SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT PERTH

[2021] FAI 19

PER-B152-20

DETERMINATION

BY

SHERIFF GILLIAN A WADE QC

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

into the death of

STEVEN ALEXANDER DICKIE
born 27/2/1995 formerly a prisoner within Cell 15, 4th Floor, B Hall, HMP Perth, 3 Edinburgh Road, Perth

Perth, 22 March 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 the deceased, Steven Alexander Dickie, date of birth 27 February 1995, formerly residing at Cell 15, 4th Floor, B Hall, HMP Perth, 3 Edinburgh Road, Perth, died at 0720 hours on the 15 November 2019.
2. In terms of section 26(2)(b) of the said Act, makes no finding as the deceased's death was not the result of an accident.

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

I a) Suspension by the neck from Fabric Ligature (Hanging)

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 Steven Alexander Dickie, hereinafter referred to as "the deceased", was held at Perth Sheriff Court on the 15 February 2021 and the 17 March 2021 using the WebEx Platform as a result of the Coronavirus Pandemic prevalent at the time.

[2] The Crown was represented by Mr Muhammed Sadiq, Procurator Fiscal Depute. Mr Liam Smith represented the Scottish Prison Service, hereinafter referred to as "SPS", Ms Kathryn Gormley appeared on behalf of the Tayside Health Board and Ms Ruth Wallace appeared on behalf of the Scottish Prison Officers' Association.

[3] The deceased's mother Ms Sonya Dickie was not represented and had not submitted a notice of intention to participate having been duly intimated on 8 September 2020. Nonetheless a WebEx invitation had been extended to her and she was able to join the hearing.

[4] Preliminary hearings had taken place on 20 October and 26 November 2020 at which drafts of a proposed joint minute had been discussed and productions had been

lodged. This had enabled me to consider the issues of concern in advance of the full hearing and issue a note to parties indicating where I anticipated the focus of the inquiry would be.

[5] As a result parties were able to provide affidavit evidence from a number of witnesses which can be summarised as follows :-

The evidence

Affidavit evidence

Prison Officer JD

[6] JD was 57 years old. He was employed as a Residential Officer by the Scottish Prison Service for 32 years and ceased employment with the SPS in August 2020. He explained that Residential Officers are responsible for the day to day management of the prison halls. They carry out duties such as numbers checks, overseeing meal times, managing the movement of prisoners in and out of the halls and carry out the lock up of the hall. As Residential Officers work on the halls they get to know the prisoners very well.

[7] At the time that the deceased was in HMP Perth, he was based in B Hall Level 4. The deceased was also located in B Hall Level 3. There is free access between B Hall Level 3 and B Hall Level 4 and, as the deceased was a passman, he would move freely between the halls. Therefore JDsaw the deceased often when he was on duty and when the deceased was carrying out his passman duties.

[8] A passman is a role that is allocated to trusted prisoners and it involves cleaning the flats, showers and serving food to the other prisoners. It is a sought after role as passmen are outwith their cells for most of the day and they receive other privileges such as use of the prison telephones. The deceased tended to associate himself with the other passmen. He had two "best friends" who were passmen and they were located on the same hall as him. He would often be seen to have a "carry on" and joke with them.

[9] The witness described having "banter back and forward" with the deceased and said they got on well as they were both interested in motorbikes and would talk about them with one another. However the witness also said that there were times when the deceased could overstep the mark saying "It was never anything serious and never anything that lasted. He was just a young man that could have his moments."

[10] The witness was on duty on 14 November 2019 and recalls seeing the deceased at some point. He was aware that the deceased had been relieved of his passman duties that day. The witness could not remember the detail of any conversation he had with the deceased regarding that issue and described it as a "frivolous conversation in the passing". He said that nothing in the deceased's presentation concerned him but if he had had any concerns he would have taken action by putting the deceased on the suicide prevention measures known as "Talk to Me".

[11] Talk to Me is the SPS's suicide prevention policy. If anyone has any concerns about a prisoner, they can complete a Talk to Me concern form and there are different measures which will be put in place to ensure the safety of the prisoner. For example the prisoner can be put on observations, located in a safer cell and can be given anti

ligature clothing and bedding. Once someone has been placed on Talk to Me, there must be a case conference within 24 hours. Usually at the case conference there is the Hall Manager, a Residential Officer and someone from healthcare present. All parties have to be in agreement with the outcome of the case conference. So for example if one person thinks that the prisoner should remain on Talk to Me and in a safer cell, then that is what will happen.

Affidavit of Prison Officer MH

[12] A further affidavit was obtained from MH. She was 58 years old and was employed by the Scottish Prison Service as a Residential Officer at HMP Perth. She had been employed as a Prison Officer by the Scottish Prison Service (the SPS) for 19 years and also worked as a residential officer.

[13] At the time of the deceased's death she was based in Bravo Hall (B Hall) and worked upstairs on the third and fourth flats. The deceased was located on the third Flat of B Hall and so she knew him quite well. She confirmed that the deceased was "on the pass" along with his friend AD . Prisoners that are on the pass are trusted to work on the halls and they do jobs such as serving the food, cleaning the Hall and picking up the meal barrows. They are unlocked for most of the day to give them time to do their work.

[14] The witness described the deceased as really pleasant to speak to. He was a tractor tyre fitter and she was involved in agriculture so they would speak to one another about things they had in common. He would talk about his family as well. Her

view was that the deceased did not like to be thought of as a typical prisoner and did not like to be seen as the same as people that he would refer to as "junkies". He had friends in the prison who were also passmen. On the whole, she thought the deceased was a pleasant prisoner who had friends and who did not cause problems.

[15] She confirmed that on the 14 November 2019, the deceased was relieved of his passman duties. The incident started the day before, on the 13 November 2019. On that day, she had been downstairs with the meal barrows and had called for the passmen to come down to collect them. When the passmen appeared they were not dressed appropriately as they were wearing shorts. If the passmen are leaving their Hall, they are expected to wear prison issue clothing. Also for collecting food, the passmen should wear what she described as "prison joggies" as the food trollies are hot. The deceased was one of the passmen who had not dressed appropriately.

[16] The witness had decided to allow the passmen to continue to collect the meal barrows, rather than sending them back up to get changed as she did not see that as her role but the situation was later observed by the Unit Manager, GS who passed comment.

