SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT PERTH

[2023] FAI 35

PER-B53-22

DETERMINATION

BY

SHERIFF JOHN A. MACRITCHIE SSC

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

into the death of

GARY ROSS

PERTH, 4 July 2023

Determination

[1] The Sheriff, having considered the information presented at the Inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act") that:

(a) In terms of subsection (2)(a) (when and where the death occurred), between 19:02 on 12 March 2020 and 08:03 on 13 March 2020, Gary Ross, aged 34, born 2 February 1986, then in legal custody, died within Cell 24, Level 1, C Hall, HM Prison Perth, 3 Edinburgh Road, Perth;

(b) In terms of subsection (2)(b) (when and where the accident occurred), Mr Ross accidentally overdosed by ingesting unprescribed Etizolam in addition to prescribed Buprenorphine (Subutex);

(c) In terms of subsection (2)(c) (cause of death), the death was caused by the combined adverse effects of said Etizolam and Buprenorphine, fatally suppressing the functioning of Mr Ross' respiratory and central nervous systems;

(d) In terms of subsection (2)(d) (cause of the accident), the cause of the said accidental drug overdose was the consumption by Mr Ross of said Etizolam in addition to said Buprenorphine;

(e) In terms of subsection (2)(e) (reasonable precautions), the Scottish Prison Service ("SPS"), through its employees, could have generally taken the reasonable precaution of strictly adhering to its Lock-up Procedures. The SPS could have specifically taken the reasonable precautions that they took after Mr Ross' death, namely providing training to residential officers in respect of the said Lock-up Procedures. Thereby, all such officers would have been fully cognisant of and appreciative of the necessity of strictly adhering to the said Lock-up Procedures, by seeing Mr Ross' face and engaging in a dialogue with him at Lock-up. The cause of Mr Ross' death was the adverse effects of his consumption of said Etizolam in addition to said Buprenorphine. However strictly adhering to the said Lock-up Procedures (particularly had officers been adequately trained in the same and had impressed upon them the importance of strictly adhering thereto), might realistically have resulted in (one) Mr Ross' medical condition being noticed at Lock-up, (two) his after that being monitored and treated by health professionals, and (three) his death thereby avoided;

(f) In terms of subsection (2)(f) (defects in the system of working), there were no defects in the system of working which contributed to Mr Ross' death or the accidental drug overdose resulting in his death;

(g) In terms of subsection (2)(g) (relevant facts), there are no other facts which are relevant to the circumstances of Mr Ross' death.

Recommendations

[2] In terms of subsection (1)(b) of section 26 of the Act, it is recommended that the SPS improve their system of working by making further provision for ongoing refresher training courses for residential officers at regular intervals, to continually ensure that all such officers remain fully cognisant of and appreciative of the necessity of strictly adhering to the said Lock-up Procedures, doing so across the entire prison estate and not just as local reactions to individual deaths, which improvement might realistically prevent other deaths in similar circumstances.

Note

Introduction

[3] The Inquiry was held under the Act into the death of Mr Ross. The death was reported to the Crown Office and Procurator Fiscal Service on 13 March 2020.

[4] The dates of Preliminary Hearings were 21 April, 30 June, 31 August, 14 October, 7, 16 and 21 November, 16 December 2022 and 11 January 2023.

[5] The dates of the Evidential Hearings were 20 January, 10 March and 4 July 2023.

[6] The representatives of the participants at the Inquiry were: Ms M Graham, procurator fiscal depute for the Crown; Ms L Clark, solicitor for the next of kin of Mr Ross; Ms L McCabe, solicitor for the SPS; Mr A Rodgers, solicitor for the Prison Officers Association Scotland ("POAS"); and Ms A Sargent, solicitor for NHS Tayside.

Evidence

[7] The SPS lodged affidavits, which were admitted in evidence and treated as if they were the parole evidence of the witnesses, from:

1) RC, Head of Operations, HMP Perth, dated 30 May 2022;
2) Prison Officer MM, HMP Perth, dated 14 September 2022;
3) Prison Officer JH, HMP Perth, dated 16 September 2022;
4) SK, Acting Unit Manager, HMP Perth, dated 16 September 2022;
5) Prison Officer JC, HMP Perth, dated 27 September 2022;
6) Prison Officer MM, aforesaid, supplementary dated 9 November 2022;
7) RW, Theme Lead for Criminal Justice at the SPS College, dated 17 November 2022;
8) RC, aforesaid, supplementary dated 24 November 2022;
9) GF, Head of Operational Planning, dated 19 January 2023.

[8] The participants in the Inquiry entered into three Joint Minutes of Agreement, agreeing the admission of the preceding affidavits in evidence and:

1) Mr Ross' date of birth, cell location and general background information;

2) Crown productions numbered 1 to 8 were true and accurate and should be admitted in evidence; Crown Production 9 is a pen drive containing CCTV footage from HMP Perth; Crown Productions 10 to 14 and 16 to 17 should be admitted in evidence as if they were the parole evidence of the relative witnesses; Crown Production 18 is a description of what can be seen in the said CCTV footage in Crown Production 9 from cameras 334 and 337 in Association Areas South 1 and 4 respectively, in C Hall, Level 1, HM Prison Perth between 1900 hours on 12 March 2020 and 0913 hours on 13 March 2020. These productions comprised of:

1. Post Mortem Report;
2. Toxicology Report dated 16 September 2020;
3. Intimation from the Registrar;
4. Book of Photographs by GB, Scene Examiner, Scottish Police Services Authority;
5. SPS Death in Custody Folder;
6. NHS Tayside Medical Records;
7. Pronunciation of Life Extinct;
8. DIPLAR Report;
9. CCTV pen drive;
10. Police Statement of MB, SPS Operation Manager, dated 13 March 2020;
11. Police Statement of Prison Officer JH, dated 16 March 2020;

12. Police Statement of Prison Officer MM, dated 13 March 2020;

13. Police Statement of XX, Prisoner at HMP Perth, dated 13 March 2020;

14. Police Statement of DR, Head of Operations, SPS, dated 15 May 2020;

15. Not used

16. Affidavit of Dr Helen Brownlow, Consultant Forensic Pathologist, dated 24 October 2022;

17. Police Statement of Prison Officer JC, dated 16 March 2020;

18. CCTV Description of what is seen in Crown Production numbered 9.

3) SPS Productions 1 to 24 were true and accurate and should be admitted in evidence. These productions comprised of:

