SHERIFFDOM OF CENTRAL, TAYSIDE AND FIFE AT PERTH

[2024] FAI 7

PER B17-20

DETERMINATION

BY

SHERIFF W M WOOD

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

into the death of

SCOTT ANDREW ROSS

PERTH, 2 February 2024

Determination

(1) The sheriff, having considering the information presented at the inquiry, determines in terms of section 26 of the Act that:

1. In terms of section 26(2)(a), the deceased is Scott Andrew Ross, born 17 October 1980. He died in cell A1, Hall, HMP Perth, 3 Edinburgh Road, Perth between 0430 and 0500 hours on 21 June 2018, although life was not pronounced extinct until 0525 hours that day. At the time of his death, he was a remand prisoner in respect of charges relating to culpable and reckless conduct and contravention in the Misuse of Drugs Act 1971 for which he had been, committed for further examination.

2. In terms of section 26(2)(c), the cause of death was probable drug withdrawal seizures. Mr Ross had given a history of significant drug use prior to

his incarceration, and drug screening upon his admission to HMP Perth had provided a positive result. Mr Ross had not received the consistent and gradual reducing dose of benzodiazapines that he required due to his repeated discharge and readmission to hospital over the course of four days.

3. In terms of section 26(2)(d), Mr Ross's death was not caused by any accident.

4. In terms of section 26(2)(e): This sub-section requires the court to set out any precautions which (i) could reasonably have been taken and (ii) had they been taken might realistically have resulted in Mr Ross's death being avoided. Mr Ross was remanded in custody from Dundee Sheriff Court on 14 June 2018. Following his initial assessment and urine screen (with was positive for methadone, opiates and benzos), he was prescribed a "standard detox". Between 16 June 2018 and 18 June 2018, Mr Ross was admitted to Perth Royal Infirmary ("PRI") on three occasions. PRI carried out their own assessment, in accordance with their own protocols, which differed from that used by the prison. The hospital was not aware of the prison protocol or the terms of the "standard detox" prescribed; and their own assessment did not indicate that diazepam medication was necessary. It follows that the reasonable precautions which, if taken could have realistically resulted in the avoidance of Mr Ross's death would be:

a. Providing the prescribed treatment to Mr Ross and increasing this in the event of further seizures;

b. The provison by PRI of a realistic detoxification plan to keep him safe.

c. Ensuring consistency in the detoxification plan beetween establishments; and

d. The readmission of Mr Ross to hosptial on 20 June 2018.

5. In terms of section 26(2)(f): This sub-section requires me to identify any defects in any system of working which contributed to Mr Ross's death. I find the following defects:

a. The "standard detox" protocol used by prison health care staff does not take into account pre-existing levels of abuse and may not be adequate in every case. For Mr Ross, he did not receive enough benzodiazepenes to prevent seizure activity and death. Had a bespoke approach been taken, and adequate levels of diazepam been administered, it may be that Mr Ross might not have required hospital admission at all.

b. There was a lack of co-ordination between the approach taken by medical teams at the prison and at the hospital regarding Mr Ross's treatment. On admission, Mr Ross ought to have been accompanied by a copy of the prison Kardex, which set out the medication prescribed to him including, in particular, what doses of diazepam had been administered.

c. The PRI protocol was based on opiates withdrawal symptoms rather than benzodiazepene withdrawal symptoms. The expert evidence was that the latter could happen without showing any other symptoms or signs of withdrawal. The protocol in place should be reassessed for its effectiveness.

d. There was a lack of communication between the prison and the hospital regarding what medication, if any, had been administered.

e. That the readmissions of Scott Ross to Perth Royal Infirmary between 16 and 18 June 2018, along with clinical concerns, should have been sufficient to alert hospital staff that further observation or treatment was required on 20 June 2018.

f. Hospital staff failed to recognise that the symptoms demonstrated by Mr Ross are normal symptoms for for those suffereing benzodiazepene withdrawal. This appears to be a training issue.

g. In spite of concerns raised by healthcare professionals at senior hospital management level, those concerns were not taken sufficiently seriously to allow Mr Ross to be readmitted on 20 June 2018.

6. In terms of section 26(2)(g): This sub-section requires the court to set out any other facts which are relevant to the circumstances of the death. In this regard, I find the following:

a. In Crown submissions, I was referred to statistics published by the National Records of Scotland for the years 2018, 2019 and 2020 (available at www.NRScotland.gov.uk). In 2018, there were 1,187 deaths attributable to drugs - an increase of 27% on the previous year. Of those, benzodiazepenes were implicated in or potentially contributed to 792 deaths (67%). Overall, the number of drug related deaths in Scotland rose by a further 6% in 2019 to 1,264. These statistics informed the need for detoxification treatment programmes to be robust and regularly scrutinised for their effectiveness.

b. On his arrival at HM Perth, Mr Ross presented as history of significant drug misuse, in particular the abuse of a large quantity of opiates and benzodiazapines and he was suffering from drug withdrawal seizures. A urine screen carried out on 14 June 2018 confirmed that. He was prescribed the "standard detox programme" for the administration of 20mgs of diazepam per day, reducing by 5mgs every three days. I accepted evidence of Professor Jonathan Chick, an expert in the treatment of alcohol dependancy and drug addiction, that this would not be a sufficient dose to prevent seizures in many of today's drug addicts, who often take 80mgs or more per day of diazepam or "street" equivalents (such as etizolam). He opined that

overprescription was less dangerous than underprescription - although the emphasis should be on clinical judgement rather than by slavish adherance to a pre-written protocol.

c. Had Scott Ross received the majority of benzodiazapine medication prescribed, he might not have died.

d. Had he not been a prisoner, it is likely that he would have been discharged to the community on the afternoon of 20 June 2018 where, in all probability, he would have recommenced the ingestion of illicit benzodiazapines, which would have prevented the seizures.

e. During the early evening of 20 June 2018, concerns were raised by medical staff at HMP Perth regarding Mr Ross's presentation and wellbeing, following further seizure activity suffered by him. Concerns were raised regarding the absence of both clinical input or clinical moitoring overnight. The head of nursing at HMP Perth escalated her concerns regarding Mr Ross's presentation to the head of prison healthcare (Jillian Galloway). In turn, she contacted the associated nurse director for NHS Tayside, James Foulis at or about 6pm that day. The prison head of nursing also spoke to Mr Foulis. Contact was made with Ward 4 at PRI who refused to readmit Mr Ross. Concerns were raised directly with the ward consultant by, variously, the ward

registrar, the prison head of nursing and the associate nurse director. It might be thought that the three admissions between 16 and 20 June 2020, the persistent seizures and the concerns of clinical staff might have alerted hospital staff that there was an underlying and persistent problem requiring further investigation.

f. The hospital staff lacked awareness of the symptoms of withdrawal from benzodiazapines, some of which were wrongly attributed to Mr Ross's behaviour.

