SHERIFFDOM OF GRAMPIAN HIGHLAND AND ISLANDS AT PETERHEAD

[2023] FAI 15

PHD-B67-22

DETERMINATION

BY

SHERIFF CHRISTINE P McCROSSAN

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

into the death of

TRACEY JUNE ANGEL AIRD

Peterhead, 8 March 2023

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

(1) Ms Aird born on 8 March 1974 died at HMP Grampian, South Road, Peterhead on 27 July 2021, life being pronounced extinct at 14 46 hours on that date;

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

(3) The cause of Ms Aird's death , confirmed by the findings of a post mortem carried out on 30 July 2021 was 1(a) Nefopam toxicity and cardiac enlargement;

(4) Following an investigation into the circumstances surrounding the death of Ms Aird the sheriff finds and determines that there were no precautions which could

reasonably have been taken, which if taken, might realistically have resulted in her death being avoided, nor were there any defects in the system of working which contributed to her death.

Background

[1] This was a mandatory inquiry due to Ms Aird dying while in legal custody. The Crown issued a Notice of Inquiry in this case on 14 June 2022. At that time the Crown did not identify any obvious failings which raised particular issues for consideration by the Inquiry. The parties who participated in the inquiry were (i) the Scottish Prison Service (SPS), (ii) the Prison Officers' Association (Scotland) (SPOA) and Grampian Health Board (hereinafter referred to as NHS Grampian). Ms Aird's sister, hereinafter referred to as Miss MG did not wish to be a participant but did indicate to the Crown that she wished to be kept informed of the outcome and be in attendance if a hearing on evidence was fixed. Miss MG did raise some issues of concern directly with SPS which were dealt with at the internal DIPLAR[1] review; these are also dealt with in this determination

Evidence before the Inquiry

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

1. Autopsy Report

[1] See paragraph [15] below.

2. Toxicological Report

3. Book of Photographs (to show the layout of Ms Aird's cell, the location of items seized and Ms Aird's presentation at the time of her death)

4. Medical Records detailing consultations and treatment Ms Aird received while within HMP Grampian

5. SPS incident Report and initial witness Statements

6. Talk to Me[2] documentation detailing assessments carried out on Ms Aird in accordance with this procedure (the Reception Risk Assessments (RRA))

7. SPS Intelligence Information (detailing information received in relation to allegations of Ms Aird being bullied in prison)

8. Record of landline calls made by Ms Aird

9. Record of mobile calls made by Ms Aird

10. DIPLAR report

11. Police Scotland drugs and medicine list (detailing medications recovered from Ms Aird's cell)

12. Regular Prescriptions sheet, detailing how medication has been dispensed to Ms Aird

13. Transcripts of landline calls Volume 1

14. Transcripts of Landline Calls Volume 2

15. Transcripts of Landline Calls Volume 3

[2] These reference the assessments conducted as part of the SPS Prevention of Suicide in Prisons Strategy.

16. Transcripts of Landline Calls Volume 4

17. Transcripts of Mobile calls

18. Email from Dr McKenzie (20/05/22) detailing forensic analyses of productions seized from Ms Aird's cell

19. Summary Report of said analyses.

[3] The Preliminary hearing in this case took place on 11 August 2022. Parties confirmed, having considered all of the evidence lodged, that they had no outstanding issues they wished investigated at the Inquiry. All parties were in a position to agree the terms of a joint minute. Given its content there was no requirement for evidence to be led from any witnesses.

[4] The Joint Minute was signed by all parties and lodged at court. It sets out the relevant circumstances leading up to and following Ms Aird's death. Parties lodged written submissions. A hearing was set down to proceed by way of WebEx on 5 October 2022. Miss MG attended this hearing by telephone. She appeared uncertain of what the purpose of the hearing was and expressed her continuing concerns about issues she had raised re bullying of her sister. In these circumstances the matter was continued until 15 November 2022 to allow her to consider whether she wished to obtain legal advice with a view to participating in the inquiry. In due course it was confirmed that she did not wish to participate but would be attended at the hearing on 15 November 2022 with her support worker. At this hearing the Crown read out the terms of the Joint Minute and thereafter all parties adopted the terms of their written submissions and asked that a formal determination be issued in the case. The concerns that Miss MG continued to

have about her sister were wholly understandable; however they did not disclose any failure on the part of SPS or NHS towards Ms Aird; I found no evidence of any precautions which could reasonably have been taken which might realistically have avoided Ms Aird's passing in the circumstances in which she did, nor were there any defects in the system of working which contributed to her death.

