract.

[240] It would be wholly impractical and indeed an encroachment on the personal autonomy of the majority of the prison population if all medication required to be given on a supervised basis. This is particularly so given the evidence that abuse of prescription drugs forms a small proportion of the problem of substance misuse within the custodial setting.

[241] Finally but importantly on my own behalf and on behalf of the parties I wish once again to extend condolences to the family and friends of the deceased for their sad loss.