Recommendations

(2) In terms of section 26(1)(b) and (4) the court is required to set out such recommendations as there may be regarding: (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. I make the following recommendations:

1. There should be a co-ordinated approach between the hospital and the prison systems in the management of a prisoner's drug withdrawal.
2. Those managing benzodiazapine withdrawal should consider carefully the proper dosage required for safe discontinuation. Under-prescription in respect of benzodiazapine discontinuation may cause seizures, which

can cause brain damage and death; the expert evidence was that overprescription was less harmful than underprescription.

3. NHS Tayside staff both in prison and in hospitals should consider the existing protocols relating to drug withdrawal. The protocols should be fit for purpose and, where appropriate, tailored to fit the needs of individual prisoners. The requirements for safe opiate withdrawal and safe benzodiazapine withdrawal are unlikely to be the same.
4. All NHS staff should be supported in their care of prisoners withdrawing from illicit substances by being able to seek expert support and advice.
5. A patient's reported use of illicit drugs ought to be taken into account and not ignored or disbelieved - particularly where there is evidence of such abuse (such as urine samples) and observed withdrawal seizures.
6. More generally, there must be a co-ordinated approach between NHS staff in prison and those working in hospitals in relation to the timely and expeditious passage of clinical information in respect of a patient moving from one facility to another.

NOTE

Introduction

[1] An inquiry was held at Perth Sheriff Court into the death of Scott Andrew Ross, born 17 October 1980. The inquiry is a mandatory inquiry under section 2(3) of the Inquiries into Fatal Accidents and Sudden Deaths, etc. (Scotland) Act 2016 ("the Act"),

the death having occurred in Scotland where the deceased was in legal custody. The death was reported to the Crown Office and Procurator Fiscal Service on 29 June 2018. Following advertisement of the preliminary hearing and inquiry hearings, notifications of intention to participate were received on behalf of the Scottish Prison Service, Scottish Prison Officers' Association, Tayside Health Board and from Karlee Lumsden (Mr Ross's sister), all of whom participated in the inquiry.

[2] Throughout the inquiry hearings, the Crown was represented by Ms C Whyte, procurator fiscal depute; the Scottish Prison Service by Ms S Philips, solicitor; Tayside Health Board by Mr R MacPherson, advocate; the Scottish Prison Officers' Association by Ms R Wallace, solicitor; and Miss Lumsden by Ms V Dow, advocate. The principal evidence came from a joint minute, setting out agreed facts that should be admitted as evidence, supplemented by the parole evidence of a number of witnesses and the available productions and affidavits. I then heard submissions on behalf of the represented parties, before closing the inquiry.

The legal framework

[3] The requirement to hold an inquiry under the Inquiries into Fatal Accidents and Sudden Deaths, etc. (Scotland) Act 2016 is principally governed by sections 1 and 2, which are in these terms:

> "1 Inquiries under this Act
>
> (1) Where an inquiry is to be held into the death of a person in accordance with sections 2 to 7, the procurator fiscal must—

(a) investigate the circumstances of the death, and

(b) arrange for the inquiry to be held.

(2) An inquiry is to be conducted by a sheriff.

(3) The purpose of an inquiry is 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.

(4) But it is not the purpose of an inquiry to establish civil or criminal liability.

(5) In this Act, unless the context requires otherwise—

(a) 'inquiry' means an inquiry held, or to be held, under this Act,

(b) references to a 'sheriff' in relation to an inquiry are to a sheriff of the sheriffdom in which the inquiry is, or is to be, held.

2 Mandatory inquiries

(1) An inquiry is to be held into the death of a person which—

(a) occurred in Scotland, and

(b) is within subsection (3) or (4).

(2) Subsection (1) is subject to section 3.

(3) The death of a person is within this subsection if the death was the result of an accident which occurred—

(a) in Scotland, and

(b) while the person was acting in the course of the person's employment or occupation.

(4) The death of a person is within this subsection if, at the time of death, the person was—

(a) in legal custody, or

(b) a child required to be kept or detained in secure accommodation.

(5) For the purposes of subsection (4)(a), a person is in legal custody if the person is—

(a) required to be imprisoned or detained in a penal institution,

(b) in police custody, within the meaning of section 64 of the Criminal Justice (Scotland) Act 2016,

(c) otherwise held in custody on court premises,

(d) required to be detained in service custody premises.

(6) For the purposes of subsections (4)(b) and (5)(a) and (d), it does not matter whether the death occurred in secure accommodation, a penal institution or, as the case may be, service custody premises.

(7) In this section—

'penal institution' means any—

(a) prison (including a legalised police cell within the meaning of section 14(1) of the Prisons (Scotland) Act 1989), other than a naval, military or air force prison,

(b) remand centre, within the meaning of section 19(1)(a) of that Act,

(c) young offenders institution, within the meaning of section 19(1)(b) of that Act,

'secure accommodation' means accommodation provided in a residential establishment, approved in accordance with regulations made under section 78(2) of the Public Services

> Reform (Scotland) Act 2010, for the purpose of restricting the liberty of children,
>
> 'service custody premises' has the meaning given by section 300(7) of the Armed Forces Act 2006."

[4] The inquiry into the circumstances of the death of Scott Andrew Ross is, therefore, a mandatory inquiry in terms of section 2(4) of the Act. In terms of section 36 of the Act, the inquiry is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the Rules").

[5] In terms of section 1(3) of the Act the purpose of the inquiry is to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. The specific matters to be determined by the court are set out in section 26 of the Act, which is in these terms:

> "26 The sheriff's determination
>
> (1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out—
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> (a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and
>
> (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.
>
> (2) The circumstances referred to in subsection (1)(a) are—
>
> (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.

(3) For the purposes of subsection (2)(e) and (f), it does not matter whether it was foreseeable before the death or accident that the death or accident might occur—

(a) if the precautions were not taken, or

(b) as the case may be, as a result of the defects.

(4) The matters referred to in subsection (1)(b) are—

(a) the taking of reasonable precautions,

(b) the making of improvements to any system of working,

(c) the introduction of a system of working,

(d) the taking of any other steps,

which might realistically prevent other deaths in similar circumstances.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to—

(a) a participant in the inquiry,

(b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature."