[17] The following day the witness took it upon herself to remind the deceased and the other passmen to "remember to put your joggies on". The deceased was adamant that he was not dressing like the other prisoners and that he was not going to wear the "joggies".

[18] The witness tried to reason with the deceased calmly but remembers the deceased saying "I'm not fucking doing it, get someone else to fucking do it". She

explained that if he did not dress properly she would have to sack him and that is ultimately what happened. On being told he was being sacked the deceased lost his temper and became quite abusive. He was shouting and swearing. About five minutes later, he asked for bags to pack up his cell as he knew he would have to move cells. The witness could hear him complaining to his friends as he was packing up his cell saying "that fucking cow did this, that fucking cow did that". She also heard him talking to his friend A about them wanting to move to C Hall. When she came back up to the Flat, after having collected the meal barrows, the deceased was locked in his cell and was shouting "fucking cunt, fucking bitch it's not up to fucking her". Shortly after this his cell was opened up for lunch and the witness saw him talking to the Unit Manager, GS.

[19] She described him as angry rather than upset. However generally she thought she knew how to handle him and if left alone she thought he would calm down. The witness said that she always makes a point of speaking with a prisoner if there has been an altercation with them while she is on shift. Before she left the Hall at the end of her shift, she asked the deceased if he was okay. She said, "He got fired up again and was still saying that she was out of order". She asked if they "were good" to which he responded "aye, whatever M". This would have been about 12.50pm and was the last time the witness saw the deceased.

[20] The following morning, she started duty at 7am. Just after starting, she heard a "Code Blue" over the radio, which means a prisoner is not breathing. She overheard the cell number as 4/15, and initially thought that the incident involved another prisoner having been unaware that the deceased had already moved cell because he was no

longer a passman. She described herself as being devastated when she heard the deceased had died.

[21] The witness went on to confirm that she was aware of and had been trained on the Talk to Me (TTM) Policy. She was able to describe in detail the processes and explained that if she had any concerns she would have no hesitation in placing a prisoner on TTM.

Prison Officer SF

[22] The third affidavit which had been lodged had been sworn by SF. She was 33 years old and was employed by the Scottish Prison Service as a Residential Officer and currently worked at HMP Perth. She has 9 years' service with the Scottish Prison Service.

[23] She began by explaining her understanding of the duties of a residential officer. Her evidence was that residential officers are allocated to one specific hall and this is where they spend most of their time interacting with prisoners particularly those serving long term sentences.

[24] The witness explained that the deceased was located in B Hall Level 3 during his time at HMP Perth. The hall that she usually worked on was C Hall but she would often work in B Hall when she was on what she described as her "variable weeks" which amounted to roughly every eight weeks. For that reason she came to know the deceased well.

[25] She described him as "a really approachable guy". They discussed their mutual interest in cars and through speaking to the deceased in the passing she considered she had built up a good relationship with him.

[26] On Tuesday 14 November 2019 the witness was working an overtime shift from 8am until 9pm. She was working on B Hall on that particular day. At about 4.30pm she was made aware that the deceased had been sacked from his role as a passman. She thought this was because he had been rude to MH but knew that as a consequence the deceased had been made to move cell to Level 4 B Hall, were she was working.

[27] She recalled that the deceased was an extremely clean and particular person and that he set about cleaning his cell and arranging it the way he wanted it. During "open association" which is between 1900hrs and lock up she had a lengthy conversation with him in the course of which he talked about cars, motorbikes and his nieces. He showed the witness photographs of his family and in her opinion did not seem overly bothered about having been relieved of his passman duties and certainly did not make an issue of it to her. She also recalled the deceased having his dinner and taking pasta sauce to his friend on Level 3. She then locked the cell door of the deceased about 2015hrs. She carried out a second check with her colleague GY about 2040hrs and remembers saying "see you later Dickie" and the deceased replying "good night".

[28] The witness saw nothing out of the ordinary in the deceased's behaviour that evening during what was quite an extensive interaction. She said, "He did not say anything or behave in any way that would have given me any cause for concern. He

just presented as his normal self and I was in complete shock when I found out what had happened the next day."

[29] She went on to rehearse what she would have done had she had any concerns and evidenced a clear understanding of the TTM policy for which she is a trainer.

Joint Minute of Agreement

[30] In addition to the 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.

[31] During the course of the hearing on the 15 February 2021 it became apparent that the joint minute which had been signed by the parties in advance of the hearing required some amendment and this was attended to during an adjournment. However, as will be discussed this led me to consider that certain further inquiries required to be carried out and I was unable to conclude the hearing on the 15 February 2021 to enable these matters to be investigated.

[32] The parties were agreed that Steven Alexander Dickie ("the deceased") was born on 27 February 1995 (age 24). The deceased was a prisoner within Cell 15, 4th Floor, B Hall, HMP Perth, 3 Edinburgh Road, Perth.

[33] The deceased was convicted of murder on 30 May 2019, and was sentenced to life imprisonment, with a 23 years tariff. The earliest date for the deceased's parole was 17 June 2041.

[34] The deceased was the sole occupant of Cell 15, Flat 4, B Hall, HMP Perth, 3 Edinburgh Road, Perth which is the place of death.

[35] The deceased was a passman within B Hall, therefore he was trusted to carry out duties such as cleaning, collecting meals for other inmates and laundry duties. When passmen are involved in collecting meal barrows, they are required to wear prison issued jogging bottoms.

[36] I was furnished with the G4S Personal Escort Records for the deceased which formed Crown Production 12. These contained, among other details, the Talk To Me Reception Risk Assessments which were carried out in relation to the deceased every time he was transferred to and from the prison to court. The parties were in agreement that the records were accurate. The deceased was assessed as "No Apparent Risk" on the 18 and 21 June 2018, 12 October 2018, 04 and 26 March 2019, daily during the course of his lengthy trial resulting in some 20 assessments being made over the period between 1 April and 3 May 2019 and again on the 30 May 2019.

[37] The Escort Records note the detail of the deceased's interaction with the reception staff and include a narrative of his presentation at that time. On each occasion he is noted as communicating or presenting well. He is also described as being relaxed and sometimes jovial with staff. He expressly denied any suicidal ideation.

