SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2024] FAI 3

EDI-B638-23

DETERMINATION

BY

SHERIFF DANIEL KELLY KC

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

into the death of

DAVID NISBET WELCH

EDINBURGH, 28 December 2023

DETERMINATION

1.1 The Sheriff, having considered the information presented at the inquiry, determines in terms of section 26 of the Act that:

> **DAVID NISBET WELCH, born 16 July 1982, residing at 7-4 Inchkeith Court, Spey Terrace, Edinburgh EH7 4PG, died on 14 February 2021 in cell 26 Glenesk Hall, HMP Edinburgh, 33 Stenhouse Road Edinburgh EH11 3LN between 7.54 am and 11.44 am.**

1.2 In terms of section 26(2)(a) the death occurred between 7.54 am and 11.44 am on 14 February 2021 in cell 26 Glenesk Hall, HMP Edinburgh, 33 Stenhouse Road Edinburgh EH11 3LN.

1.3 In terms of section 26(2)(c) the causes of the death were:

1a. buprenorphine and etizolam toxicity and

2. coronary artery atherosclerosis.

RECOMMENDATIONS

2.1 In terms of section 26(1)(b) there are no recommendations to be made 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, or

(d) the taking of any other steps which might realistically prevent other deaths in similar circumstances.

NOTE

Introduction

[1] The inquiry was held under the Act into the death of David Nisbet Welch.

[2] Preliminary hearings took place on 4 August and 15 November and the inquiry hearing took place on 5 December, all 2023.

[3] The representatives of the participants of the inquiry were:

(a) Mr Kerr, Procurator Fiscal Depute,

(b) Ms Thornton, Scottish Ministers acting on behalf of the Scottish Prison Service,

(c) Ms Langlands on behalf of NHS Scotland, and

(d) Ms McIlwham on behalf of the Prison Officers Association Scotland.

[4] The witnesses were:

(a) Jon Davidson, Prison Officer,

(b) Bryan Gardiner, Prison Officer, and

(c) Stephen McCann, Head of Operations at HMP Edinburgh, who also provided an affidavit.

[5] Further affidavit evidence was given by:

(a) Garry Thomas Horsburgh, Prison Officer, and

(b) Anthony Martin, Head of Operations and Public Protect at the Scottish Prison Service.

The legal framework

[6] The inquiry was held under section 1 of the 2016 Act, which was a mandatory inquiry since the death of Mr Welch occurred while he was in legal custody.

[7] Fatal accident inquiries and the procedure to be followed in the conduct of such inquiries are governed by the provisions of the 2016 Act and of the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[8] The purpose of an inquiry is to establish the circumstances of the death and to consider what steps, if any, may be taken to prevent other deaths in similar circumstances. The sheriff must make a determination which sets out factors relevant to

the circumstances of the death, in so far as they have been established to his satisfaction. These are:

(a) when and where the death occurred,

(b) when and where any accident resulting in the death occurred, and

(c) the cause or causes of the death.

[9] Had they been applicable, also set out would have been:

(d) the cause or causes of any accident resulting in the death,

(e) any precautions which could reasonably have been taken and which had they been taken might realistically have resulted in the death being avoided,

(f) any defects in any system of working which contributed to the death or accident resulting in the death, and

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

[10] The inquiry makes such recommendations (if any) as considered appropriate 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, and

(d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

There are no such recommendations to be made as to the death of David Nisbet Welch.

[11] The procurator fiscal represents the public interest. An inquiry is an inquisitorial process and the manner in which evidence is presented is not restricted. The

determination must be based on the evidence presented at the inquiry. It is not the purpose of an inquiry to establish civil or criminal liability.

Summary

[12] On 16 March 2020 Mr Welch was remanded at Edinburgh Sheriff Court in relation to allegations of assault to severe injury, permanent impairment and danger of life.

[13] On admission to prison Mr Welch declared a history of illicit drug use and received a medically assisted detox within the first 10 day period of incarceration with no subsequent interventions. Prison medical records disclose that this was the only medication prescribed to Mr Welch throughout his time in custody.