[6] It will be evident from the above that it is not the purpose of an inquiry to establish civil or criminal liability. The nature of the inquiry hearing is that this is part of an inquisitorial process, in which the procurator fiscal represents the public interest and other interested parties can participate to assist the court in reaching its findings.

Summary

[7] Scott Andrew Ross was born on 17 October 1980. At the time of his death in the early hours of 21 June 2018 he was a remand prisoner at HMP, Perth. He was an habitual user of illicit drugs, particularly benzodiazepenes and opiates.

[8] Mr Ross had appeared on petition at Dundee Sheriff Court on 14 June 2018 in relation to charges of culpable and reckless conduct and contraventions of the Misuse of Drugs Act 1971. He was committed for further examination and remanded in custody. He was transported to HMP Perth by G4S officers, arriving at 1630 hours that day. On arrival, he was put through due process. This includes an initial assessment by prison staff followed by an assessment by nursing staff to establish if a prisoner suffers from any health or mental health issues that present a risk of harm to the prisoner (the "Talk to Me" protocol). Prison records indicate that he "communicated well", with "no thoughts of suicide or self-harm". One of the prison staff nurses recalled that he had told her that he had suspected epilepsy and that he had been experiencing drug related

seizures. She noted that he told her that he had been "snorting" 1.5g of heroin per day and taking between 40 and 50 Valium per day as well as methadone and pregabalin. She noted that Mr Ross said that he suffered from depression and anxiety although he was not currently suicidal and had no thoughts of self-harm. He had prescription medication for a chest infection and for mirtazapine, an antidepressant. A urine sample tested positive for methadone, opiates and benzodiazepine.

[9] On 15 June 2018, the prison GP consulted with Mr Ross in relation to opiate and benzodiazepine detoxification. Mr Ross told him that he had suffered seizures and that he had been seen by neurology, who had said that his seizures were drug related. The GP sent an email to the addictions team to liaise with the Tayside Substance Misuse Service ("TSMS") to ascertain if an extended detox was required, and meantime prescribed a "standard" detox of 20mgs of diazepam on a reducing basis.

[10] On the morning of 16 June 2018, prison staff saw Mr Ross having a seizure, which lasted for about ten minutes. A prison nurse (Ogilvie) ensured that he was given his medication. At about 4.00pm that day, Mr Ross had a second seizure and he was moved to a ground floor observation cell, where he could be monitored. The prison GP observed him to have a third seizure that afternoon and at 1727 hours, Mr Ross was taken by ambulance to Perth Royal Infirmary, where he was admitted as an inpatient on Ward 4. G4S officers who accompanied the deceased maintained their record of observations while he remained an inpatient between 16 and 17 June 2018. At 2019 hours on 16 June, the ward doctor had told Mr Ross that his seizures were due to "going cold turkey from heroin". Mr Ross was recorded as having been sick at

2058 hours and 2141 hours. The following day (17 June 2018), he was sick at 0857 hours and this continued, sporadically, until about 1012 hours. At 1030 hours, he was reviewed by a doctor, who confirmed that he could be returned to prison. This decision was not altered by a further bout of sickness at 1040 hours. Further bouts of sickness are recorded between 1150 hours and 1220 hours and between 1235 hours and 1310 hours, Mr Ross is recorded as having been sick twice. At 1321 hours, a doctor brought Mr Ross's discharge letter but was not concerned that Mr Ross had been sick again. At 1435 hours, he left hospital and arrived back at the prison at 1448 hours.

[11] On the journey back to the prison, Mr Ross was sick in the van. On his arrival, the "Talk to Me" protocol was again followed and there were no issues or concerns. Despite this, Mr Ross's presentation continued to cause concern. Nurse Petrie attended and saw him shortly after 1530 hours. He was vomiting and appeared disorientated and confused. She assessed that he may have had a seizure in the van. Arrangements were made for him to be monitored hourly. About 1600 hours, nurse Ogilvie attended to administer his benzo detox medication and observed his eyes flickering and an inability to respond to verbal prompts. Nurse Ogilvie considered that he was having a further seizure. Nurse Petrie spoke to the senior registrar on Ward 4. The doctor, having considered the description of Mr Ross's presentation, said that his behaviour was "behavioural" as there had been no seizure activity reported whilst on the ward. The doctor had described the symptoms as a "behavioural," "pseudo" seizure, which was believed to be false. The registrar then agreed to Mr Ross's return to the hospital. An ambulance was dispatched. Before the ambulance arrived, the registrar called back to

say that they had "changed their minds" and wanted prison NHS staff to monitor Mr Ross for an hour; but if still not happy, then to send him to hospital. After 30 minutes, prison staff were still unhappy with Mr Ross's condition and requested his admission. At 1730 hours, Mr Ross was again taken to PRI by prison vehicle. Further bouts of sickness that evening are recorded. At 2103 hours, Mr Ross had to be assisted into bed by the accompanying G4S officers.

[12] On 18 June 2018, Mr Ross was incontinent whilst the doctor was present. At 1605 hours, a doctor had confirmed to Mr Ross that the results of a CT scan and blood tests were normal and therefore it was proposed to discharge him. At 1645 hours, the deceased is recorded as having "seizure like activity". Two doctors attended at 1648 hours, and provided a discharge letter. At 1715 hours, the deceased was recorded as "heavy breathing, pretending to have a fit but doctors are not believing him". Thereafter, Mr Ross refused to cooperate with his discharge. He is recorded as having "faked a fit" at the lifts, and having to be carried on to the prison van.

[13] On arrival at the prison at 1835 hours, the "Talk to Me" protocol was again carried out, the assessment being "no apparent risk" in respect of suicide. The form records that he had been sick in the van once again and, on arrival, he had "Very poor communication. Could not answer any questions". His presentation was recorded as being "poor". He was later assessed by nurse Fraser and a health care support worker. Prison officers had described Mr Ross as having been "unable to speak or respond to simple commands"; the fact that he was wearing a nappy was indicative of incontinence. Nurse Fraser found Mr Ross lying on the floor of the cell, having either

crawled or fallen from his mattress. She found him in "a state of stupor", unresponsive and uncoordinated. His vision appeared uncoordinated, both pupils were dilated and the mucus membranes of his mouth were dry. Nurse Fraser telephoned Ward 4 to determine Mr Ross's presentation and general wellness prior to his discharge; she was told that her description was the same as he had been at the time of his discharge. Having attended to other duties, nurse Fraser returned to check on Mr Ross's welfare. She remained concerned and determined that Mr Ross ought to be considered for readmission to the ward. While she was on the telephone to the doctor, she was alerted by other staff that Mr Ross was having a further seizure. She asked staff to call for an ambulance and Mr Ross was returned to PRI. Nurse Fraser sent a summary of her observations to the team leader of the primary care teams, such were her concerns at Mr Ross's presentation on discharge from hospital.