[38] On 3 May 2019, the deceased was placed on Talk to Me due to the concerns raised by the family of the deceased with the Floor Manager, TM. Page 151 of Crown Production number 10 contains the Talk to Me initiating form for the deceased. The deceased was placed on 60 minute observations by Reception Officer GP and an

immediate care plan was generated and a case conference was scheduled for 04 May 2019.

[39] When a prisoner is placed on Talk to Me, a case conference takes place at which a care plan is put in place with a further case conference scheduled within the next 7 days. In the period between case conferences, the care plan which has been put in place is monitored to see how the prisoner is doing. I was provided with both the Care Plan Report and the record of the monitoring.

[40] On 4 May 2019 the deceased was seen by Mental Health Nurse MLCG for a TTM Pre Case Conference Healthcare Assessment. Following on from the Healthcare Assessment a Case Conference was held. In attendance at the Case Conference were the deceased, HMcG, Officer T and First Line Manager E. The deceased appeared as bright and reactive and reported no suicidal ideation. At the Case Conference a joint decision was made between SPS, NHS and the deceased to retain the deceased on 60 minutes observations. A further case conference was scheduled for 08 May 2019. Pages 167 and 168 of Crown Production number 10 contains a record of this case conference and care plan.

[41] On 8 May 2019 the deceased was seen by Officer F, First Line Manager A, AMcK and HMcG at the next scheduled Talk to Me Case Conference. The deceased was assessed as being at "No Apparent Risk". All person present agreed that the deceased should be removed from Talk to Me policy. The deceased was made aware that he could self refer to the mental health team if his mental health was to deteriorate. Page 170 of Crown Production number 10 contains a record of the said case conference.

[42] Other than this period, the deceased was not placed on Talk to Me throughout his time in custody.

[43] The Mental Health Team arranged a routine Talk to Me follow up appointment for 29 May 2019. The deceased did not attend this appointment.

[44] On 30 May 2019, the deceased returned to prison having been convicted of murder. On his return, he was assessed by primary care nurse CP. There were no concerns or anxieties noted at this appointment. The deceased was made aware of support services such as chaplaincy and the listener service.

[45] On 31 May 2019, the deceased attended an appointment with the prison dentist following a self-referral for toothache. On 19 July 2019, the deceased had a follow up appointment with the prison dentist but refused to attend this appointment.

[46] On 26 September 2019, the deceased attended the primary care team regarding a suspected fracture after a fall in the hall. The deceased attended A&E on 29 September where no fracture was evident on x ray.

[47] On 11 October 2019 the deceased had an appointment with the prison dentist following a self-referral on 26 September. The deceased refused to attend this appointment.

[48] On 29 October 2019, the deceased self-referred to the dentist. An appointment was fixed for 13 December 2019.

[49] On 4 November 2019 the deceased attended an appointment with podiatry. This appointment was the last contact that healthcare staff had with the deceased. At this appointment no concerns were noted about the deceased.

[50] On the morning of Thursday 14 November 2019 Prison Officer MH sacked the deceased from his role as a passman. This was as a result of the deceased's refusal to wear prison issue jogging bottoms when collecting the meal barrows. The deceased required to be moved to another cell as he was no longer a passman. All passmen are located in the same flat so they can be easily let out to carry out their duties.

[51] As a result of no longer being a passman the deceased was moved to Cell 15, Flat 4, B Hall. Prison Officer SF was working on B Hall at the time the deceased moved cells. Officer F interacted with the deceased and noted that, despite having been sacked, the deceased was chatty, having "banter" and seemed his usual self. Officer F observed that the deceased had dinner as usual and was out on the Hall during recreation time between 1900 hours and 2015 hours. During recreation, Officer F observed the deceased talking and interacting with his" usual crowd". There was nothing about the deceased's behaviour that gave Officer F any cause for concern. The deceased was locked in his cell for the evening at approximately 2015 hours that evening. A final routine check was carried out by officers F and GY at approximately 2040 hours. The deceased was alive and well at this time and bade officer F goodnight.

[52] About 0710 hours on Friday 15 November 2019, prison staff began the numbers check of the prisoners on the fourth flat within B Hall. About 0715 hours same date, prison staff entered cell 15 and found the deceased hanging from the bars across the window with a blue ligature around his neck. The said staff shouted out "CODE BLUE" over the radio and thereafter prison nurses and other staff attended and removed the ligature from deceased's neck.

[53] The deceased was rigid, cold to the touch and his lips and hands were swollen to the touch and prison staff contacted an ambulance. CPR was therefore not attempted. An ambulance had been requested to attend.

[54] Paramedics attended and pronounced life extinct at 0720 hours.

[55] Prison staff reported the death to the police and detective constables of the Police Service of Scotland attended at the scene and thereafter conveyed the deceased's body to the Police Mortuary Dundee.

[56] I was provided with SPS Production 4 which is Governors & Managers: Action (GMA) 060A/16 – Code Red/ Code Blue Policy and SPS Production 5 which is Governors & Managers: Action (GMA) 50A/15 – Procedure following a suicide or attempted suicide using a ligature. These policies detail how staff should respond in the event an individual is found hanging by a ligature. The staff response to finding the deceased was in accordance with these policies.

[57] On 19 November 2019 at the instance of the Procurator Fiscal, Dundee, Dr David William Sadler carried out an autopsy examination on the body of the deceased. Due to the strong objection to autopsy by the family, internal examination was not performed.

[58] Examination of the body revealed no significant injuries to give any cause of concern. The ligature remained in situ around the neck and comprised a length of torn blue fabric material which had been ashioned into a simple running noose coming to a point of suspension behind the left ear.

[59] There was an underlying pale and abraded ligature mark encircling the neck, the pattern of the ligature mark matched exactly the ligature and its irregularities and contours.

[60] The absence of petechial haemorrhages above the level of the ligature would suggest rapid and complete occlusion of carotid arteries of the neck which would have resulted in loss of consciousness within a matter of seconds and death within a minute or two.

[61] Dr David William Sadler certified the cause of his death as: I a) Suspension by the neck from Fabric Ligature (Hanging). The results of said examination are accurately recorded in Post-mortem Examination Report (Crown Production number 1) and the contents of said Report are agreed to be true and accurate by all parties.