1. GMA 079A/14 – Management of an Offender at Risk due to any substance - Policy and Guidance, dated 30 December 2014;

2. GMA 010A/15 - Witnessing the Administration of a Controlled Drug, dated 5 March 2015;

3. Standard Operating Procedure: Searching Prisoners, dated May 2015;

4. Standard Operating Procedure: Searching Visitors, dated May 2015;

5. Standard Operating Procedure: Visits Procedures, dated May 2015;

6. GMA 016A/16 - Revised Requirements During Locking and Unlocking Periods, dated 28 March 2016;

7. Standard Operating Procedure: Issuing of Medication, dated June 2016;

8. Standard Operating Procedure: Suspect Mail, dated February 2018;

9. Standard Operating Procedure: Cell Searches, dated May 2019;

10. Cell Search Record relating to Gary Ross from 1 January 2018 to 22 September 2021;

11. Standard Operating Procedure: Residential Number Check, dated July 2022;

12. Numbers Check Awareness Refresher – Attendance Record;

13. Programme Specification for the Officer Foundation Programme;

14. Programme Specification for Residential Officer Foundation Programme;

15. Session Plan for the Locking & Numbers Session on the Residential Officer Foundation Programme;

16. Course Descriptor for the Locking & Numbers Session on the Residential Officer Foundation Programme;

17. A PowerPoint presentation that is used during the Locking & Numbers Session on the Residential Officer Foundation Programme;

18. Locking & Numbers Session pre-reading containing PRL Standard 1.3.3.3 (Population Counts/Number Checks);

19. Standard Operating Procedure: for Residential Numbers Check dated April 2020;

20. Standard Operating Procedure: for Residential Number Check dated June 2016;

21. Comparison of the Standard Operating Procedure: for Residential Number Check, dated June 2016 and the Standard Operating Procedure: for Residential Number Check, dated April 2020;

22. Comparison of the Standard Operating Procedure: for Residential Number Check, dated April 2020 and the Standard Operating Procedure: for Residential Number Check, dated July 2022;

23. GMA – Induction for Operations Officers Acting-up to Residential Officers (C-D Band) dated January 2023.

24. The HMP Perth Standard Operating Procedure for "Recreational Activities" dated July 2022.

4) NHS Tayside Health Board's Production 1 was true and accurate and should be admitted in evidence, namely:

1. NHS Tayside Full Adverse Event Review Report dated 19 June 2020.

[9] In-person, parole evidence was taken from Prison Officers JC, JH and Mr SK. In general terms, despite having significant service, including as residential officers, it was only after the death of Mr Ross that Prison Officers JC and JH became fully cognisant of the said Lock-up Procedures and thereby appreciated the necessity, in terms thereof, of strictly adhering to such, by seeing Mr Ross' face and engaging in a dialogue with him at Lock-up.

[10] However, Prison Officer JH accepted that he "probably" knew that he had been required to get a response from Mr Ross at Lock-Up, although his detailed understanding of this responsibility at the time, had been vague. Prison Officer JH accepted that in practice he did not ensure that he obtained a response from all prisoners and in giving his evidence was patently emotionally concerned at not having done so in this instance.

[11] SK, a First Line Manager ("FLM") at HMP Perth at the time of Mr Ross' death, gave evidence that he had been unaware of there being any issues around the said Lock-up Procedures not being adhered to in this respect.

The Legal Framework

[12] The Inquiry was held under section 1 of the Act. The Inquiry was a mandatory Inquiry under subsections (1), (4)(a) and (5)(a) of Section 2 of the Act, as it related to the

death of a person which occurred in Scotland, who at the time of their death was in legal custody.

[13] The Inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[14] The purpose of the Inquiry under section 1(3) of the Act was to (a) establish the circumstances of the death and (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

[15] The matters which require to be covered in this Determination under section 26 of the Act in relation to the death to which the Inquiry relates, are findings as to:

(1) (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;

and

(2) such recommendations (if any) as to:

(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) taking any other steps;

which might realistically prevent other deaths in similar circumstances.

[16] This Determination is not admissible in evidence and May not be founded on in any judicial proceedings of any nature.

[17] The procurator fiscal depute represents the public interest, an Inquiry is an inquisitional process, and it is not the purpose of an Inquiry to establish civil or criminal liability.

[18] As referred to in Macphail, *Sheriff Court Practice*, (3rd edn, ed. Welsh, KC) para 28.17 (referring to similar provisions in the legislation preceding the Act), "… speculation must be avoided; … there has to be evidence which satisfies the sheriff on the material points."

[19] "Accident" is referred to in *Fenton* v *Thorley* [1903] AC 443, per Lord Linley, as "… any unintended and unexpected occurrence which produces hurt or loss…"

[20] As regards any finding in terms of subsection (2)(e) of section 26 of the Act:

> "… it is clearly not necessary for the court to be satisfied that the proposed precaution would in fact have avoided the accident or the death, only that it might have done, … The phrase "might have been avoided" is a wide one …. It means less than "would, on the balance of probabilities have been avoided' and rather directs one's mind in the direction of the lively possibilities" per Sheriff Kearney, *Inquiry re Death of James McAlpine* (Glasgow, 17 January 1986) and referred to at Carmichael, *Sudden Deaths and Fatal Accident Inquiries*, 3rd edn (Edinburgh 2005) para 8.99; and

> "... what is envisaged is not a 'probability' but a real or lively possibility that the death might have been avoided by the reasonable precaution." per Carmichael, *supra* para 5.75; and
>
> "…the term 'might' should be applied in the sense that it incorporates a notion of something qualitatively more than a remote possibility: a possibility with some substance or potential rather than a fanciful or notional possibility", per Sheriff Ruxton, *Inquiry re Death of Kathryn Beattie* (Glasgow, 4 July 2014); and
>
> "… the interpretation of the word 'might"' in the previous analogous legislation to the Act "was not intended to be construed as 'any chance at all no matter how slim" and that the inclusion of the word 'realistically' in the Act "is intended to imply an actual rather than fanciful possibility that the recommendation might have prevented the death", per the Scottish Government's Policy Memorandum to the Act, paras 178-179.