[14] Mr Ross arrived back at PRI shortly before 2022 hours on 18 June 2018. At 0125 hours, on 19 June 2018, he was admitted to the high dependency unit ("HDU") and intubated at 0200 hours. Mr Ross woke up around 11.00am and at 1110 hours, he was recorded by G4S staff as having asked lots of questions, and appearing confused. At 1845 hours, he was moved from HDU to Ward 4. At 2222 hours, Mr Ross was recorded as being in better spirits, laughing when asked whether he was trying to spend his remand period in hospital. At 1020 hours on 20 June 2018 the doctor is recorded as planning Mr Ross's discharge later that day. At 1213 hours, transport was requested. At 1415 hours the transport arrived and Mr Ross was recorded as "throwing himself off the bed and having a fit on the floor". Medical staff are recorded as having attended and

confirming that Mr Ross remained fit to be discharged. At 1445 hours, Mr Ross arrived back at the prison and he was described as being unsteady on his feet. The "Talk to Me" protocol recorded that he had "very poor communication, slurred words, poor eye contact, poor motor skills", as being "unable to properly converse". Assistance was sought from the prison NHS staff.

[15] Shortly after 1500 hours on 20 June 2018 Mr Ross was assessed within the G4S vehicle by nurses Barclay and Petrie. Nurse Petrie had spoken to Ward 4, who had assessed that any observed fitting was likely to be behavioural, and that he should be monitored. Mr Ross was continuing to be incontinent and needed assistance in being cleaned and changed from prison staff. Once in a cell, Mr Ross was closely monitored by residential officers. Concerns were raised with the prison GP. Nurse Millar administered 20mgs of diazepam to Mr Ross around 1700 hours. At 1840 hours, nurse Millar again attended Mr Ross to carry out observations and to give him dihydrocodeine, mirtazapine and cotrimoxazole, which Mr Ross was unable to retain due to sickness. Nurse Millar called NHS 24 to discuss his conditions with a doctor, who agreed that Mr Ross should be assessed the following day by the prison GP. Nurse Millar shared her concerns with the then head of nursing Dawn Wigley.

[16] Ms Wigley then contacted Jillian Galloway, NHS Tayside head of prison health care in order to raise concerns about caring for Mr Ross within the prison estate, where there was no out of hours medical care. It was agreed that a 999 emergency assessment was not required at that time, but Ms Galloway nevertheless agreed to contact associate nurse director James Foulis to make him aware of the situation. In turn, Mr Foulis

agreed to contact the medical team on Ward 4. Mr Foulis reported to her that the ward felt that there was no requirement for Mr Ross's re-admission as there had been no change in his clinical status.

[17] In the meantime, Ms Wigley had also spoken to Mr Foulis herself, repeating her concerns. Indeed, she was sufficiently concerned that she took it upon herself to telephone the on call consultant (who happened to have been responsible for Mr Ross's earlier hospital care on Ward 4), to whom she explained that Mr Ross might well be "fit to go home" but that did not necessarily mean "fit for prison". The consultant confirmed that Mr Ross had been medically assessed as being fit for discharge, which she was satisfied was the correct decision.

[18] In his parole evidence, Mr Foulis (associate nurse director) confirmed that Ms Wigley had first called him in relation to Mr Ross on 16 or 17 June 2018. He suggested that she liaise with the head of nursing in PRI, to organise a local review to look at the circumstances of Mr Ross's discharge. This was not an uncommon procedure. She had called him again when he was leaving work around 6.00pm on 20 June 2018. Mr Foulis had spoken to the head of nursing and asked for the matter to be discussed with a consultant. Around 7.30pm – when out on his bike - he noted nine or ten missed calls from Ms Galloway, the service manager, raising concerns that there had been no agreement for Mr Ross to be re-admitted. He had tried to speak to a consultant, who was not immediately available. He had spoken to the registrar, who was aware that Mr Ross had had a further fit that afternoon in prison. He made him aware that there would be no medical cover available within the prison estate overnight.

The doctor had described Mr Ross as having had "pseudo-fits" but other "fitting" behaviour was deemed to be behavioural. In speaking to the consultant, Mr Foulis had made her aware of his concerns in relation to the circumstances: the absence of any medical staff overnight within the prison estate; Mr Ross's presentation as described by nursing staff; and his further, recent fit following his discharge. The consultant remained satisfied that Mr Ross had been appropriately discharged and that, if need be, either the out of hours service or a 999 ambulance would be appropriate.

[19] The CCTV footage from A Hall between 20 June 2018 and 21 June 2018 0600 hours confirms the half hourly checks carried out by prison officers during that period. For most of that time, Mr Ross was seen to be asleep and breathing. At 0500 hours, it was noted that Mr Ross had not moved since the previous check and concerns were raised. When found to be unresponsive, an ambulance was called, chest compressions were started and the defibrillator was applied. Paramedics later declared life extinct at 0525 hours on 21 June 2018.

[20] A post-mortem examination of the deceased was carried out on 26 June 2018. The cause of death was established as "probable drug withdrawal seizures".

Expert evidence

[21] Dr Timothy Mark Morse MB ChB, BSc (Immunology) MSc FRCP is a consultant physician in acute and general medicine, a position he has held since 2007. He has significant experience of managing patients who come from within the prison service and he is used to managing patients who are at risk of withdrawal from opiates,

benzodiazepines or alcohol as part of their admission to hospital. He is also used to managing patients who have seizures or a diagnosis of epilepsy as well as those who have concomitant non-epileptic seizure activity. He is also used to managing patients with personality disorder and functional presentation.

[22] He had noted from the records, that Mr Ross had been identified as being a poly drug misuser from his arrival at the prison. Following assessment, he was started on the routine regime of detoxification, which Dr Morse understands to be the recommended protocol across all prisons in Scotland. This is for a fixed regime of reducing doses of diazepam to manage benzodiazepine withdrawal and dihydrocodeine to manage the opiate withdrawal. He noted that Mr Ross was started on this regime, but it was interrupted each time he was admitted to PRI, a total of three times over three consecutive days. On his admission to hospital, a more detailed drug history was taken by a junior doctor and recorded in the notes. This included the high level of pre-admission benzodiazepine use and the regular use of heroin. He was started on an opiate withdrawal protocol during one of his admissions. The scale used by the hospital relies on "scoring" based on symptoms; but during the 18 hours of recorded symptoms, Mr Ross did not score highly enough to require any methadone. On his last admission on 18 June 2018, Mr Ross was prescribed two doses of intravenous lorazepam in Accident and Emergency in order to terminate the seizure activity. Later that night, he was intubated and managed overnight in intensive care with propofol, which would suppress any seizure activity whilst he was on the infusion. Dr Morse noted that there

was no evidence that there was any other management for benzodiazepine withdrawal whilst in PRI.