[62] Toxicology analyses were performed on the body fluids of the deceased which detected Mirtazapine (a prescription anti-depressant which was not prescribed to the deceased) and 4F-MDMB-BINACA metabolite which is a synthetic cannabinoid receptor antagonist.

[63] Mirtazapine was detected at concentration of 0.01 mg/l of femoral blood. The range of levels found in published fatalities is from 1 to 4.4 mg/l (average 2.1 mg/l, 8 cases). The usual therapeutic level of the said medication is below 0.2 mg/l. Toxic effects of Mirtazapine include drowsiness, dizziness, agitation, increased blood pressure and tachycardia.

[64] Adverse effects of 4F-MDMB-BINACA are uncertain but include cannabis like effects as well as anxiety, irritability, agitations, low mood, hallucinations, and

psychosis. The presence in urine is indicative of use of 4F-MDMB-BINACA prior to death. This substance is not a prescription medication and its significance in this case is uncertain. The results of these analyses are accurately recorded in the Toxicology Report dated 16 March 2020 (Crown Production number 2).

[65] It only became clear to me that the deceased had consumed non-prescription drugs and prescription drugs which had not been prescribed to him in the course of the hearing on 15 February 2021. I had been concerned that Mirtazapine, which is a prescription anti-depressant had been found in the deceased's blood but there seemed to be no record of him having been prescribed this in prison. If he had been on such medication it would have indicated an underlying mental health issue and would have indicated far more frequent contact with mental health services than the deceased appeared to have had.

[66] On inquiry it transpired that both substances which were found within the deceased's blood had clearly been sourced by him and had not been prescribed. The confusion arose because of the reference to therapeutic levels in the toxicology report and previous drafts of the joint minute.

[67] The issue of substance abuse then appeared to be a live one for me to consider and in particular whether the deceased's ingestion of either or both of these substances could have had any effect on his mental state such as would cause him to deteriorate from a normal and indeed jovial presentation to taking his own life. This would require more evidence about a) the effects of these drugs generally and also in particular, given the low levels of toxicity found in his blood, b) the time scale within which they were

consumed and whether it was likely to have been immediately before the deceased took his own life, and c) whether there could have been a causative link between his ingestion of these drugs and his suicide.

[68] This required a continuation of the inquiry for further investigations to take place by way of affidavit from the toxicologist instructed by the Crown and in the event that the answer to point c) was in the positive to explore what reasonable precautions or measures if any could have been taken to prevent the deceased consuming the illicit substances in the first place.

[69] This additional material was provided on 12 and 16 March 2021 and I was therefore able to consider it fully in advance of the hearing on 17 March 2021.

[70] The parties had obtained two additional affidavits dealing with the toxicology issue and what precautions the SPS had in place to try to prevent the introduction of illicit substances into the prison estate and to monitor the distribution of prescription medication to counter the use of it as a commodity within the prison.

[71] In addition the parties had been able to enter into a further joint minute which agreed the provenance of the documents to which these witnesses referred.

Affidavit of Denise Anne McKeown, Forensic Toxicologist dated 11 March 2021

[72] Denise Anne McKeown is a Forensic Toxicologist currently working at the Forensic Toxicology Service (FTS) of Forensic Medicine and Science (FMS), University of Glasgow.

[73] She has held this position since September 2012. She holds a Masters in Science (MSci) degree in Forensic and Analytical Chemistry and has been an Analytical Toxicologist for eighteen years and for eight of these years and is also a Reporting Forensic Toxicologist.

[74] As such it was clear to me that she was well qualified to author the Toxicology Report, FT2019/3460 dated 16 March 2020 and to provide the further evidence which I had requested.

[75] She explained the process analysis of samples for alcohol and drugs is performed in the FTS laboratories by the Laboratory Technicians under the supervision of the Forensic Toxicologists.

[76] She went on to address the specific questions which I had posed in the course of the first day of evidence in the Inquiry.

Mirtazapine

[77] Mirtazapine is an antidepressant drug and was found at a concentration of O.Olmg/L (milligrams per litre) in femoral blood sample FT2019/3460(2). This mirtazapine concentration is at the low end of the therapeutic concentration ranges reported in the literature. Mirtazapine is not present at concentrations reported in the literature for fatalities. It is not possible from the mirtazapine post-mortem blood concentration to predict when the deceased may have ingested this drug.

Alcohol

[78] The level of alcohol found was also low being 20mg /100ml and is consistent with both previous alcohol consumption and post mortem bacterial production of ethanol which can occur after death.

4F-MDMB-BINACA metabolite

[79] This was also found to be present in the preserved urine sample and suggests use of a synthetic cannabinoid receptor but as there are many such synthetic drugs on the illicit market it is difficult to say precisely which SCRA was ingested and indeed when. Although the SCRA was found in the urine it was not found in the blood sample.

[80] The witness explained that the laboratory test confirmed the presence of the cannabinoid but was not quantitative and furthermore the concentration of the drug in the urine would not correlate to its effects.

[81] It was also impossible to determine from the findings when the drug was consumed as there is a paucity of literature to assist with this issue due to the fact that these drugs are relatively new. The witness was asked to explain her comment in the original report to the effect that the significance of the finding of the SCRA was "unclear". In response she said that all that could be said with certainty was that the drug had been consumed but it could not be determined whether the deceased would have been experiencing any effects as a result of the use of the drug.

[82] She was able to confirm that the drug is usually smoked or vaped but she could not say what the route of administration had been in this case.

[83] The witness was also asked directly whether either of the drugs found in the deceased's urine sample either on their own or in combination have been likely to affect the deceased's mental state adversely to the extent that it would have led to his decision to take his own life and whether someone presenting as normal could in fact be under the influence of these substances. She was also asked whether a significant amount of the synthetic cannabinoid would be required before the user would experience the more severe adverse effects such as hallucinations and psychotic symptoms.

[84] She confirmed that SCRAs are potent drugs and have been associated with adverse physical and mental health effects. However it is not possible to state the amounts which would be required before a particular individual would be affected as this would vary from case to case. She stated that adverse effects had been reported in both naive and chronic users and in some cases episodes such as psychosis had lasted up to four weeks. In relation to the mental health effects of these drugs she deferred to the expertise of forensic psychiatrists.

Affidavit of Richard William Coupe

[85] Of particular assistance in relation to the precautions and measures which are in place to prevent the consumption of illicit drugs and the reasonableness of these measures was the evidence provided in the affidavit of Richard William Coupe.

