SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT PERTH

[2025] FAI 9

PER-B46-24

DETERMINATION

BY

SHERIFF ALISON MCKAY

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

into the death of

JAMES RUSSELL GORRIE

PERTH, 16 January 2025

Determination

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 (hereinafter referred to as "the 2016 Act") the following:

1. In terms of section 26(2)(a) of the 2016 Act that James Russell Gorrie (hereinafter referred to as "Mr Gorrie") died in legal custody at some point between 1657 on 10 July 2021 and 0840 hours on 11 July 2021 and life was formally pronounced extinct at 0840 hours on 11 July 2021.
2. In terms of section 26(2)(c) of the 2016 (the cause or causes of death) finds that the cause of death was a combination of the acute and chronic adverse effects of Buprenorphine and Etizolam and agonal choking on food.

3. In terms of section 26(2)(e) of the 2016 Act, that there were no precautions which could reasonably have been taken to prevent Mr Gorrie's death.

4. Makes no finding in respect of sections 26(2)(b), (d), (f) and (g) of the 2016 Act.

6. No recommendations are made in terms of section 26(1)(b) of the 2016 Act.

NOTE

The legal framework

[1] The 2016 Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 Rules") govern fatal accident inquiries.

[2] A fatal accident inquiry is held under section 1 of the 2016 Act and its purpose in terms of section 1(3) 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.

[3] The purpose of the inquiry is not to establish civil or criminal liability. The process is inquisitorial in character. The procurator fiscal represents the public interest at the inquiry.

[4] The present inquiry was mandatory in terms of sections 2(1) and (4) of the 2016 Act as Mr Gorrie was in legal custody at the time of his death.

Introduction

[5] This inquiry took place at Perth Sheriff Court on 26 and 27 August 2024.

[6] During the inquiry Ms Graham, Procurator Fiscal Depute represented the Crown, Ms Turner, Solicitor represented the Scottish Prison Service ("SPS") ,

Mr Rodgers, solicitor represented the Prison Officers Association ("POA") and Ms Muir, Advocate represented Tayside Health Board ("THB").

[7] Prior to the inquiry preliminary hearings were held on 23 April, 17 June, 15 July, 23 July and 19 August 2024. A number of preliminary hearings were required primarily due to difficulties in formatting digital footage for viewing by all parties and myself.

[8] Prior to evidence being led parties lodged a detailed and comprehensive Joint Minute of Admissions, and I am grateful to them for their efforts in this regard. It was agreed that a number of affidavits and witness statements should be admitted in evidence and treated as the parole evidence of the witnesses, or part thereof and also that all productions lodged were true and accurate.

[9] Affidavits were lodged on behalf of SPS by Tom William Hendry Martin, employed as Head of offender Outcomes for SPS dated 23 August 2024; Anthony Martin, employed as Head of Operations and Public Protection for SPS dated 22 August 2024; Jane Brown, employed as a Learning and Development Manager for SPS dated 22 August 2024; and Andrew Hodge, current Governor at HMP Perth dated 27 August 2024.

[10] In addition THB lodged an affidavit by David Hope, Senior Nurse employed by NHS Tayside at HMP Perth dated 23 August 2024.

[11] I heard parole evidence from Prison Officer Michelle McLean on 26 August 2024.

[12] On 27 August I heard evidence from Prison Officer David Goligher and from the current Governor of HMP Perth, Andrew Hodge.

[13] Following the conclusion of evidence I directed parties to lodge written submissions. The written submissions lodged by all parties succeeded in being both thorough and succinct. I heard additional oral submissions on 25 November 2024. I will not narrate the submissions made, but have taken account of them while writing this determination and thank agents and counsel for their assistance in this regard.

Productions and labels

[14] The following productions and labels were lodged:

Crown Productions

1. Final Post Mortem Examination Report authored by Doctor David Sadler, Consultant Forensic Pathologist, Dundee (Crown Production number 1);
2. Toxicology Report dated 6 August 2021, authored by Doctor Peter Maskell and Doctor Fiona Wylie, both Forensic Toxicologists based at the University of Glasgow (Crown Production number 2);
3. Redacted Intimation of Death to Procurator Fiscal form in respect of Mr Gorrie , dated 14 July 2021(Crown Production number 3);
4. Redacted book of photographs taken on 11 July 2021 at the locus by witness Anne Cheeney, Scene Examiner and member of the Scottish Police Services Authority, Forensic Services, Scene Examination, Dundee containing images of the locus with Mr Gorrie's body in situ; (Crown Production number 4);

5. Redacted copy of the Death in Custody Folder prepared by the SPS including redacted Prison Intelligence records in relation to Mr Gorrie (Crown Production number 5);

6. Redacted Tayside Health Board medical records pertaining to Mr Gorrie (Crown Production number 6);

7. Redacted "Death in Prison Learning, Audit & Review" Report (hereinafter referred to as the "DIPLAR" report) prepared by SPS and NHS Health Scotland in respect of Mr Gorrie (Crown Production number 7);