[23] Issues also arose due to Mr Ross having a previous diagnosis of personality disorder which would make interactions and consultations challenging at times. Such patients can become aggressive or disengaged with the process. Anyone attempting to engage with such a patient may have to use a level of patience and experience that can be very challenging. From the notes, Dr Morse also noted that Mr Ross had been exhibiting signs of non-epileptic seizure activity in addition to suffering from "true" seizure activity. Evidence for this is that he was treated for seizures with lorazepam (benzodiazepine) and then required an overnight admission to the intensive care unit to manage his respiratory distress and agitation. True seizure activity can co-exist with non-epileptic seizure activity, and frequently does in patients with epilepsy. The combination of personality disorder with non-epileptic attacks would make looking after any patient more challenging, whilst they still are at risk of true seizure activity if they are in withdrawal from drugs or alcohol.

[24] The risk associated with seizure activity is one of brain damage and potential death. In hospital, rapid administration of benzodiazepines can terminate a seizure. If the seizures are refractory there are other pharmacological interventions that can terminate seizure activity and ultimately a patient can be intubated and ventilated in intensive care to manage extremely refractory seizure activity. Acute seizure activity is treated as a medical emergency in hospital.

[25] Having reviewed the documentation, Dr Morse opined that Mr Ross's moves between two different approaches to managing drug misuse in two different establishments meant that he did not get the treatment that he would have done had he stayed at one establishment. He had missed out on doses of diazepam and dihydrocodeine in HMP Perth when he was in PRI who used an opiate withdrawal programme which used methadone as opiate replacement when symptoms of withdrawal are displayed. If Mr Ross had not been in prison it is not clear if he would have had any seizure activity and therefore may not have required admission to hospital. Had he collapsed and suffered a seizure in the street (rather than within the prison estate) then management of his admission on 16 June 2018 is unlikely to have been any different than it was; on discharge on 17 June, he would have returned to his normal routine of taking drugs that he obtained in the community. This could have had a protective effect in terms of preventing him having further seizures.

[26] There was documentation of what from the notes sounded like a "functional seizure-like episode" in the late afternoon of 18 June just before he was discharged back to HMP Perth. Dr Morse believes that he would have been discharged back into the community at this stage if he had not been a prisoner. Similar considerations apply in relation to the functional seizure-like episode shortly prior to discharge on 20 June 2018 and Dr Morse believed that, again, Mr Ross would have been discharged at this point even if he had not been a prisoner.

[27] Dr Morse had previously seen a report prepared by Professor Jonathan Chick (see *infra*). He agreed with Professor Chick that, had Mr Ross received more

benzodiazepines during the time that he was moving between HMP Perth and PRI, the seizure activity that is believed to have led to his death might have been prevented. Given the large amounts of benzodiazepine that Mr Ross had been taking in the community it would not have been unreasonable to give more benzodiazepine in a hospital setting. He further agreed with Professor Chick that there was a lot of emphasis on using an opiate scoring system to prescribe methadone which was not going to prevent seizure activity as a result of benzodiazepine withdrawal; and the latter could happen without objective signs of withdrawal. Dr Morse personally had not used anticonvulsant therapy in this situation and would only start those with the support and guidance of the neurology team. He would expect to discuss with the on call neurology team how best to manage a patient who was having recurrent seizure activity despite adequate management of their withdrawal symptoms.

[28] Dr Morse would not normally stop a medication such as pregabalin suddenly as there are risks of withdrawal from that, too; normally, the aim was to reduce this slowly over a planned period of time. Similarly, he would not have routinely stopped Mr Ross's mirtazapine during an acute admission. Although he may have withheld it for a brief period, as with pregabalin, he would normally reduce and stop or change to an alternative in a planned manner, often in conjunction with advice from a pharmacist.

[29] Based on the documentation he had considered, Dr Morse did not believe that the plans for discharge would have been different were Mr Ross not a prisoner. The only difference would be that, in prison, he was returning to an opiate and benzodiazepine withdrawal programme whereas, if discharged to the community, he

would resume previous drug taking activity. The communication between HMP Perth and PRI with regards to what he had been given in terms of medication to treat Mr Ross's poly drug misuse withdrawal was not clear from the documentation. If there had been a more coordinated approach as to how his withdrawal regime was managed, then he believed that the outcome could have been different. Professor Chick had confirmed that the levels of benzodiazepine in Mr Ross's blood post-mortem indicated that he was not receiving sufficient prescribed medication to prevent benzodiazepine associated withdrawal. Dr Morse agreed that the planned 20mgs of benzodiazepine prescribed by the standard prison regime seemed a low dose to replace the very high levels of benzodiazepines that the deceased had been taking before he was taken into custody.

[30] The lack of clear communication between the PRI medical team and those looking after Mr Ross in prison contributed to the final outcome. The use of two different protocols as well as the fact that Mr Ross missed most doses of the only regime that was giving him planned replacement (of benzodiazepines) to prevent withdrawal problems was a contributory factor. Mr Ross had only received one dose of 20mgs of diazepam on 15 June 2018 and a further dose on the night of 20 June 2018, following his third discharge from PRI. It was a concern that this would not be enough to have prevented Mr Ross from withdrawal, given the much larger doses he was taking habitually.

[31] Mr Ross was admitted three times to PRI between 16 June and 18 June 2018. After the last discharge on 20 June 2018, prison nursing staff had raised concerns about

the safety of his discharge back to the prison environment due to the lack of clinical input overnight. Re-admissions and clinical concern would be suggestive of a persisting underlying problem to the hospital teams and should have raised professional concern that further observation or treatment was required.

[32] Had there been a single system for a withdrawal protocol that was followed by both the health and the prison system then this might have helped prevent the death of Mr Ross. In hospital, it was much easier to manage patients with such needs where rapid access to nursing and medical staff was available to respond to changes in clinical presentation if a person starts to suffer from withdrawal symptoms. The standard protocol currently used in prison might well undertreat some individuals who routinely take large quantities of street drugs.