Summary

Background

[21] On 02 February 1986, Mr Ross was born.

[22] On 15 April 2008, Mr Ross was sentenced to 6 years imprisonment for assault to danger of life, with an extended sentence of 3 years.

[23] In May 2011, Mr Ross was sentenced to 6 years imprisonment for mobbing and rioting, with a further extended sentence of 3 years.

[24] On 30 December 2014, Mr Ross was believed to have consumed illicit drugs and was placed on 15-minute observations under the said SPS Management of an Offender at Risk due to any substance ("MORS") policy (SPS Production number 1).

[25] On 8 April 2016, Mr Ross was released from legal custody on licence.

[26] On 11 July 2016, Mr Ross was returned to legal custody and his licence was revoked.

[27] In October 2016, Mr Ross was found on his cell floor under the influence of an unknown substance and again required to be placed under said MORS policy observation.

[28] Following further offences, Mr Ross was sentenced to additional periods of imprisonment. As a result, Mr Ross' earliest release date from lawful custody was to be 20 July 2026.

[29] On 5 October 2019, Mr Ross was moved to C Hall in HM Prison, Perth.

[30] On 17 October 2019, Mr Ross was moved to and after that until his death was the sole occupant of Cell 24, Level 1, in C Hall.

[31] On 3 and 24 October, 21 November 2019, 6 and 29 January 2020, Mr Ross was the subject of a "Talk to Me" risk assessment. These assessments specifically concluded or inferred that Mr Ross was at no apparent risk of suicide.

SPS Policies

[32] The SPS Prisons Resource Library ("PRL") is a library of policy and procedure standards to be applied across the SPS estate. The SPS PRL Standard 1.3.3.3 states that:

> "… when conducting [numbers] checks … steps must be taken to confirm the presence and identity of each prisoner by seeing the face of and getting a response from each prisoner in their cells …" (SPS Production 6).

[33] A Governors & Managers Action ("GMA") document is a circular notice issued by the SPS's headquarters to a select readership. Those within the readership are obliged to take the action stated in the GMA. GMAs are a mechanism used to share information across the prison estate and ensure that SPS estate-wide policy is implemented in local establishments.

[34] Establishments May supplement SPS-wide policies with local policies and procedures (such as said Standard Operating Procedures "SOPs"), which provide further detail on the process to be followed to ensure compliance with GMAs, while taking account of the specific regime at that establishment.

[35] On 30 December 2014, the SPS issued said GMA entitled "Management of an Offender at Risk due to any substance "MORS" - Reference 079A/14 – (SPS Production 1). Essentially, if a prisoner is believed to have consumed illicit substances, they May be medically treated and placed on observations, as is considered necessary per such policy.

[36] The SPS also operates said "Talk to Me Suicide Prevention Strategy", which assesses a prisoner's risk of suicide, such as repeatedly happened to Mr Ross, as aforesaid.

[37] On 28 March 2016, the SPS issued said further GMA entitled "Revised requirements during Locking and Unlocking Periods" Reference 016A/16. This GMA stated that a:

> "review of … FAI determinations identified four cases where no verbal response was obtained either before Lock-Up or during unlock following a patrol period, morning unlock or evening Lock-Up. The Sheriffs determined that the lack of a verbal response did not directly contribute to the death of the individual, however they did make comment on SPS reviewing their locking and unlocking procedures".

[38] This revised guidance repeated that to:

> "ensure compliance with PRL Standard 1.3.3.3, appropriate steps should be taken to see the face of, and get a verbal response from all prisoners during all Lock-Up and unlocking periods".

[39] The guidance further stated that the measure was "to reduce the risk of suicide and also identify any person with a deteriorating health condition" (SPS Production 6).

[40] In June 2016, the SPS issued said local SOP for HMP Perth entitled "Residential Numbers Check" Reference Number PM006(C). This SOP stated that these:

> "procedures will ensure … all prisoners … are safe and secure. Staff should engage with the prisoner in a pro-social manner by way of open dialogue, while conducting these checks".

[41] This further provided that:

> "the numbers check will be carried out by two residential officers". "Each cell will be systematically checked as follows; the first officer will physically unlock each door, seeing the face and gaining a response from the occupant within. If no response is received then staff must gain a response using appropriate methods, such as the officer raising their voice to an acceptable level or as a last resort shake the prisoner gently to gain a response. If no response is gained, staff should then check for signs of life and if necessary raise the alarm. The second officer, who will follow immediately behind the first officer, must also see the face and gain a response from the occupant and then secure the door".

[42] This SOP then proceeds to expressly provide that for the:

> "Lock-Up and Numbers Check Monday to Friday (2030-2045hrs prior to nightshift)" "… officers in pairs … will commence securing prisoners in their cells" "One officer will physically check the occupant is present and safe by engaging in dialogue. The second officer will follow immediately behind the first officer, and will also check the occupant is present before securing the cell door".

[43] On weekdays staff are required to carry out unlock and numbers checks in the morning between 07:00 and 07:20 and in the evening between 20:30 hours and 20:45 (SPS Production 20).

[44] As of April 2020 (SPS Production 19) and then July 2022, after the death of Mr Ross, this "Residential Numbers Check" SOP Reference Number PM006(C) was amended, but not to alter the preceding specific provisions.

[45] All these required numbers checks and other procedures at Lock-up, are more generally referred to as “the said Lock-up Procedures” in this Determination.

Events of 12 March 2020

[46] On 12 March 2020, Mr Ross was not subject to observation in terms of the said MORS policy or subject to any care plan in terms of the said “Talk to Me” Suicide Prevention Strategy.

[47] At 19:01:39, Prison Officer JH unlocked Mr Ross’ cell door.

[48] At 19:01:54 hours, Mr Ross exited his cell into the immediately adjacent open area, the Association Area South, on Level 1 in C Hall. Mr Ross was patently unsteady on his feet. He attracted the attention of other prisoners who approached and interacted with him. Mr Ross then stood outside his cell for a short time. He then stumbled.

[49] At 19:02:22, Mr Ross staggered back into his cell, banging against the wall as he did so.

[50] All this activity is seen on said CCTV footage. No SPS staff member saw Mr Ross in this state at this time. Mr Ross was demonstrably under the influence of at least some of the drugs, which were determined from later toxicological analysis to have been consumed by him prior to his later death.