[14] An indictment was served on Mr Welch and on 8 February 2021, after a preliminary hearing in the High Court was continued to 19 April 2021, Mr Welch was further remanded in custody. A Talk to Me risk assessment was carried out after the hearing and Mr Welch was noted to have communicated well, with good eye contact and to have been comfortable with bail continuing to be refused. The outcome of the risk assessment was that he presented no apparent risk.

[15] While on remand in HMP Edinburgh Mr Welch worked as a pantry passman and was well liked in the hall. He had a good relationship with staff. In the months leading up to his death staff reported no concerns, including medical ones, and noted nothing suspicious.

[16] On Saturday 13 February 2021 Mr Welch appeared fit and well. At 4.33pm he was in his cell when the door was locked and secured.

[17] At 7.40am on Sunday 14 February 2021 two prison officers, Jon Davidson and Garry Horsburgh, checked the cells of the 64 prisoners on level 1 of Glenesk Hall, the remand unit. They unlocked the doors, looking through the window hatches. They were satisfied that they had done visual and verbal checks for all of the cells.
Jon Davidson said that they have to obtain a verbal response and to see the face of the prisoner, which would have happened for each one although he was unable to recall each cell individually. Garry Horsburgh, who was unavailable for the Hearing, gave broadly similar evidence by way of an affidavit.

[18] At 7.54am, after the roll call was completed and the numbers had been given to the patrol room, the two prison officers took breakfast to the cells where the prisoners were still eating post Covid. When Mr Welch did not come to the door for breakfast, Mr Davidson took it in for him and left it on the desk. In so doing, Mr Davidson knocked the chair with his foot and Mr Welch grunted, as if annoyed that his sleep had been disturbed. Mr Davidson apologised but received no further response.

[19] At 11.44am the same officers went into Mr Welch's cell when he did not emerge for lunch. Mr Welch was lying face down on the bed. Mr Davidson radioed a Code Blue, which was the protocol put in place to alert others to a prisoner being unresponsive.

[20] At about 11.47am, having heard the Code Blue message, staff nurses attended Mr Welch's cell. Nurse Robyn Carnie commenced chest compressions with Mr Welch

on his back on the bed. Advanced Nurse Practitioner Elaine McAdam arrived at the cell shortly thereafter. As the compressions were ineffective due to Mr Welch being on the bed, he was placed on the floor with the assistance of prison officers. Having originally been found face down on the bed, Mr Welch was noted as being purple in colour and there was blood coming from his nose. An ambulance was contacted and a defibrillator set up. An attempt to insert an airway was made but Mr Welch's teeth were clenched tightly shut. Advanced Nurse McAdam formed the view that rigor mortis had set in. The defibrillator stated "no shock advised." The nurses on scene took it in turn to continue chest compressions until paramedics arrived. At 12.15pm on 14 February 2021 Paramedic Graeme Murray pronounced life extinct.

[21] At about 3.00pm Detective Constable Derek Schulz and Detective Constable Simpson attended at cell 26. Mr Welch was lying on his back on the cell floor with his head closest to the door and his feet towards the window. He was wearing shorts and a sweatshirt and there was blood and bodily fluids coming from his nose and mouth. Scenes of Crime and a scene examiner attended. A search of Mr Welch's cell for controlled drugs, illicit substances or drugs paraphernalia was negative.

[22] Following Mr Welch's death intelligence was received by prison staff that Mr Welch had shortly beforehand shown another prisoner a quantity of etizolam. It was reported that he had been told that it was far too much to be taking at one time. It was further reported that over the weekend he had consumed a new drug, which was being called Amo, which was being smuggled into prisons across Scotland by being

soaked into paper and then sent as letters to prisoners. The paper was boiled in a kettle and the water was drunk or used to make tea.

[23] Initially, the cause of death was recorded as unascertained pending laboratory studies. On 23 February 2021 a post mortem examination was carried out by Consultant Forensic Pathologist Dr Ralph BouHaidar at Edinburgh City Mortuary. Samples were taken for toxicology. Thereafter, the cause of death was amended to:

1a. buprenorphine and etizolam toxicity and

2. coronary artery atherosclerosis.