[33] Professor Jonathan Chick MA, MB ChB, MPhil DSc FRCPE FRCPsych is a consultant psychiatrist and physician who has specialised in the brain and body's response to alcohol and drugs. He prepared reports for this inquiry dated 18 May 2020 and 8 June 2020. Having reviewed the productions, he made a number of observations, which I summarise (where possible) as follows:

(a) The Perth Prison "Standard Detox Exemplar" produced was an example of an NHS Tayside prescription chart showing that, for prisoners addicted to substances, there are various standard methods including a sample reducing regimen of diazepam. It allows a space for the prescriber's initials as the name of the medication, the dose and the frequency of administration is handwritten by a doctor. This could be tailored for each prisoner, but there was no space on the

form to tailor the dose to an individual on a daily basis. There was no column for the nurse administering the medication to initial that it had been administered, nor the timing of such administration, nor any other observation. The standard protocol for the prevention of withdrawal symptoms was used across Scotland. In relation to benzodiazapines, this was for the administration of 20mgs of diazepam per day, reducing by 5mgs every three days. As the patient was not seen frequently, there was no option for a symptom-triggered regimen - unlike the method used in PRI.

(b) There was no obvious record of advice given by PRI to the prison medical team about a continuing medication regime to prevent seizures. The levels of benzodiazapines found post mortem were too low to have been effective in preventing seizures in a person with a previous high usage. As Mr Ross had missed several doses of diazepam prescribed in prison while he was in PRI, it was possible that equivalent doses of diazepam might not have been given in PRI, which would explain the low level of benzodiazapines found post mortem.

(c) **Recommendations regarding management of benzodiazapine withdrawal in prison**

1. An account of substances that a person has been consuming prior to admission to prison should be obtained. This could be difficult to assess because addicts may either minimise amounts to avoid

opprobrium or exaggerate amounts because they fear withdrawal discomfort and/or are prone to seek extra drugs.

2. It can be problematic to estimate the doses needed for safe discontinuation: when drugs like benzodiazapines have been used it can be dangerous to underprescribe because seizures may occur. Typically, the first dose in a reducing regime will be somewhat less than the dose the person claimed to be taking; but if the initial dose has been overestimated the person will appear sedated. The "starting dose" recommended of 20mgs of diazepam per day would not be sufficient to prevent seizures in many of today's drug addicts who often take 80mgs or more per day of diazepam or equivalent. On their arrival in prison, a person may have had no access to their drug supply for 72 hours if they have been in police custody over a weekend, pending appearance in court. Overprescribing is less dangerous than underprescribing: disinhibited behaviour or unsteadiness possibly leading to a fall are the only hazardous consequences of overprescribing. Unsteadiness will be readily identified by prison staff and the following dose can readily be ommitted or reduced.

3. Consideration should be given to continuing any other drugs with anti-convulsant actions that the person claims to be taking or to have been prescribed (in this case, pregabalin which is an anticonvulsant that was not continued either in prison or in hospital).

4. Consideration should be given to stopping prescribed medication that are pro-convulsant such as most antidepressants (in Mr Ross's case, mirtazapine was continued).

5. People with epilepsy may also manifest seudo-seizures.

6. Consideration should be given to adding another anti-convulsant such as Keppra in a regular dose during the period of withdrawal from benzodiazapines.

7. If a patient vomits shortly after swallowing medication, the medication might not be absorbed and the dose might need to be repeated.

8. Obtaining advice from the local NHS Substance Misuse Service should be helpful in establishing the detox regime. Each HM prison should have a link with the local Substance Misuse Service (to which some drug addicted prisoners might be known).

9. **Monitoring**

(a) When monitoring withdrawal signs and symptoms, a person who has been using long acting benzodiazapines such as diazepam or clonezepam will not show withdrawal signs for several days, but seizured may still occur.

(b) Unlike with alcohol withdrawal, there is no scale which uses the score on the scale to link to dosage of the protective medication. Professor Chick could not recommend for prison use any existing

benzodiazapine withdrawal scale because they depend mainly on subjective reports of anxiety, aggitation, insomnia and distress which are likely to be exaggerated by addicts in prison and to be equally reported by any prisoner distressed by incarceration.

(c) Objective signs are sweating, high blood pressure, pulse over 100 beats per minute and tremor. These should be recorded and will assist the doctor in estimating necessary doses.

(d) Seizures due to withdrawal can still occur without those objective signs being present.

10. Information on benzodiazapine withdrawal can be found on Scenario: Benzodiazepine and z-drug withdrawal | Management | Benzodiazepine and z-drug withdrawal | CKS | NICE. However, this mainly refers to outpatient withdrawal where a slow dose reduction is recommended because this improves patient compliance when the patient is managing his/her prescription at home.

[34] In the addendum to his report of 18 May 2020, Professor Chick made the following observations:

(a) **System failures.** Professor Chick accepted that a note from Ward 4 of 20 June 2018 provided advice regarding diazepam to prison staff. However, it was not clear what advice was given or received following Mr Ross's return on 17 June 2018. The prison medical records did not have copies of the immediate discharge notification sent by NHS

hospitals to another care service showing the diagnosis, treatment received and treatment recommended. This appeared to be a defect of either the hospital or the prison documents system.

(b) **Reasonable precautions whereby the deceased's death might have been prevented.** Higher doses of a benzodiazapine (either lorazepam or diazepam) given either in hospital or in prison on 19-20 June 2018 could have had a major contribution to preventing death by seizure. The hospital staff may have limited their prescribing of benzodiazapine because Mr Ross did not "score highly enough". However, benzodiazapine withdrawal scales are only a guideline, and the current and previous seizures and the reported high usage by Mr Ross would indicate to an average clinician the need for slower decrease than resulted in this case. It is possible for Mr Ross to have not scored highly on the scales and still suffer from a drug withdrawal seizure. A dose recommendation of only 20mgs/day by a Substance Misuse Consultant, as a "standard dose", would be a major contributant to subsequent death by seizure. In the Professor's opinion there are dangers in suggesting a "standard recommended dose": other factors must be considered including past seizures and the size of recent daily doses being reported by or prescribed to the patient (prisoner).

(c) **Seizure protection or exacerbation by other medications.** Given his past seizures, starting a prescription of an anticonvulsant such as Keppra

could have been a major contributant to preventing death by seizure, especially if commenced early, for example on 15 or 16 June 2018 and continued - it can take between 36 and 48 hours for an effective anticonvulsant protection to be reached. Continuing, instead of discontinuing a medication that had an anticonvulsant effect (in this case pregabalin) would have made a major contribution to preventing death by seizure. Given his past seizures, discontinuing the pro-convulsant drug (mirtazapine) that he had been prescribed, instead of continuing it, could have been a major contributant to preventing death by seizure.