[51] Between 19:03:01 and 20:17:44, various other prisoners visited and left Mr Ross' cell.

[52] At 20:18:59, Prison Officer JC, after briefly looking into Mr Ross' cell, locked the cell door.

[53] At 20:31:18, Prison Officers JH and JC attended at Mr Ross' cell while performing the said Lock-up Procedures. Prison Officer JH unlocked the cell door and briefly looked into the cell. Prison Officer JH saw that Mr Ross was present in the cell. Mr Ross appeared to be sleeping. Prison Officer JH did not wish to disturb him. Prison Officer JH did not obtain a response from Mr Ross or engage in dialogue with him. Prison Officer JH then moved on to the next cell. Prison Officer JC also did not engage in any way with Mr Ross. Prison Officer JC was unsure if Prison Officer JH had received a response from Mr Ross. Prison Officer JC then shut and locked Mr Ross' cell door.

[54] To have strictly complied with the said Lock-up Procedures, Prison Officers JH and JC should have collectively endeavoured to ensure that Mr Ross was safe, by seeing his face and engaging him in dialogue.

[55] Had Prison Officer JH and JC so engaged with Mr Ross, at this relatively short time after he can be seen on said CCTV and after being visited by other prisoners, there is a lively possibility that Mr Ross might realistically have been unresponsive or have remained so noticeably intoxicated and thereby restricted in his ability to have a dialogue with the prison officers, that his said condition would have been noticed by them.

[56] Had Prison Officers JH or JC identified Mr Ross as unresponsive or so noticeably intoxicated, they would have called a nurse to check on Mr Ross per said MORS policy.

[57] Had Mr Ross' extreme intoxication been so identified, medical personnel would have made arrangements for Mr Ross to receive necessary treatment and placed him on observations in accordance with the said MORS Policy. There was also a lively possibility that his death might realistically have been thereby avoided by his receiving medical treatment and being observed in respect of his said condition, as aforesaid.

[58] Despite having nearly 19 years of service with the SPS, including from 2009 to 2020 being employed as a Residential Officer, Prison Officer JC only looked up the said Lock-up Procedures after Mr Ross' death and had no recall of seeing these beforehand.

[59] Despite having 25 years' service with the SPS, including 12 years as a residential officer from 2008 until 2020, Prison Officer JH while accepting that he "probably" did know that he had been required to get a response from Mr Ross, had no recollection of having seen the specifics of the written Lock-up Procedures. At the time Prison Office JH had no full appreciation of the necessity of strictly adhering to the said Lock-up Procedures.

[60] The extent of any formal training then provided regarding the said Lock-up Procedures was limited, with principally an expectation of learning "on the job" from more experienced residential officers.

[61] Prison Officers JH and JC did not seek to flagrantly disobey the said Lock-up Procedures. Even though Prison Officer JH had been vaguely aware from his work experience of a need to get such a response from Mr Ross, without significant formal

training or refresher courses, these evening lock-up Prison Officers were not sufficiently cognisant of the necessity of strictly adhering to the Lock-up Procedures.

[62] Between 21:02:43 and 21:18:11, prison officers and nurses attended at a cell near to that of Mr Ross to carry out pre-arranged checks on a prisoner therein who had earlier been found to be under the influence of drugs and was, therefore, subject to said MORS treatment and observation. This exemplified the operation of the MORS policy and the potential for such to avoid the death of a prisoner who required such treatment and observation.

Events of 13 March 2020

[63] At or about 06:45, Prison Officers MM, MG, RY and MY commenced duties at Level 1 of C Hall. At this time, they were made aware via the handover from their colleagues that there were in fact two prisoners (in Cells 19 and 72) who were subject to said MORS policy and, as such, were subject to 15-minute and hourly observations, respectively. These prisoners had been suspected of being under the influence of an unknown substance.

[64] From when Mr Ross' cell was locked the previous evening until 13 March 2020, at or about 07:10, no one attended at Mr Ross' cell door. At or about that time, Prison Officer MM placed milk on each cell door handle. After that, Prison Officer MM started to unlock cell doors, walk in and out of the cells briefly and then close the cell doors again.

[65] At 07:12:13, Prison Officer MM unlocked Mr Ross' cell door. Prison Officer MM briefly entered Mr Ross' cell. Mr Ross was in his bed under a blanket. Prison Officer MM said, "Morning". Prison Officer MM did not obtain a verbal response from or engage in dialogue with Mr Ross as required by said Lock-up Procedures. Prison Officer MM did this alone, not with a second officer as again required by said Lock-up Procedures. Prison Officer MM thought they had seen Mr Ross move under the blanket. Prison Officer MM was mistaken in thinking so, as Mr Ross had been deceased for some hours. Prison Officer MM left the cell, shut the cell door and moved on to the next cell.

[66] Prison Officer MM had four years of experience as a prison officer. The previous approximately two years were "acting up" as a Residential Officer. Acting up is where, for example, an operations officer carries out the role of a residential officer (in effect a temporary promotion). Residential officers, working in the halls where the prisoners sleep, have different and additional duties which involve more engagement with prisoners, such as in the said Lock-up Procedures. Prison Officers inexperienced in acting as residential officers could be "paired up" together. Prison Officer MM had received no training in or have any specific knowledge of the said Lock-up Procedures and was only made aware of such after the death of Mr Ross. For this reason, Prison Officer MM also unwittingly failed to accord with the said Lock-up Procedures by not obtaining or ensuring that a response was received from Mr Ross and by operating alone at the morning unlock.

[67] Having not received adequate training to have been fully aware of the requirements of the said Lock-up Procedures, Prison Officer MM was under the impression that a visual or verbal response was all that was required to be obtained.

[68] At 08:03:05, Prison Officer RY unlocked Mr Ross' cell.

[69] At 08:03:41, prisoner YY entered Mr Ross' cell. He found Mr Ross to be unresponsive. Prisoner YY told Prison Officer RY that he had better get into Mr Ross' cell as Mr Ross was "blue". Prison Officer RY immediately entered Mr Ross' cell. Prison Officer RY observed Mr Ross lying on his bed on his right side. Mr Ross was cold to the touch with no pulse. Prison Officer RY radioed for help and for the residential manager to attend. Prison Officer RY stood outside Mr Ross' cell to preserve the locus.