Relevant Circumstances

[5] Ms Aird had been remanded to HMP Grampian on 13 May 2021 following her arrest on a warrant in respect of an alleged assault with a knife. Information was provided about events on the day of Ms Aird's death. It was noted that Ms Aird had attended a virtual court hearing on the morning at 10.00am. Following this, before re-admission to the residential hall, a standard Reception Risk Assessment (RRA) under the Talk-to-Me procedure was carried out. This did not raise any concerns about Ms Aird's well-being at that time; she did not present as being at risk of self-harm. Indeed the following is noted: "Tracey engaged with staff, was in a good mood. No signs of anger or anxiety." At the end of the assessment Ms Aird did disclose that that she was having issues with another inmate in the Hall. The prison officer conducting the assessment followed Scottish Prison Service (SPS) procedure by passing this information to a residential officer within the Hall and submitting an intelligence report to the Intelligence Management Unit (IMU). There is reference on the RRA form to Ms Aird being "the victim of bullying". Following the assessment Ms Aird was escorted back to

Banff Hall. Shortly thereafter she was witnessed having an argument with a fellow inmate. The incident was diffused quickly with both parties apologizing to each other.

[6] Ms Aird was noted to be safe and well at 11:56 when prison officers carried out a lunchtime numbers check. It is not uncommon for prisoners to spend time within their cells even when the cells are unlocked. Individual prisoners will not be routinely checked by prison staff when they are within their cells, other than during these specific numbers checks carried out at certain times of the day. There was nothing unusual in Ms Aird being alone within her cell during this period.

[7] At 14:20 another prisoner, while in the process of carrying out cleaning duties, was wiping down Ms Aird's cell door. She opened the observation hatch and saw Ms Aird lying on the floor. She called out several times to Ms Aird. When she was not able to rouse her she raised the alarm with staff. A Code Blue alarm was raised by the first prison officer on the scene. Medical staff attended from the health centre. Ms Aird was not breathing and she was unresponsive. Attempts were made to resuscitate her to no avail.[3] An emergency ambulance was called at 14:33. The prison Doctor attended at 14:41. He tried to gain IV access but was not successful. The paramedics arrived at 14:44. They conducted an ECG but this provided no trace. The Doctor pronounced Ms Aird's life extinct at 14:46 hours.

[8] A post mortem was carried out on Ms Aird on 30 July 2021. This revealed potentially significant natural disease of the heart. The degree of disease present could

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[3] Staff in rotation carried out rounds of CPR. Oxygen was provided, nyxoid was administered and a guedel airway was inserted. Defibrillator pads were applied to Ms Aird's chest but no shocks were administered as no heart trace or rhythm was traced.

have rendered Ms Aird susceptible to ischaemia and the development of a potentially fatal cardiac arrhythmia (abnormal heart rhythm) at any time and could account for death. Toxicological analysis revealed a higher than expected concentration of prescribed Nefopam. This is an analgesic and antidepressant. It was prescribed to Ms Aird as a pain relief at her first appointment with the prison GP following her admission to HMP Grampian on 14 May 2021. The level within Ms Aird's blood was within the reported "toxic" range. The toxic effects of Nefopam include sedation, cardiac arrhythmia and seizures. The opinion of the pathologist was that these were the most significant findings in the case and given that the death of Ms Aird was not witnessed "the cause is best regarded as due to a combination of these findings."

[9] Following Ms Aird's death in custody the Scottish Prison Service and NHS Scotland conducted a joint "Death in Prison Learning Audit Review". This Review examined the following:

(i) Ms Aird's custodial history including contact with the prison health service;

(ii) a timeline of contact with SPS services and any significant events in the months leading up to her death;

(iii) Ms Aird's behaviour and mood in the month prior to her death; and

(iv) whether any relevant information came to light following Ms Aird's death.