(d) **Vomiting after receiving medication.** In this case, the deceased's diazepam at 4.30pm on 20 June 2018 would have been fully absorbed before vomiting at 7.30pm. Repeating that dose would have made a difference because he was already under-dosed, but the nurse was correct in not, on her own initiative, repeating the dose because of earlier vomiting, due to the interval.

(f) **Scoring severity of withdrawal.** As previously stated, the symptom scale is not a sufficiently reliable indicator of risk of withdrawal seizures in someone with long acting abuse of benzodiazapines especially with a history of seizures. Adding objective signs - sweating, high blood pressure, rapid pulse rate and tremor - would not have made a difference in this case. The nurses in Perth Prison had sometimes recorded these,

but good practice could include them in the drug administration chart where there is alchol or drug withdrawal in process.

[35] In his oral evidence, Professor Chick reiterated the need for a bespoke assessment of a prisoner's needs. Diazepam is not a drug that required to be administered regularly and it could be topped up at any point before the dosage was gradually reduced, subject to monitoring clinical features. If need be, large doses might be helpful to prevent a sudden seizure which can be delivered either intravenously or per rectum, although its effect would be shorter lasting than if taken orally. Although he saw value in the use of protocols or guidelines in relation to the administration of benzodiazapines, consideration still had to be given to a patient's previous usage in assessing the appropriate level of medication.

Post-death review action

[36] Following Mr Ross's death, the Scottish Prison Service carried out a "Death In Prison Learning, Audit & Review" ("DIPLAR"). A copy of the SPS guidance was produced. The DIPLAR is described as being "the joint SPS & NHS process for reviewing all deaths in custody and provides a system for recording any learning and identified actions." It is chaired by the SPS governor-in-charge or deputy governor and it is attended by representatives from both staff and the NHS. The review was carried out on 15 August 2018 and it was completed on 26 September 2019, following the

development of a learning plan. The terms of the meeting were also made available as part of the evidence.

[37] It is significant that the DIPLAR correctly identified the difference between a patient being discharged home and one being discharged to prison: in the latter circumstances, there would be no one to monitor an individual overnight (or, as I have identified elsewhere in this determination, any means of "self-medication" through the acquisition of illicit substances). It was clear that staff had made every effort to have Mr Ross re-admitted to the ward. I note that Mr Ross's death is reported as having had a profound effect on both SPS and NHS staff - to many of whom in the prison, he was well known. Whilst recognising that prison staff had gone above and beyond the general call of duty in relation to the care provided for Mr Ross, the DIPLAR recommended that:

- A joint protocol between NHS/SPS to be developed and implemented to assist staff in the obseravations of prisoners who require additional assistance but who do not fall within existing SPS/NHS policies or procedures.
- A joint consultation between NHS/SPS to set up a support system for staff involved in the ongoing care of an individual but not necessarily involved in the direct incident.
- Escort forms for the use of SPS staff during escorts.
- Time for social care packages to be created when required.
- Extend invitations to NHS staff to attend local CIRS meeting.

[38] Tayside Health Board carried out a "Local Adverse Event Review" ("LAER") ON 29 June 2018, a copy of which was produced. The stated purpose of the report was to

> "identify in detail the route causes and key learning from this adverse event. The information in this report will be used to reduced the likelihood of future harm to patients and to share learing."

It was of some significance that Mr Ross's presentation with substance abuse related seizures (objectively evidenced by an increased white blood cell count) was complicated by pseudo-seizures and his own abnormal behaviour, making clinical assessment challenging. Following his second admission to hospital and subsequent discharge back to prison, he was noted as being unco-operative despite having been incontinent of both faeces and urine. During his final admission, Mr Ross was intubated and in ICU because of the risk of aspiration due to his unusual and fast respiratory pattern - and not as a result of his seizures. It was noted that there was a conflict in the notes and the recollection between the prison GP and the medical registrar on call on the afternoon of 20 June 2018: the GP recalls requesting that Mr Ross be admitted, the medical registrar saying that they did not think that admission was required; and PRI recollections that, although there had been discussion about the patient being admitted, there was no specific request for that. It was identified that hospital staff should have improved access to a patient's prison admission documentation. Overall, there was an acknowledgment that communication between medical staff at the prison and PRI could be improved as well as the availability of clinical and other patient level information.

Discussion

[39] The cause of Scott Ross's death was drug withdrawal seizure. It seems clear that this was the result of the absence of a coordinated approach between medical staff at HMP Perth and PRI regarding how to treat his drug withdrawal. The prison Kardex (detailing the diazepam prescription and confirming the doses administered) was not made available to the hospital medical staff and the discharge letters from the hospital did not detail the medication administered at PRI. This resulted in insufficient diazepam medication being administered to Mr Ross to prevent a seizure where he was a higher user of, *inter alia*, illicit benzodiazapines and where he presented with a history of drug withdrawal seizures. Although each of the protocols adopted by HMP Perth and PRI are - arguably, at least - suitable for their respective settings, as a consequence of a lack of clear communication and co-ordination, Mr Ross missed essential diazepam medication, leading to his fatal seizures.

[40] It is important to note that, on Mr Ross's admission to HMP Perth, he was recorded as being at significant risk of the adverse effects of illicit drug withdrawal. It is not in dispute that abrupt termination of benzodiazapines is more significant in an habitual and heavy user. Without gradual cessation of benzodiazapines or substitution therapy, withdrawal is associated with confusion, agitation, headaches, vomiting, seizures, coma and death. Mr Ross missed doses of his diazepam treatment under the prison protocol because of his repeated discharge and readmission to hospital over the course of a four day period. Between his first admission to Perth Royal Infirmary and his final discharge on 20 June 2018, Mr Ross spent only approximately 4 hours within

Perth Prison. Dr Morse confirmed that it was as a consequence of HMP Perth and Perth Royal Infirmary adopting two separate and entirely different treatment protocols that Mr Ross did not receive the vast majority of his diazepam prescription and therefore he did not receive the consistent and gradually reducing dose of benzodiazapine he required.

[41] Although Mr Ross was given diazepam on 15 June 2018, he was not given any on 16 June (having been admitted to PRI) nor does it appear that he was provided with benzodiazapines on 17 June 2018. On 18 June 2018, medical staff attempted to give Mr Ross 15mgs of diazepam but he was unable to swallow. Intravenous lorezepam was administered whilst he was an in-patient in order to stop an ongoing seizure, but this is shortlasting and would not provide sufficient protection against a further seizure. No further diazepam was given to Mr Ross until he returned to Perth Prison on 19 June, when he was given 20mgs of diazepam. It may be of note that he was sick shortly thereafter, meaning that it may not have been fully absorbed.