[70] At 08:05:29, a nurse responded to said radio message and entered Mr Ross' cell. They were joined shortly thereafter that by another nurse and other medical staff.

[71] At 08:23:32 hours, General Practitioner Dr Mark Wallace attended and verified that Mr Ross was deceased. At or about 08:37, Paramedic Alan Martin then attended and formally pronounced Mr Ross' life extinct.

[72] At or about 13:20 hours, Detective Constable Lowndes, in the presence of witness Detective Constable Macleod seized a sample of what appeared to be tea from a cup found beside Mr Ross' bed. This cup appeared to have a white dissolved substance in it, which was later analysed.

[73] Police officers then conveyed Mr Ross' body to the Police Mortuary in Dundee.

[74] A crude estimation of Mr Ross' time of death would be between his being seen on said CCTV at 19:02 the previous evening and 8 hours before his being found deceased, that is at or about midnight.

[75] Prison Officers JC and JH are caring and capable Prison Officers. All said officers involved in the evening lock-up and subsequent morning unlock having not strictly adhered to the said Lock-up Procedures is indicative of such non-adherence being systemic rather than any thought-through choice made by informed individual officers.

Subsequent Investigations

[76] On 16 March 2020, at the Police Mortuary, Dundee, Mr Ross' mother and his sister identified his body.

[77] On 19 March 2020, at the instance of the Procurator Fiscal, Dundee, Doctors Helen Brownlow and Shaun Walsh, Consultant Forensic Pathologists, conducted an autopsy examination of Mr Ross. External examination of Mr Ross' body failed to reveal any suspicious or concerning marks or injuries. The lungs were noted to have severe pulmonary oedema and congestion. The remainder of the internal organs were normal.

[78] The cause of death was certified by Dr Brownlow to be:

I a) Combined Adverse Effects of Etizolam and Buprenorphine.

[79] Both Etizolam and Buprenorphine depress respiratory and central nervous system functions. When consumed in combination, their effects are enhanced and, as here, can be fatal.

[80] Forensic analyses of the blood and urine samples taken from Mr Ross, by Doctors Peter Maskill and Fiona Wylie, both Forensic Toxicologists, detected:

(1) Etizolam (0.65 mg/L);

(2) Buprenorphine and its metabolite at therapeutic levels; and

(3) Mirtazapine at therapeutic levels.

[81] Etizolam is a benzodiazepine; Buprenorphine is an opioid substitute; Mirtazapine is an antidepressant medication. Forensic analysis by said Doctors Maskill and Wylie of the liquid in the cup found next to Mr Ross' bed detected:

(1) Etizolam; and

(2) 6-monoacetylmorphine (6-MAM)

[82] 6-MAM is a metabolite of Heroin-derived morphine. Despite identifying this white substance in the teacup beside Mr Ross' bed as containing such a metabolite and Etizolam, there was no morphine, 6-MAM, or other morphine metabolites detected in Mr Ross' post-mortem blood and urine samples. It is not possible to determine from such post-mortem blood analysis alone whether or not Mr Ross had also consumed any heroin-derived morphine in the hours before his death.

[83] Mr Ross had been prescribed Buprenorphine-based medication daily, namely Espranor 8mg, as part of Opiate Replacement Therapy. Mr Ross had not been prescribed Etizolam or Mirtazapine. Etizolam is not licenced for medical use in the United Kingdom.

Subsequent Training

[84] Following the death of Mr Ross, investigations carried out by the SPS identified that the said Lock-up Procedures were not being strictly adhered to by staff at HMP Perth. Mr SK's role as FLM was to ensure procedures were being followed correctly. He was surprised that Prison Officers inexperienced in acting as residential officers could be "paired up" together. Secondly, it had come as "news to him" that prison officers were not following the said Lock-up Procedures correctly. Mr SK was unaware of any issue of staff training being required in this respect.

[85] In 2020/2021, to address this issue, Mr SK ran awareness/refresher sessions on the said Lock-up Procedures for all staff at HMP Perth. During these sessions, these procedures were explained to staff, and there was an opportunity for staff to ask any questions; after that, staff were required to sign off on a record that they had completed the session and were thereby deemed competent in carrying out the said Lock-up Procedures thereafter (SPS Production number 19).

[86] Prison Officers JH, JC, and MM all attended these sessions (as seen at SPS Production 12 - Numbers Check Awareness Refresher – Attendance Record; pages 1, 17 and 18).

[87] On or about March 2020, the SPS introduced comprehensive induction courses for residential officers called the Residential Officer Foundation Programme (ROFP) (SPS Productions 14 to 16). This course is now compulsory for those who apply to become substantive residential officers. This course includes being taught about the said Lock-up Procedures.

[88] On or about 31 March 2023, during this Inquiry, the SPS also issued a GMA Induction for Operations Officers Acting-up to Residential Officers (C-D Band). This GMA is described as a:

> "… new policy/process which will ensure that Operations Officers, acting-up in a Residential Role, have a sufficiency of knowledge to commence duties within a residential area and their knowledge and skills are developed throughout their acting-up tenure" (which includes training in the said Lock-up Procedures)

and states:

> "Following a recent Fatal Accident Inquiry (FAI), Operations Directorate conducted a review of current acting up induction practices, in partnership with the Scottish Prison Service College (SPSC). As a result, any Officer who is acting-up to a residential role must complete a recorded induction process prior to commencing duty. This should be the initial stage of ongoing development throughout the reporting year as part of a role specific Personal Development Plan".

Submissions

[89] All participants submitted that there should be said formal findings in respect of subsection (2)(a) (when and where the death occurred) and (c) (the cause of the death). While only NHS Tayside had initially submitted that there be a latitude in the time of death, after discussion, all participants agreed that the time of death should be recorded with said latitude as the exact time of death was unknown.

[90] While no participants in their original submissions had initially advocated that there should also be findings in terms of subsection 2(b) (when and where the accident occurred) and (d) (the cause of any accident), after discussion, all participants had no

issue with the Inquiry finding that Mr Ross had 'accidentally' fatally overdosed, applying the said broad definition of 'accident' in *Fenton* v *Thorley, supra*.