[10] As outlined above Ms Aird's sister Miss MG raised a number of concerns at the DIPLAR review about her sister's death. In particular she questioned how it been

possible for Ms Aird to "get enough medication for this to happen to her". She had become aware of reports that Ms Aird was being bullied in prison, she wanted to know whether these were taken seriously. She also questioned why no one appeared to have been around when her sister was found, given that it was in the afternoon.[4]

Medication

[11] Ms Aird was prescribed certain medications during her remand at HMP Grampian. On admission on 13 May 2021 her blood pressure reading was very high. She was prescribed appropriate medication for this. She complained of pain from a previous fracture to her Coccyx and was prescribed Nefopam 30mg for this to be taken 3 times per day. This medication was issued to Ms Aird weekly on a self-administration basis. There was no indication that Ms Aird was at risk of self-harm and thus that she should not be trusted to manage her own pain relief medication. She was assessed on admission to prison under the Talk To Me procedure and again following her virtual court hearings, the most recent assessment being carried out on the morning of her death. On that day she engaged well with staff and was reported as being in a good mood. Whilst there was a suggestion by prison social work shortly after her admission that Ms Aird was awaiting psychology review in the community; this is not borne out by her original assessment.[5] Ms Aird did suffer from other physical ailments for which she

[4] As noted in paragraph [6] there was nothing untoward in Ms Aird being alone within her cell at the time leading up to her death.

[5] This initial assessment process requires the NHS staff to check directly with the prisoner's community GP practice to determine whether there is any ongoing treatment needs or reviews. This was completed for Ms Aird and disclosed no ongoing psychological review.

received medication and treatment while within the prison. None of these issues was relevant to Ms Aird's death.

[12] On the whole Ms Aird was reported as getting on well with staff and other prisoners. She appeared to be preparing for eventual release as she had signed up for support from SHINE[6] and had made arrangements to have a phone call with Castlehill Housing association to discuss her tenancy. She spoke about her pet cats a lot and was visibly upset about having to arrange for them to be rehomed but she had sought assistance from the prison staff to help her with this; and indeed for the meeting with the housing association. She had shared that she felt better once these matters were being attended to. Another prison officer reported speaking with Ms Aird on 9 July 2021 as she appeared quieter than normal and somewhat withdrawn. She confided that she was concerned about not being fit enough to re-sit her offshore survival training; but had reported remaining positive and taking steps to regain fitness by working with physiotherapy.

[13] The post mortem report does not rule out Nefopam toxicity as the cause of Ms Aird's death.[7] The evidence available to the court does not suggest Ms Aird deliberately self-administered a toxic dosage of this medication to cause herself harm. She engaged well with the prison staff who conducted her RRA and escorted her back to her hall on the day of her death. Her behaviour until then had not been a cause of any concern. Whilst she had on that day reported bullying there was no indication from her

[6] Shine is a national mentoring service for women offenders.

[7]. It should of course not be overlooked that it is also possible that Ms Aird died from a cardiac arrhythmia caused by the significant natural disease in her heart.

recent interactions with staff that this was causing such distress that it would lead to her taking her own life. When she had made a similar complaint previously it had been dealt with immediately; thus it can reasonably be assumed that she had made the disclosure with the expectation that it was going to be handled and without delay. She was looking forward by making plans in expectation of her release from prison and pragmatically making preparations for a period serving a sentence.

[14] The post mortem examination and toxicology analyses cannot conclusively establish that the concentrations of Nefopam in Ms Aird's system proved toxic to her. She may have developed a high tolerance. Having said that the higher than expected concentration of prescribed Nefopam indicates that she was not taking the medication in accordance with the prescription. There is no evidence to suggest this is a situation which should have been anticipated by SPS or NHS staff. There was no indication that Ms Aird's use of this drug required to be supervised in any way. There was no indication that she would not be able to manage a prescription for a painkiller administered for back pain. She had no history of drug misuse. She was not assessed as at risk of self- harm. Nefopam is a strong painkiller but it does not contain morphine derivatives; thus does not have the potential risks that those type of prescription drugs have, either to the patient or within a prison community.

[15] In circumstances where a prisoner is issued with a prescription they require to sign a document entitled: "Patient responsibilities for in possession medicines".