[86] He is currently the Deputy Governor (Acting) at HMP Perth, having been in this role for around two months. He previously held the roles of Head of Offender

Outcomes and then Head of Operations (both at HMP Perth). He has also extensive experience working at other establishments in a range of roles.

[87] As Deputy Governor, his main remit is the head of residential meaning that he is in charge of all residential halls, the Segregation and Reintegration Unit (SRU) and the OLR (Order of Lifelong Restriction) prisoners.

[88] In his evidence he made clear that he had had no personal involvement with the deceased but was addressing the issues around the use of prescription and non-prescription drugs in the prison setting and commenting on the existing policies and procedures in place to combat illicit drug use.

[89] He explained NHS are responsible for prescribing medication to prisoners. Much of the prescribed medication assists prisoners with addictions and mental health issues and 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.

[90] 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 9) and HMP Perth's Standard Operating Procedure (SoP) *"PM003(b) – Issuing of Medication"* (SPS Production 10).

[91] The healthcare staff decide whether a prisoner receives their medication on an "in possession" or "supervised" basis. The SPS staff would not be aware of such a decision, due to reasons of patient confidentiality.

[92] The witness went on to outline a number of steps which SPS had taken to monitor the consumption and circulation of prescribed medication with the establishment.

[93] Medication spot checks are carried out within each hall each week. Around ten 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.

[94] 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.

[95] 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. The SPS have no involvement in this process. They may also be placed on a Governor's Report by the SPS.

[96] The deceased does 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.

[97] In addition the SPS also carry out cell searches to look for illicit items. This includes searching for weapons, non-prescribed prescription medication and illicit substances. These are carried out in three ways: (1) randomly; (2) intelligence focussed; and (3) changeover.

[98] 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.

[99] Having examined the records of the deceased for the purposes of giving his affidavit the witness said it confirms that deceased's cells were subject to random searches on 17 March 2019 (Cell 3/11, B Hall); 14 May 2019 (Cell 3/11, B Hall); 15 June 2019 (Cell 3/11, B Hall); 31 July 2019 (Cell 3/13, B Hall); and 11 November 2019 (Cell 3/13, B Hall). This extract confirms that the deceased's cell was randomly searched five times in the eight months prior to his death and nothing was recovered during any of these searches. This includes one search three days prior to his death.

[100] HMP Perth has around 500 cells and currently has around 651 prisoners. To properly carry out a standard random search, it normally takes around 45 to 60 minutes.

[101] 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. If a tactical/intelligence focussed search is carried out, this normally takes around 2 hours. This is because the Officers "rip the entire cell apart, remove light fittings etc. – everything".

[102] Finally, cells are searched and cleaned every time a prisoner is moved from a cell (prior to the new occupant being assigned). When a cell search is carried out, this should be done in accordance with HMP Perth's SoP *"PM011 – Routine Cell Searches"* (SPS Production 12). Everything that is in the cell would be searched including the prisoner.

[103] 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.

[104] 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 13). 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 the witness understood they carry out a medication review.

[105] Turning the issue of New Psychoactive Substances (NPS) which were found in the deceased's blood the witness acknowledged that there are a whole range of further drug prevention measures dealing with illicit substances. These cover every aspect of the prison regime from external walls, including searching of incoming deliveries and mail to searching of visitors.

[106] Regarding the NPS found in the deceased's system the witness was able to say that it was referred to as "SPICE" by the prisoners. The witness first became aware of NPS around five years ago so it is a relatively new drug. NPS is a drug which comes in liquid form and the vapours are then usually inhaled/smoked. It comes into prison on paper onto which it is soaked. Once it dries out, it is near invisible. When you hold the paper up to a light, you may see a light water mark where the paper has been soaked. Prisoners then heat the paper using their vape and then inhale the vapours. I also understand they can put the paper in their kettle, heat the water and then drink the tea.

[107] The witness explained that the biggest challenge with NPS is detection which is incredibly difficult. It can come into the prison on any piece of paper. There are all sorts of paper which the prisoners could historically access – letters, leaflets, books, magazines, etc. Although SPS have tried to limit the paper coming in to the prison they cannot stop prisoners receiving letters. This was attempted south of the border but was challenged and stopped.

[108] The SPS have invested heavily in RapiScan machines. All SPS establishments now have a RapiScan machine. This is a machine that scans paper or surfaces to detect illicit substances. This has been extremely helpful for the detection of NPS.

[109] SPS now scan all incoming mail but cannot legally open the mail. The staff scan the envelope and hope that traces of NPS are detected on the outside, having soaked through when the letter was being put inside the envelope. It is more difficult to detect when the envelope is thick and the NPS sheet is put in the middle of many pages. If there is a detection, the prisoner is then asked to open the mail in front of the staff and all of the pages are scanned.

[110] This task is extremely time consuming particularly because when there is a detection, that envelope has usually rubbed off on many other envelopes in the bag resulting in numerous prisoners having their mail scanned.

[111] If intelligence is received that a prisoner is smuggling NPS, the SPS staff then have "just cause" to open their mail and scan it. However, if there is no reading on the outside or intelligence, there is very little more that can be done.

[112] The scanning and checks are all done in accordance with HMP Perth's SoP *"OPS 910 – Rapiscan Operation"* (SPS Production 14).

[113] Once NPS gets into the prison, it is near impossible to detect. Only a small amount is required to give an effect and it may be distributed on paper no bigger than a postage stamp.

[114] NPS is the overall term for a wide range of compounds/substances. These are all different chemical compounds and they are continually changing. The RapiScan machine can only pick up the NPS compounds that are actually known about. The machine needs to be continually calibrated to ensure it has as up to date a list of compounds as possible. This is done by working in conjunction with Dundee

University. All recovered substances are passed to the University to analyse. They look for trends in the substances coming in and try to identify any new NPS compounds.

[115] Although mail cannot be stopped steps have been taken to limit other types of paper coming into the prison. For example, family members can no longer send in books or magazines. Prisoners have to buy them direct from approved suppliers or borrow from the library.

[116] Finally the witness clarified that if a prisoner fails a medication spot check or cell search, or is found in possession of an illicit substance, they can be placed on a Governor's Report. This would be where, for example, they are in possession of prescription medication outwith their own prescription or in another's name. A prisoner is placed on a Governor's Report where they are suspected of breaking the prison rules.