Crown and Next of Kin

IDENTIFICATION OF MR ROSS' CONDITION

[91] The Crown and Next of Kin essentially agreed on much of their submissions. The Crown referred to the specific evidence of Prison Officer JH, who, on looking at the CCTV footage of Mr Ross when giving his evidence, stated that Mr Ross appeared to be one of the "worst he had ever seen". Had Prison Officer JH noticed Mr Ross in that condition, he would have called a nurse to come and check on Mr Ross and put him on observation. Accordingly, had the Prison Officers noticed Mr Ross, it was possible that Mr Ross could have been placed on observations in line with MORS policy and that he would then have been monitored by SPS staff for his safety. Had Mr Ross' condition deteriorated, further medical assistance could have been provided.

[92] Dr Brownlow, Consultant Forensic Pathologist, had confirmed that it was likely that Mr Ross had already died by the time Prison Officer MM had unlocked Mr Ross' cell. The more concerning issue, in the instant Inquiry, was the failure to adhere to Lock-up Procedures in the evening lock-up. This lock-up had been, in effect, the last opportunity for staff to interact directly with Mr Ross, and this needed to have been done correctly. It was initially submitted by the Crown that there were several variables and that it would be speculative to suggest how Mr Ross May or May not have

presented at different stages and whether any particular action May have changed the outcome.

[93] Accordingly, it was initially submitted by the Crown that as the non-adherence with the Lock-up Procedures did not directly contribute to Mr Ross' death this May not justify a finding in terms of subsection (2)(e) (reasonable precautions) of section 26 of the Act.

[94] The Crown also submitted that the lack of obtaining a verbal response from Mr Ross on lock-up did not directly contribute to his death in terms of subsection (2)(f) (defects in the system of working).

[95] The Next of Kin's submissions were that "perhaps in the absence of conclusive medical evidence, the Crown’s analysis is quite correct, and that the failure of the officers cannot be deemed directly contributory to Mr Ross’ death". However, it was submitted that findings in terms of subsection 2(e) (reasonable precautions) and (f) (defects in the system of working) were a matter for the Inquiry to conclude and determine.

[96] Both the Crown and Next of Kin submitted that comment could be made in the Determination on the non-compliance of SPS staff with the said Lock-up Procedures. Prison Officer JH emotionally spoke of his regret that he did not obtain a verbal response when conducting the evening check and that, with the benefit of hindsight, he wished that he had done so.

[97] Accordingly, the Inquiry was invited by the Crown and next of kin to at least make findings in terms of subsection (2)(g) (other relevant facts) of section 26 of the Act,

that there had been ongoing issues in ensuring adherence with the said Lock-up Procedures.

[98] The Crown and next of kin submitted that not all officers "acting up" had been provided with relative training and there was an absence of refresher training for those previously trained. This resulted in enduring issues with the said Lock-up Procedures not being adhered to, despite prior Inquiries having addressed this same issue.

[99] The Crown referred to two Inquiries, in particular: Sheriff Wade KC (now Sheriff Principal Wade), *Inquiry re the Death of Mark Allan* (Perth, 6 February 2020) and Sheriff McCrossan, *Inquiry re the Death of Alan Hastings* (Peterhead, 30 December 2022).

[100] In the *Mark Allan Inquiry*, the deceased had died from the combined adverse effects of Buprenorphine and Chlordiazepoxide while in lawful custody at HMP Perth on or about 19 July 2018. In this instance, the Prison Officer performing the morning unlock had not obtained a verbal response from the deceased.

[101] It was recognised, as is recognised in this Inquiry, that no formal training had been provided to operational officers "acting up" as residential officers. No one had ever told the "acting up" prison officer precisely what was required when carrying out Lock-up Procedures and specifically that they were required to obtain a verbal response from the prisoner.

[102] Sheriff Principal Wade made relative formal findings in terms of subsections (2)(a) (when and where the death occurred) and (c) (the cause of the death). However, Sheriff Principal Wade commented when referring to SPS SOPs that it "does not matter how fit for purpose the system of checks is if it is not applied rigorously"

(para [19]). While finding it unnecessary to make other than formal findings, as the issues had already been identified in a DIPLAR report, Sheriff Principal Wade stated that:

> "There are some lessons to be learnt in terms of the training to be given to those acting up to roles with which they are not familiar. In particular, it has been highlighted that it is important to obtain a verbal response in a numbers check but the failure to do so in this case would have made no difference as the onset of rigor mortis indicated death had occurred sometime before he was found … while it should be observed that the procedure for obtaining a verbal response was not followed in this case that has already been identified in the DIPLAR and no doubt the appropriate training measures will be put in place" [para 145-146].

[103] In the *Alan Hastings Inquiry*, the deceased had died from a coronary artery atheroma and cardiac enlargement while in lawful custody at HMP Grampian on or about 21 January 2021. The Prison Officer performing the morning unlock had received a response from the deceased by the latter lifting his hand. Evidence suggested that the deceased had got up and moved around his cell since then, before his being found deceased. Sheriff McCrossan made relative formal findings in terms of subsections (2)(a) (when and where the death occurred) and (c) (the cause of the death). Sheriff McCrossan stated:

> "What is also clear is that the specific requirements of the Unlocking/Locking procedure were not followed; in particular the Officers did not see Mr Hastings' face nor did they receive a verbal response from him" [Para 14].

[104] While also finding it unnecessary to make other than formal findings as the SPS had already taken the necessary steps, Sheriff McCrossan stated that:

> "… the Unlocking Procedure of course requires the officers to do more than they did that morning, recognising that it is possible for someone whose health is deteriorating still to raise a hand. Therefore, whilst there was a wholly adequate

> system in place to mitigate against such an eventuality it appears at the time of Mr Hastings' death it was not being followed scrupulously". [Para 16]
>
> "… steps needed to be taken to ensure strict adherence not only to the spirt but also the letter of this policy. I am satisfied that SPS have taken the necessary steps to that end. In particular, by way of email dated 16 May 2022 the Residential Unit Manager (Acting) of HMP Grampian circulated to all Operational Staff at HMP Grampian a copy of the Revised Unlocking and Locking Procedure … This issue has also been discussed at residential handover meetings in recent weeks. Given that these steps have now been taken by SPS it is neither necessary nor appropriate for this Inquiry to make any statutory recommendations under the Act. I would simply make the observation that it is expected such reinforcement will be a core element of regular training". [Para 21]

[105] The Crown and next of kin submitted that while the SPS had now put in place provisions for training all acting as residential officers, refresher training still appeared to be reactive to events, as opposed to being something that would be continuously done.