[42] Within the hospital setting, Mr Ross was correctly assessed on 16 June 2018 as suffering from seizures due to drug abuse or withdrawal. The consultant was not aware of the urine screen conducted at the prison which would have confirmed Mr Ross's drug use prior to his remand. The prison Kardex which confirmed the prescription that he was on and the doses of benzodiazapine he had received and/or missed was not made available to the hospital medical staff. Mr Ross received no diazepam medication then and a decision was made that he would to be monitored for 24 hours and prescribed diazepam should he show further signs of withdrawal.

[43] On 17 June 2018, a registrar assessed Mr Ross and determined that as he did not score sufficiently on the hospital drug withdrawal protocol, no diazepam medication was appropriate - notwithstanding the fact that Mr Ross had suffered multiple seizures, had a history of drug withdrawal seizures and a history of drug abuse. Further, emphasis was placed by the medical staff at PRI on using an opiate scoring system to prescribe methadone which would not have prevented seizure activity as a result of benzodiazapine withdrawal, which could happen without other objective signs of withdrawal. Professor Chick's report is very clear about that. Accordingly, the scoring system used to assess Mr Ross's withdrawal symptoms in PRI was inappropriate where it determined that he did not score highly enough to merit receiving the necessary benzodiazapine medication.

[44] That Mr Ross was underprescribed is graphically illustrated by the post mortem toxicology report, to which Professor Chick made reference.

[45] The sequence of events following Mr Ross's discharge on 19 June 2018 has also been of some concern. The ward registrar who had authorised Mr Ross's discharge was not told of the two seizures that Mr Ross experiences whilst awaiting discharge on 18 and 19 June 2018. It cannot be determined with any certainty whether knowledge of these (and a subsequent examination of Mr Ross) would have changed the decision to discharge, but it is concerning that the person responsible for making the decision did not have a change of presentation communicated to them.

[46] What is clear, is that, immediately upon his arrival back at Perth Prison, both non-medical and medical staff were extremely concerned about Mr Ross's presentation.

Within the prison, this was escalated to the staff nurse and the GP and the head of nursing. The latter contacted her own line manager. Both spoke with the associate director of nursing and then the on-call consultant (who happened to be the consultant responsible for Mr Ross's care). Both the head of nursing and the duty doctor on Ward 4 on the evening of 20 June 2018 said that they had explained to the consultant the concerns regarding the care of Mr Ross within the prison setting and relayed the fact that he had had a further fit. The consultant could not recall that. At the conclusion of her evidence, I asked the consultant how often she had received an out of hours telephone call from the associate director of nursing in relation to concerns about a discharged patient. She thought this had been the only time that had happened.

[47] The prison GP was somewhat circumspect as to whether he had made a direct request for Mr Ross to be re-admitted. His evidence was that he telephoned the ward to express concerns with a view to persuading the registrar that re-admission was required. While I understand that a degree of circumspection may be politic between fellow healthcare professionals, the absence of a direct request was not helpful for Mr Ross, and undermined the vigour with which re-admission was being sought. Even so, the staff at PRI could have been in no doubt what was being sought, given the multi-layered approaches through both medical and nursing avenues.

[48] It would appear that perhaps an error has been made in equiparating "discharge from hospital" with "discharge home"; and where Mr Ross would have fallen into the former category, he certainly did not fall into the latter, being a remand prisoner. The helpful observations of Dr Morris and Professor Chick clearly identify that, if a patient is

discharged home, there maybe others to whom he can turn for support or care - or, for someone like Mr Ross, the facility to access illicit drugs that would ease his withdrawal. Although he was cared for in prison, administered 20mgs of diazepam and thereafter subject to half hourly checks this was plainly insufficient to prevent his death; crucially, there was no overnight medical cover or the depth of routine monitoring that would have been available in hospital.

[49] I was impressed by the extraordinary level of care and commitment shown to Mr Ross following his final return to the prison. He was assisted by prison officers to undress, shower and change (having been incontinent of both faeces and urine) and his presentation was such that the medical staff plainly did all that they could to ensure that he received appropriate treatment beyond the confines of their own, limited service. The escalation to associate nursing director/consultant level is indicative of significant commitment to the health and welfare of their patient, for which they are to be commended.

Conclusions

[50] The death of Scott Ross on 21 June 2018 was unusual, although it has laid bare the possible consequences of inadequate communication between one branch of health care and another. The discharge from hospital of a patient who might otherwise return home must be seen as different from discharging a patient back to a prison setting where, by definition, he/she will be kept under lock and key. It may well be a rare occurrence that there are fatal consequences from the failure to communicate effectively

and timeously but that does not mean that there are no faults in the system. It is not clear when Scott Ross was apprehended in respect of the matters in which he appeared on petition and Dundee Sheriff Court on 14 June 2018. All that can be said with certainty from the available evidence is that, from on or about 13 June 2018, Mr Ross did not have access to the illicit drugs that he had been taking habitually. On admission, he was asked for and provided a history of his regular drug intake which was later confirmed by his urine screen on his admission to PRI, a full history was taken, which would have included the same information - although his prescription (as recorded by Kardex) did not go with him.

[51] Although it is accepted that the detox programmes in hospital and HM prisons may well both be adequate for most patients, the expert evidence makes it clear that there is scope for improvement and discretion by treating physicians having access to the appropriate expert advice. Had Mr Ross remained in hospital, it is entirely possible that his further presentation would have caused concern leading to the prescription of further benzodiazepines/substitutes that might have prevented further seizures and, ultimately, his death. Given Mr Ross's repeated seizures, he could not reasonably have remained within a prison setting (given the limitations on the available service there), but had he so remained, it is possible that he would have had the necessary consistency of care that would have allowed for the "standard" detox to be either continued or tailored to fit his needs, in line with expert advice. As it was, he was subject to a "revolving door" of admissions and discharges leading to a lack of proper assessment of his needs and a lack of awareness of the levels of medication he had received. One

might have thought that the safe course for the hospital on 20 June 2018, given the nature, number and escalations of the approaches by healthcare professionals within the prison, would have been to have readmitted him to Ward 4. I must accept, however, that even his readmission might not have prevented his death, given that the half hourly monitoring carried out by prison staff had not raised any concerns before he passed away.

[52] Following Mr Ross's death, both the SPS and NHS Tayside carried out a review of their procedures. While I understand that more information is now transmitted from the prison to the hospital, it remains a concern that the improved communications appear to go only in one direction.

[53] I offer my condolences to Mr Ross's sister and family.

Sheriff