[117] Once on report, an investigation takes place. The officers involved will fill out a report and note their findings. The prisoner would then appear before the Duty Governor in the Orderly Room. This is essentially where the decision is made as to whether the prisoner has broken the prison rules. If they are found to have broken the rules, they will be punished. This may involve the removal of certain privileges. This information is then fed into the Intelligence Unit and therefore the process also helps to builds up a picture of the repeat offenders. This information will then allow staff to target drug prevention measures – for example, search certain people's cells or mail.

[118] The parties were able to agree the provenance and content of a number of documents and productions including,

- Crown Production number 3, the Intimation of Death from the Registrar.
- Crown Production number 4 is a memory stick containing a record of telephone calls made by the deceased. It is believed that the telephone call made by the deceased on 14 November 2019 was made to his mother. This was played in full at the Inquiry and is commented upon in the discussion section.
- Crown Production number 5 is a handwritten note found by the police officers during the search of the deceased's cell on 15 November 2019. It is believed that the said note was written by the deceased to an inmate known as A.
- Crown Production number 6 is a handwritten note found by the police officers during the search of the deceased's cell on 15 November 2019. It is believed that the said note was written by the deceased to his parents.
- Crown Production number 7 is a handwritten note found by the police officers during the search of the deceased's cell on 15 November 2019. It is believed that the said note was written by the deceased. The said note contains his wishes regarding the disposal of his personal belongings.

[119] I was also furnished with the Scottish Prison Service Health records pertaining to the deceased. The Death in Custody Folder prepared by Scottish Prison Service included a book of photographs taken on 15 November 2019 at the locus by a

photographer who is a Scene Examiner and a member of the Scottish Police Services Authority, Forensic Services, Scene Examination, Dundee. The said book of photographs contains the following. These showed various views of Cell 15, Level 4, B Hall, HMP Perth and items found within. They also showed views of the deceased.

[120] TTM (SPS Productions 1-3) is the SPS' suicide prevention strategy. It details the SPS policy and procedure for dealing with prisoners who present as a suicide risk. All operational staff (i.e. SPS and NHS staff who come into contact with prisoners) are trained on TTM.

[121] The deceased was not on TTM at the time of his death. If at any time, any member of staff has a concern that a prisoner is at risk of suicide, they can initiate TTM. This will lead to an assessment (i.e. case conference) taking place and an appropriate care plan being put in place (e.g. observations, anti-ligature clothing, anti-ligature cell).

[122] Three prison officers came into contact with the deceased on 14 November 2019. The deceased did not give these individuals any cause for concern that he was at risk of suicide.

[123] I was provided with copies of the following policies and documents in order to assist in coming to my determination. It was agreed by all parties that the documents provided were true and accurate.

- SPS Production 1 is the Talk to Me (TTM): Strategy. TTM the SPS' suicide prevention policy.
- SPS Production 2 is TTM: Guidance (Part 1).
- SPS Production 3 is TTM: Guidance (Part 2).

- SPS Production 4 is Governors & Managers: Action (GMA) 060A/16 – Code Red/Code Blue Policy.
- SPS Production 5 is Governors & Managers: Action (GMA) 50A/15 – Procedure following a suicide or attempted suicide using a ligature.
- SPS Production 6 is Governors & Managers: Action (GMA) 001A/20 – Procedure following a suicide or attempted suicide using a ligature (revised). GMA's are national SPS policies. SPS Productions 1 to 6 are SPS policies and procedures.

[124] SPS Production 7 is a Death in Prison Learning, Audit & Review (DIPLAR) relating to the said deceased. A DIPLAR is a joint SPS/NHS review following a death in custody. I have made further reference to the discussions and conclusions reached by those in attendance at the DIPLAR in relation to this said death in the discussion section of my determination.

[125] The following findings and conclusions are reached at page 9 of the DIPLAR:

> "All agreed that there were no indications that Mr Dickie was going to take his own life. He engaged with staff and they knew him well with all agreeing that there were no cues and clues that were missed which could have prevented this death."

[126] Tayside Health Board Production 1 is the Local Adverse Event Review carried out by Tayside Health Board into this death. The discussions and conclusions reached by those in attendance at this meeting in relation to this death are recorded in that Review. It was agreed by the review group that all appropriate assessments were

carried out by the Healthcare Team and the patient received appropriate support and advice during his time in custody.

[127] Having read the joint minute the procurator fiscal then played a recording of a call between the deceased and his mother on the day before he was found dead.

[128] The discussion centred on arrangements for collection of a car and a bike and if and how they should be stored. The deceased explains to his mother that he no longer had his job on the hall because he refused to wear trousers. He indicated to his mother that he had in effect resigned from the job before he was sacked and his account of how he came to be sacked differs from that provided by MH but it is clear that he is not unduly bothered about the fact that he has lost this job and on the contrary says that his friend A has also quit and that he would secure a new job the following day. We know that this may not in fact have been entirely true but certainly demonstrates no anxiety on his part about the loss of his position as a passman. On his version of events he wishes to be transferred to C Hall where it is believed his former co-accused was housed. His mother expresses some concern about that but in any event that never transpired and the deceased was moved to another cell within the same hall.

[129] It is clear that the deceased held MH responsible for his sacking and bore some ill will towards her for that but in the end of the day the deceased had failed to abide by prison regulations and regardless of his views on the matter left the prison officer with very little choice. Had she not taken the steps which she did then the manager who had observed the situation would doubtless have done.

[130] The conversation included reference to the deceased's appeal. It is clear from documentation elsewhere in the productions that the appeal had been deemed abandoned as no substantive note of appeal against either conviction or sentence had been lodged. The deceased would have been aware of this and although his mother does not appear to have known that the appeal would not proceed the deceased was not at the time of his death expecting any positive outcome from that process.

[131] The content of the telephone call would not give the objective listener any cause for concern. It may have been a little fraught at times but the deceased is articulate and orientated throughout and does not speak to his mother in any way which would suggest that would be their last conversation.