[106] In discussion, the Inquiry sought assistance as to whether on the evidence findings in terms of subsection (2)(e) (reasonable precautions) could be made. After consideration, the Crown (as had the next of kin) accepted that for such a finding, any reasonable precautions identified did not require to be precautions, the absence of which had directly contributed to the death of the deceased (cf subsection 2(f) (defects in system of working)), as had initially been submitted May be a barrier to such a finding. After consideration the Crown and the next of kin were in agreement that the Inquiry could make such a finding, if satisfied that the said statutory criteria was met, namely that had the reasonable precaution been taken, it might realistically have resulted in the death being avoided.

AVAILABILITY OF ILLICIT DRUGS

[107] The affidavit of RC, Head of Operations at HMP Perth, was comprehensive in detailing the various and extensive operations employed to prevent, disrupt and detect the circulation of illicit drugs within the prison estate. The circulation of illicit drugs within the entirety of the UK's prison estate is well known and is a matter of serious public concern. That being said, the Crown submitted that it could be seen that the SPS was making extensive efforts to mitigate this. Accordingly, the Crown did not submit that there was a defect in the system of work relating to such efforts to prevent drugs from entering the prison estate.

SPS

IDENTIFICATION OF MR ROSS' CONDITION

[108] It was accepted by the SPS from the outset of this Inquiry that, in certain respects, some staff did not follow the Lock-up Procedures in the evening and in the morning.

[109] It was the SPS submission that Prison Officer JH, in particular, knew he had to obtain a verbal response but chose not to. The SPS indicated that this was regrettable and has never been in dispute. However, the SPS's position was that no findings or recommendations, other than formal findings, were necessary in the circumstances.

[110] Regarding any findings in terms of subsection 2(g) (other relevant facts), the SPS submitted the Inquiry heard no evidence that "annual training… with regular testing" would achieve anything different to what is currently in place and planned by the SPS.

It was submitted that there was no evidence about the resources needed for refresher training and how regular such should be, to make a relative finding.

[111] The SPS submitted that with the Lock-Up SOP dated July 2022 (SPS Production 11), the Lock-Up Awareness Refresher Course (SPS Production 12 to 18), the ROFP (SPS Productions 14 to 16) and the GMA Acting-up (SPS Production 23), the SPS had now taken appropriate steps after the death of Mr Ross to ensure that the staff carrying out Lock-up Procedures at HMP Perth are aware of the correct procedure.

[112] In discussion prompted by the court as to whether the Inquiry would be entitled on the evidence to make findings in terms of subsection (2)(e) (reasonable precautions), the SPS accepted, after consideration, that it was "arguable" that the Inquiry could make such a finding. However, it was submitted that, in the absence of specific medical evidence regarding Mr Ross' likely state on his being required to verbally respond to the prison officer, such a finding would be speculative and not a "lively possibility".

POAS

IDENTIFICATION OF MR ROSS' CONDITION

[113] The POAS submitted that only said formal findings should be made in terms of subsections (2)(a) (when and where the death occurred) and (c) (the cause of the death).

[114] Regarding any findings in terms of subsection 2(e) (reasonable precautions), the POAS submitted the Inquiry heard no evidence suggesting a "lively possibility" that Mr Ross' death might realistically have been avoided. It was clear that some confusion, or perhaps a lax approach, existed to training on Lock-up Procedures. No evidence

suggested any failure or omission on the part of any Officer contributed to Mr Ross' death. In particular, it was unknown how Mr Ross would have responded had Prison Officer JH sought to elicit a verbal response from him.

[115] Mr Ross could have responded despite being under the influence. There was no evidence which would assist in ascertaining which scenario was more likely, and thus one can only speculate as to what would have occurred if a verbal response had been sought. It was submitted that it accordingly could not be said that there existed a "lively possibility" that the death might realistically have been avoided if this (admittedly reasonable) precaution had been taken.

[116] In discussion, prompted by the Inquiry, as to whether on the evidence there could be a finding in terms of subsection (2)(e) (reasonable precautions), the POAS accepted, after consideration, that it was "arguable" that such a finding could be made. However, it was again submitted that, in the absence of specific medical evidence regarding Mr Ross' likely state on his being required to verbally respond to a prison officer, such a finding would be "too much of a leap" and there was an "evidential gap" as physical impairment did not necessarily mean that there would have been verbal impairment.

[117] Regarding the need for ongoing refresher training, the POAS were "largely neutral" on any such recommendation.

Tayside Health Board

[118] Tayside Health Board submitted that the said formal findings could be made in terms of subsections (2)(a) (when and where the death occurred) and (c) (the cause of the death). In the absence of any issues identified concerning Mr Ross' healthcare provision, Tayside Health Board had no further submissions to make.

Discussions and Conclusions

[119] The determinations made in terms of subsections (2)(a) (when and where the death occurred) and (c) (cause of death) are, in this instance, formal.

[120] The definition of accident in *Fenton* v *Thorley supra*, is sufficiently wide to encompass an inferred finding that Mr Ross had overdosed accidentally. Mr Ross had a long history of misusing drugs, even while in prison. There were no signs at the post mortem examination of any force being used against Mr Ross. There was no evidence of Mr Ross having any desire to take his own life in the various "Talk to Me" assessments or otherwise. While an Inquiry can focus on more traditional accidents, where relevant, this specific issue can be important to the families of the deceased. In the foregoing circumstances it is therefore reasonable to infer the findings made in terms of subsections (2)(b) (when and where any accident occurred) and (d) (the cause of any accident), namely that Mr Ross had accidentally overdosed.

[121] In terms of subsection (2)(e) (reasonable precautions), there ultimately appeared to be little real opposition to a conclusion that the SPS, through their employees, could

have generally taken the reasonable precaution of strictly adhering to its Lock-up Procedures.

[122] Naturally, it also appeared to be accepted that the SPS could have specifically taken the reasonable precautions that they took after Mr Ross' death, namely providing training to residential officers in respect of said Lock-up Procedures.