Etizolam (benzodiazepine) is a Class C drug under the Misuse of Drugs Act 1971. Buprenorphine is an opioid. The body mass index was elevated falling within the obese range. The post mortem examination identified congestion of the liver and mild coronary artery disease. Histological examination of the main organs identified patchy pre-existing damage in the heart and confirmed the presence of coronary artery disease. There were no findings of note that could explain the death.

[24] Toxicology identified etizolam and buprenorphine and their metabolites in the blood. Buprenorphine and metabolite were also noted in the urine. Both drugs share similar effects on the central nervous system. It would be likely that they acted in combination leading to progressive respiratory depression, coma (associated with a period of "sleep") and ultimately death. Their effects would have been all the more significant in view of the likelihood of the reduced or complete lack of tolerance to their effects.

[25] The findings of coronary artery disease and pre-existing cardiac damage could have been the result of:

(a) drug use, particularly stimulants,

(b) an inherited condition such as hypercholesterolaemia, or

(c) obesity, which also affects breathing abilities, even more so in a face down position.

The risk of cardiac arrhythmias could well have been increased by the drugs used.

[26] Steven McCann, the Head of operations at HMP Edinburgh, gave evidence as to the extensive measures undertaken at the prison in relation to drug prevention and detection. Anthony Martin in his affidavit provided evidence as to locking and unlocking standards, practices and training. Mr McCann outlined changes which have been introduced, contained in the Scottish Prison Service Management of Prisoner Correspondence Guidance, Revised 17 March 2022, giving effect to amendments to the Prison Rules on prisoner general correspondence which came in to force on 13 December 2021. General correspondence is a category distinct from confidential correspondence, which comprises court, legal, medical and privileged correspondence. The governor may authorise general correspondence to be photocopied and has done so in Edinburgh. The original is placed in the prisoner's property and he is given the photocopy. Original mail being passed to a prisoner, including cards and photographs, are first tested using a RapiScan machine. Should mail test positive it is passed to Police Scotland. Parcels are opened in front of the prisoner, tested and then sent to security for further testing, issued to the prisoner or, if not allowed in use, sent to the prisoner's

property. Decisions to implement the photocopying of general correspondence are reviewed at least every 6 months.

[27] All parties submitted that only formal findings should be made. The Scottish Ministers acting on behalf of the Scottish Prison Service drew attention to the changes since introduced in photocopying or testing prisoners' mail.

Discussion and conclusions

[28] Based upon the information presented it has been established that the death of Mr Welch resulted from ingestion of a combination of drugs, combined with pre-existing coronary artery atherosclerosis. These likely acted in combination leading to progressive respiratory depression, coma and ultimately death.

[29] Prisoner numbers are checked four times daily, though only three times daily at weekends. These checks occur on taking up duty, at lunch time, at tea time and, on weekdays, prior to closure for the night. Following recommendations made at previous Fatal Accident Inquiries during all lock up and unlocking the Scottish Prison Service's policy directs patrols to take appropriate steps to see the face of and obtain a response from all prisoners: *Governors & Managers: Action 016A/15, Revised requirements during Locking and Unlocking Periods, 28 March 2016*. Evidence was provided of steps taken to improve the system of working by providing for refresher training courses for residential officers. The residential officers who checked Mr Welch in the morning were of the position that they would not have completed their check without having seen the face of and obtained a response from all prisoners. There was understandable

vagueness due to the number of checks being carried out and nothing of note being observed at the time. However, in this instance one officer did attest to hearing a verbal response when entering the cell when taking in breakfast shortly after the number check, thus providing a positive sign of life at that time. This Inquiry strengthened the need to take due care in these routines to be sure that officers see the face of and obtain a response from all prisoners. With numerous cells to check and with checks being required three or four times per day, the risk of becoming slapdash in receiving a verbal response is evident.

[30] It is tragically regrettable that this combination of drugs did find its way into the prison estate and contributed to the untimely death of Mr Welch.