Submissions

[132] Parties provided written submissions which they augmented orally at the end of the hearing on 15th February 2021. However they were given a further opportunity to make additional submissions in light of the additional evidence led on the 17th March 2021. I do not intend to repeat these at length as all parties concurred with the submission of the Crown that this was a case in which I should make formal findings only.

Discussion and determination

The legal framework

[133] 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.*

[134] 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.

[135] 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.

[136] 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.

[137] However sections 26(2) (b) and (d) and section 26(2) (e) merit further discussion. In conducting inquiries it is essential that the Sheriff considers the cause of the deceased's death. In this case the proximate cause was of course the deceased having hanged himself with a ligature. That is not in dispute. However it is my view that the inquiry should go further and explore, if possible, what caused the deceased to do that and whether looking at the evidence as a whole there is anything that those responsible for his care while within the prison estate could have done to prevent either his death or deaths occurring in similar circumstances in the future.

[138] That, as I have repeatedly pointed out in previous determinations, involves more than simply providing the court with the policies which were in place at the time of the deceased's death but also the leading of evidence sufficient to satisfy the Sheriff that the policies were robustly applied and adhered to in this particular case.

[139] In the course of the hearing of 15 February 2021 it became apparent that some confusion had arisen at least in my mind in relation to the toxicology evidence. It was not initially clear to me whether the deceased had been prescribed Mirtazapine, which is an anti-depressant, and was described as being found in his blood analysis as being at a therapeutic level.

[140] I had of course had sight of the medical records pertaining to the deceased and was not aware that the deceased had been treated for depression at all let alone

prescribed an anti-depressant. Had he been receiving any such treatment that would have resulted in regular contact with mental health services and a far greater concern about his mental state generally.

[141] Further examination of the toxicology report and discussion with parties in the course of the hearing revealed that the deceased had not reported any issues of depression and was not being treated for such a condition. Accordingly he had not received the drugs which were initially described as prescription drugs therapeutically and had clearly sourced them himself. In addition 4F-MDMB-BINACA is a synthetic cannabinoid which is not a prescription drug but is available as an illicit commodity within the prison estate.

[142] Having been furnished with this clarification a further issue then arose as to what the effect of these drugs either alone or in combination could have been on the deceased's state of mind if they were ingested shortly before his death and whether the consumption of these drugs could in any way have contributed to his death. This would of course have opened up the inquiry into consideration of the availability of illicit drugs within the prison setting and the measures which are taken to combat substance misuse. This had not previously emerged as an obvious line of inquiry.

[143] On the basis of my concerns I instructed further investigation to be carried out in the form of affidavit evidence to be obtained from the toxicologist who prepared the initial report to ascertain whether any further light could be shed on whether there was a causative link between the deceased's consumption of these substances and his death.

[144] I have dealt with the evidence pertaining to the deceased's death under two specific chapters.

Talk To Me and the Risk Assessments carried out in respect of the deceased

[145] The Talk to Me Suicide Strategy has now been in place for some years and enables anyone having contact with a prisoner to alert the SPS and NHS in the event of any concerns. In addition these are robust risk assessment measures undertaken each time the prisoner is admitted back into the prison. The detail which is required to be inserted on the Escort records makes clear that this is far from a tick box exercise.

[146] It is, for example, of note that when the deceased was returned to HMP Perth on 30 May 2019 after receiving his sentence he is expressly noted as communicating well with no thoughts of self-harm or suicide at the present time. The officer completing the form is invited to comment objectively on the individual's presentation and noted that he presented well, had good eye contact and relaxed mood throughout.

[147] The deceased was then seen by a mental health nurse for a full assessment. It is noted that on interview the deceased stated that he had had no suicide or self harm attempts, had had no previous input or treatment or psychological support for mental health issues. He had no thoughts of self harm or suicide and expressed no anxieties or concerns.

[148] He was described as "alert, orientated and communicating well, good eye contact, spoke about sentence but he states he is just going to get on with it. Happy to be returning to B Hall where he has a job. He was made aware of the listener and chaplaincy services and expressed no anxieties or concerns."

[149] Nevertheless we know that on 3 May 2019 when the deceased was returned to the prison having just been convicted he was placed on 60 minute observations despite his own statement at reception that he had no thoughts of suicide or self-harm. It transpired that the reason for placing him on TTM was as a result of a conversation between a manager and the deceased's family expressing concerns about his mental health.

[150] This demonstrates that the policy did operate in so far as any individual could highlight concerns and even if those concerns were not supported by the individual or by observed behavioural change the TTM procedures would be implemented.

[151] I also note that in the subsequent DIPLAR the deceased is noted as being unable to understand why he has been placed on TTM and expressed the view that his mother was more concerned about his sentence than he was. In particular it is noted,

"An initial case conference was held on the 4th May 2019 for the purposes of "Talk to me" (Suicide Prevention). A Registered Nurse – Mental Health assessed and attended the case conference. The case conference was held because of concerns raised by the patients' mother, who contacted the prison to say she was worried about his mental state because he was possibly going to be given a lengthy sentence.

The patient attended the case conference and there were no obvious concerns regarding the way he presented, being well groomed and neatly dressed. He said that he was surprised and embarrassed that he had been placed on "Talk to me", and stated his mother was more worried about his sentence than he was.

At this point, the patient had not received his sentence, but was aware that it could be 20 years or more. He was very bright in presentation, and said that he was keeping his spirits high and needed to be positive. He denied any previous or current thoughts of self harm or suicide, and said that he would never do that to his mother. He made good eye contact and his mood was objectively positive. He reported no previous mental health concerns prior to prison and reported no Substance Misuse history nor was he currently using any illicit drugs. He reported no childhood trauma, and said that his life was normal prior to prison.

The collective decision following the case conference was that the patient would stay on Talk to Me just as a means of support over the next few days as he had just returned from a week's worth of high court trial. A further case conference was scheduled for the 8th May, again a Registered Nurse – Mental Health attended the case conference, at which staff met again with the patient. Again, he presented as well groomed, maintained good eye contact and had an open posture and was bright and reactive. He stated that he had a visit today with his mother to calm her down and he had told her that he was fine. He said that he continues to be positive for grounds of appeal.

He denied thoughts of suicide or self-harm, and had been engaging well with SPS, who had no concerns regarding his mental state. The collective decision following this case conference was to remove the patient from Talk to Me, and the patient was advised that if he felt that his mental health was starting to deteriorate, to self-refer back to the Mental Health team."