Ms Aird did sign such a document on 13 May 2021[8]. This document advises prisoners that they must cooperate with healthcare staff spot checks on medicines "to verify appropriate medicines and quantities are in your possession". SPS and NHS staff share the responsibility of carrying out any such spot checks which are required under this policy. In general terms such checks are carried out in circumstances where staff have a suspicion or intelligence is received that an inmate is supplying the drug to others or is placed on the Management of an offender at risk due to any substance (MORS) policy. The purpose of such a search would be to find and confiscate any drugs that were being stockpiled by the prisoner. No such concerns were raised or existed for Ms Aird, therefore there was no reason for carrying out any such search on her cell.

[16] A drug of this nature has little currency in the prison, thus Ms Aird's having access to a prescription for quantities of this drug would not, in itself, make her a target for bullying within the prison establishment.

Bullying allegations

[17] Ms Aird had been moved to Banff 2C from Banff 2A on 2 June 2021 following an allegation of bullying. Ms Aird reported that she was having a hard time and getting picked on by "all of the other prisoners." It was alleged that her weekly medication was being stolen from her cell; food was being thrown at her and she was having issues with other prisoners due to her use of the phone. She was moved to another area of the

[8] Page 43 Crown Production 5

prison on the same day the allegations were made. An entry on Ms Aird's Community Integration Plan, made by her Personal officer on 9 June 2021 states that she has settled well into the new section. No further concerns were raised by Ms Aird, or indeed by anyone on her behalf, until Ms Aird herself raised concerns on the day of her death. There was no evidence to suggest that staff should otherwise have been aware of anything untoward going on.

[18] After her virtual court appearance on 27 July 2021 Ms Aird disclosed during the RRA that she was being bullied by another person within her section of the prison. This intelligence was recorded by the prison officer and in accordance with SPS procedure reported to the Intelligence Management Unit (IMU) within the prison. When Ms Aird returned to Banff hall after her assessment she is reported to have become involved in an altercation with this named prisoner but the situation was defused quickly and apologies exchanged. Ms Aird returned to her cell.

[19] Following Ms Aird's death further intelligence was received from other prisoners about the bullying allegations. A variety of allegations were received. It was alleged that Ms Aird was being bullied for her medication; that a particular person was going into her cell and removing her belongings and food; that she was calling her derogatory names while in the exercise yard. Allegations were made also about Ms Aird's conduct (not relating to bullying but that she had been selling her medication). It appears that SPS staff did not consider certain of the allegations about Ms Aird to be particularly credible given the lack of resale value of such medications within the prison establishment.

[20] It is recorded in the DIPLAR report that the IMU staff were in the process of planning what action to take about Ms Aird's allegations when news came through to the effect that Ms Aird had been found unresponsive in her cell. It is clear from the history of this case that when Ms Aird made the allegation of bullying on 2 June 2021 steps had been taken without delay to deal with these concerns. Ms Aird was moved to a different area of the prison immediately on 2 June when she made an allegation against other prisoners. There was an appropriate follow up on 9 June; when it was reported that there were no ongoing issues. I am satisfied that when Ms Aird made a disclosure at her RRA on 27 July 2021 the appropriate procedures were again followed. Matters were noted and reported immediately to the IMU. Unfortunately there was no time to put a plan into action before Ms Aird was found within her cell, all as outlined above. There was no failure on the part of the SPS in this regard.

Conclusion

[21] Ms Aird's death was a tragedy for her family and friends. It is clear that both SPS and NHS staff made valiant attempts to save Ms Aird's life on the afternoon she was found within her cell; alas to no avail. Her death caused great upset for the other prisoners within her Hall and indeed some unrest due to ill-feeling around the allegations that bullying had been taking place. Staff involved were also distressed. It is noted that on the day following Ms Aird's death the FLM[9] in Banff Hall arranged a

[9] Floor Level Manager

candle lighting service led by the prison Chaplaincy team and a book of condolence was opened up. The uptake among the prisoners was positive. It is hoped that this act of remembrance for Ms Aird will offer some level of comfort to her family at this time.

[22] In conclusion, having examined all of the relevant circumstance surrounding Ms Aird's tragic death I make no findings in terms of section 26(2)(e), (f) and (g) and have no recommendations to make in terms of section 26(4). Finally I add my sincere condolences to Ms Aird's next of kin and her other family and friends.