[123] Again there appeared to be little dispute that by providing training, all such officers would have been more fully cognisant of and appreciated the necessity, in terms thereof, of strictly adhering to the said Lock-up Procedures, by seeing Mr Ross' face and engaging in a dialogue with him at Lock-up.

[124] However, while the cause of Mr Ross' death was the adverse effects of his consumption of said Etizolam and Buprenorphine, the issue arose as to whether there was a lively possibility that strictly adhering to the said Lock-up Procedures (which adherence would have been made more probable by providing such training) might realistically have resulted in (one) Mr Ross' medical condition being noticed at Lock-up, (two) his after that being monitored and treated by health professionals, and (three) his death thereby avoided.

[125] Much of the discussion during submissions centred around whether, in the absence of specific medical evidence regarding Mr Ross' likely verbal abilities on his being required to enter into a dialogue with the prison officers, a finding in terms of subsection (2)(e) (reasonable precautions) would be too speculative.

[126] Unlike in the other Inquiries referred to by the Crown, this Inquiry had the considerable advantage of seeing Mr Ross on the said CCTV footage at or about 19:01.

Mr Ross was then patently physically uncoordinated. It is reasonable to infer that Mr Ross was then under the influence of at least some of the drugs, which it was later determined from said toxicological analysis that he had consumed before his death.

[127] The evening lock-up was at or about 20:31.

[128] Unlike in those other Inquiries, there is therefore little difficulty in reasonably inferring from seeing Mr Ross' extreme physical state of intoxication and noting his said subsequent cause of death, that at or about this time of the evening lock-up there was a "lively possibility" (as referred to in Carmichael, paras 5.75 and 8.99 and the James McAlpine and Kathryn Beattie Determinations, supra) that Mr Ross might realistically have been still extremely intoxicated, whether conscious or not.

[129] There is no requirement for this Inquiry to have specific medical evidence to reasonably infer from having seen Mr Ross in such an extremely uncoordinated state, that there was a "lively possibility" that had Prison Officers attempted to obtain a response from and engage him in a dialogue, his inability or restricted ability to respond (if alive) might realistically have become apparent to those officers and that he would then have been given any medical treatment needed and placed under medical supervision per said MORS policy.

[130] This is not speculation (as must be avoided per Macphail, supra, para 28.17) but utilising judicial knowledge gained from simple common sense and a basic knowledge deemed to be held by all, as to how extreme intoxication might realistically affect a person's ability to communicate. In any event, the very specification in the said Lock-up Procedures, that such procedures were *inter alia* to "identify any person with a

deteriorating health condition", recognises that this sequence of events was patently a "lively possibility" which might realistically have arisen. There was evidence about and indeed examples of the operation of the MORS policy on this very evening, in respect of two other prisoners. It is reasonable to infer from such that there was a "lively possibility" that had Mr Ross' condition been identified, such observation and treatment might realistically have avoided Mr Ross' death.

[131] As stated in the *James McAlpine Inquiry, supra* "it is clearly not necessary for the court to be satisfied that the proposed precaution would in fact have avoided the accident or the death, only that it might have done". While improbable, due to Mr Ross having been visited in his cell by other prisoners until shortly before the evening lock-up, who might reasonably be expected to have alerted prison officers to Mr Ross' passing, it might realistically also be that Mr Ross had already been deceased at the time of the evening lock-up. This does not prevent a reasoned conclusion that, had the prison officers performing the evening lock-up strictly adhered to the said Lock-up Procedures, (made more likely by their having been provided beforehand with the said induction and refresher courses so that they were fully cognisant of and appreciated the necessity, in terms thereof, of strictly adhering to the said Lock-up Procedures), there remains a "lively possibility" that such adherence might realistically have resulted in (one) Mr Ross' condition being detected, (two) his being treated and observed, all as aforesaid, and (three) his death being thereby avoided.

[132] Such a conclusion is not a fanciful or notional possibility (as referred to in the *Kathryn Beattie Inquiry, supra* and the said Policy Memorandum, supra paras 178-179)

[133] In terms of subsection (2)(f) (defects in the system of working), there might be a debate to be had as to whether there is inherently a defect in any system of working, when the system of working is not being adhered to, as here. However, ultimately, Mr Ross having consumed said drugs in combination was what caused his death. Such inaction by SPS staff cannot properly be described as having contributed in any real sense to this specific cause of death. The said non-adherence with and the lack of a detailed knowledge of the Lock-up Procedures did not therefore in any real sense cause or contribute to the death of Mr Ross.

[134] In terms of subsection (2)(g) (relevant facts), there are no other facts which are relevant to the circumstances of the death, in that the issues which have arisen are adequately addressed in this Determination under subsection 2(e) (reasonable precautions).

[135] In terms of subsection (1)(b) (recommendations), it is a significant concern to read the said previous Inquiry findings (particularly the *Mark Allan Inquiry, supra*), and to note that there has been a continued non-adherence to the said Lock-up Procedures across the prison estate despite such Inquiry findings. While the SPS has now introduced said induction and refresher training, it is recommended that the SPS improve their system of working by making further provision for ongoing refresher training courses for residential officers at regular intervals. Thereby, all such officers should be fully cognisant of and appreciate the necessity of strictly adhering to the said Lock-up Procedures, by seeing a prisoner's face and engaging in a dialogue with them at Lock-up. It is also important to do so across the entire prison estate and not just as local

reactions to individual deaths as appears to have been done after Mr Ross' death and in the said other Inquiries.

[136] This improvement might realistically prevent other deaths in similar circumstances, as aforesaid. The timescale for this has been left in general terms as it is not for this Inquiry to endeavour to micromanage the SPS. Therefore, an appropriate refresher time scale and the extent of such are a matter for the SPS to consider and manage.

[137] While the Crown addressed the more general issue of preventing drugs circulating in the prison estate, this Inquiry was satisfied as outlined by the Crown that the SPS is making significant efforts in this regard at present, in so far as an Inquiry on this scale can determine.

OTHER INFORMATION, OBSERVATION OR COMMENT

[138] Participants are all to be commended for how they diligently met repeated requests to provide and consider a significant amount of additional evidence and ultimately their having saved significant Inquiry time in agreeing the said three joint minutes.

[139] This Determination closes by affirming and repeating the sincere condolences offered to the family and friends of Mr Ross for their loss, as repeatedly expressed by all of the participants at the Inquiry.