[152] Standing the content of this very full assessment and the precaution of keeping the deceased on observations despite a positive presentation it is clear that in the case of

the deceased the SPS and NHS were quite prepared to act on concerns and take a protective and cautious approach.

[153] In light of the very extensive evidence before me it does not appear that the deceased was presenting in any way which would have caused concern in the days before he took his own life.

[154] I am obliged to consider whether there are any precautions which SPS and the NHS operating within the prison 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.

[155] In this case I am satisfied not only that the policies and procedures which were in place were robust but that they were followed. It must be remembered that the requirement is to take reasonable precautions and the system will never be able to prevent those who are determined enough to do so from self-harm or suicide.

[156] In the course of the hearing the deceased's mother, although not a party to the inquiry in the formal sense, made a number of comments and observations which I have taken on board. In particular she was of the view that her son should have been on suicide watch at the time of his death. While I can fully understand that she believes that would have been a preventative measure there was nothing in the evidence to suggest that such measures were even remotely indicated.

[157] It is clear that while the deceased's mother was under the impression that there may still be a likelihood of a positive outcome from an appeal that was factually incorrect both in terms of sentence and conviction. The deceased was aware of that and

at least superficially had resigned himself to the reality that he was facing a long prison sentence. Again we cannot speculate about how that affected him on the night in question or whether it was a contributing factor in his decision to end his life but he was not expressing or displaying undue anxiety or distress about his fate. Indeed he was specifically asked about that and said he was just going to get on with it and that his mother was more concerned than he was.

[158] When he had been placed on 60 minute observations he could not understand why but nevertheless was kept on this regime despite his protestations.

[159] It should be noted that being placed on TTM is a short term solution to an immediate risk and that the follow up is engagement with mental health services which would have been available to the deceased had he shown any inclination towards suicide or self-harm. It is clear that when the deceased felt a need he did take up medical or dental services but would often disengage when the acute problem had passed. Maintaining the deceased on long term observations without any clear evidence base for doing so would have been neither reasonable nor practicable.

[160] In short I did not find any failings in relation to the operation of the suicide prevention strategy in place and this appears to me to have been a most unfortunate case where the deceased's actions could not have been anticipated.

The Toxicology Evidence

[161] Having regard to the toxicology report and the additional evidence provided by the forensic toxicologist it is impossible for me to determine that the deceased's

ingestion of illicit substances which included the SCRA and the prescription drug which had not been prescribed to him caused or contributed to his death.

[162] It is quite clear that the substances were not found at levels which would in themselves have produced a fatality but my interest was to try to determine, if possible, what effect these substances on their own or in combination could have on a person's mental state.

[163] The toxicologist was unable to be case specific either about when these substances had been ingested or what effect they may or may not have had on the deceased. However it is clear that the SCRA in particular can have serious effects of a relatively long term nature.

[164] I accepted the submission of the Procurator Fiscal to the effect that the deceased was unlikely to have been acting under some sort of psychosis or hallucination at the time of his death as he had left a number of notes for his friends and family and specific directions about what he wished to be done with his property. It was therefore clear that whatever his motivation the deceased's actions in taking his life were deliberate and planned.

[165] It is quite impossible for me to find any causal link between the consumption of these substances and the deceased's death on the basis of the evidence before me. All that can be said with certainly is that the deceased was clearly using drugs within the prison system while expressly denying that this was the case. He had no history of substance abuse and had not sought any help for any such problem. There was no overt sign that he was ever under the effects of any substance and on the contrary seems to

have held a position of responsibility within the prison without being compromised by apparent substance misuse.

[166] The question to which I must then turn is whether there are any precautions which SPS and the NHS operating within the prison 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.

[167] Furthermore I am obliged to consider whether there were any defects in any system of working which contributed to the death.

[168] In this regard I am informed by the evidence of the Deputy Governor who explained in detail the measures which are taken to prevent an illicit market in prescription drugs within the prison setting. In this case it is clear that despite the measures the deceased was able to obtain drugs which had not been prescribed to him and drugs which had entered the prison system by other means.

[169] It is clearly a very difficult if not impossible task to prevent drugs from being brought into the prison estate. The evidence of the witness made clear the lengths to which prisoners would go to ensure a supply and the SCRAs seem particularly difficult to detect.

[170] Again the SPS can only take measures which are reasonable. The evidence that the deceased's cell was randomly searched 3 days before his death in conjunction with the testimony that it would have been searched when he was moved to a new cell indicates that he was clearly able to conceal the substances or had acquired them shortly before his death.

[171] I am satisfied that there are measures in place to try to counter the use of and admission of drugs in the prison estate but again this cannot be eliminated if there are increasingly novel and determined efforts to circumvent the measures in place.

[172] It is impossible to conclude that there are any reasonably practical measures which could have been taken in relation to the use of illicit drugs which would have prevented this death and in any event no real causal link can be established in this case.

[173] The SPS addressed the response on 15th November 2019 and the Code Blue procedures. From the evidence available to me it seems that by the time the deceased was found nothing could have been done to revive him. I have reviewed the documents provided and do not consider there were any failings in this regard.

Conclusion

[174] After what has been a lengthy and, in my view, a thorough and complete examination of the facts pertaining to the deceased's death, I am in agreement with the parties' submissions that in this case it is appropriate to make formal findings only.

[175] The precautions which were taken both in terms of suicide prevention and illicit drug misuse were reasonable and the policies in place were followed.

[176] The prison is in the end of the day a reflection of society outside the prison walls. Prisoners cannot be forced to take up the services which are provided to them and while there are rules to be followed to try to prevent deaths in custody whether due to suicide or drug misuse those who are determined to circumvent these provisions will inevitably find ways of so doing.

[177] There are many factors which could have affected the deceased such as the loss of his job as a passman, his ingestion of drugs with unknown consequences, the lack of prospects of an appeal or simply the prospect of having to spend a lengthy period of time in custody. None of these on their own seem to have been the motivating factor behind the deceased's actions and any attempt to attribute a motive would be speculation.

[178] On the basis of the evidence I cannot suggest any recommendations of the sort suggested in section 26(4) which might realistically have prevented this or other deaths in similar circumstances.

[179] 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.

Sheriff Gillian A Wade QC

22 March 2021.