8. Redacted "Full Adverse Event Review Report" (hereinafter referred to as the "LAER") conducted by the NHS in relation to the death of Mr Gorrie (Crown Production number 7);

9. Police statement of John Baird, who was employed as a Prison Officer at HMP Perth at the time of Mr Gorrie's death (Crown Production number 9);

10. Police statement of James Hutt, who was employed as a Prison Officer at HMP Perth at the time of Mr Gorrie's death (Crown Production number 10);

11. Police statement of Michelle McLean, who was employed as a Prison Officer at HMP Perth at the time of Mr Gorrie's death (Crown Production number 11);

12. Police statement of Daniel Williamson, who was employed as a Prison Officer at HMP Perth at the time of Mr Gorrie's death (Crown Production number 12);

13. Police statement of Alexandra Oswald, who was employed as a Staff Nurse working at HMP Perth at the time of Mr Gorrie's death (Crown Production number 13);

14. Police statement of Kirsty Hosie, who was employed as a Paramedic Team Leader for the Scottish Ambulance Service at the time of Mr Gorrie's death (Crown Production number 14);

15. Redacted police statement of Carl Dyson, Detective Constable of the Police Service of Scotland (Crown Production number 15);

16. Police statement of Dale Hendry, Detective Constable of the Police Service of Scotland (Crown Production number 16);

17. Police statement of Stuart Martin, Detective Sergeant of the Police Service of Scotland (Crown Production number 17);

18. Police statement of Sean McCabe, Detective Sergeant of the Police Service of Scotland (Crown Production number 18);

19. Redacted police statement of Mark Ross, Detective Constable of the Police Service of Scotland (Crown Production number 19);

20. Police statement of Anne Cheeney, Scene Examiner and a member of the Scottish Police Services Authority, Forensic Services, Scene Examination Unit, Dundee (Crown Production number 20);

21. Redacted email chain between the Procurator Fiscal Depute Ms Graham and Dr David Sadler, the now-retired Forensic Pathologist who conducted Mr Gorrie's post mortem examination in which a number of

supplementary questions were put to Dr Sadler, to which he responded (Crown Production number 21); and

22. Redacted email chain between the Procurator Fiscal Depute Ms Graham and Fiona Wylie, one of the Forensic Toxicologists who authored the Toxicology Report in respect of Mr Gorrie's death, in which a number of supplementary questions were put to the toxicologists, and to which a joint response was provided by said Fiona Wylie and Peter Maskell (Crown Production number 22).

Crown Labels

1. Crown Label number 1 which is a pen drive containing the following:
   (a) CCTV footage from within C Hall, HMP Perth, seized by officers of the Police Service of Scotland showing (i) footage from camera 373 which points from one end of the corridor towards the grille gates and prison officers' station showing Association Area South 1, and (ii) footage from camera 374, which points from the grille gates and prison officers' station down towards the far end of the corridor showing Association Area South 2; with Clips numbered 1 - 3 being taken from both cameras and covering the period from 0827 hours until 1705 hours on 10 July 2021 and Clips numbered 4 - 6 being taken from camera 373 and covering the period from 1630 hours on 10 July 2021 until 0900 hours on 11 July 2021;

(b) Recordings of the "Code Blue" radio alert made at approximately 0738 hours on 11 July 2021 at HMP Perth when Mr Gorrie was discovered by staff in his cell, and the subsequent radio messages that followed; and

(c) A recording of a telephone call made by Mr Gorrie within HMP Perth in June 2021, where he was advised of a death in his family.

SPS Productions

1. Copy of "007A/23", a Governor and Managers: Action document ("GMA") dated 24 February 2023 (SPS Production number 1);
2. Copy of SPS Standard Operating Procedures ("SOP") document "SOP-OPS-226" regarding "Suspect Mail", dated February 2018 with a review date of 15 April 2022 (SPS Production number 2);
3. Copy of the SPS GMA document "079A/14", which contains the Management of an Offender at Risk due to any Substance ("MORS") policy and guidance, dated 30 December 2014 (SPS Production number 3);
4. Copy of the SPS GMA document "010A/15" regarding "Witnessing the Administration of a Controlled Drug", dated 5 March 2015 (SPS Production number 4);
5. Copy of SPS "SOP-PM003(B)" for "Issuing Medication", dated June 2016 with a review date of June 2017 (SPS Production number 5);

6. Copy of "SOP-PM011" for "Routine Cell Searches", dated May 2019 with a review date of May 2020 (SPS Production number 6);
7. Copy of "SOP-OPS-302" for "Searching Prisoners", dated May 2015 with a review date of 18 March 2020 (SPS Production number 7);
8. Copy of "SOP-OPS-108" for "Visiting Procedures", dated May 2015 with a review date of May 2020 (SPS Production number 8);
9. Copy of "SOP-OPS-304" for "Searching Visitors", dated May 2015 with a review date of January 2022 (SPS Production number 9);
10. Copy of SOP "OPS-910" for "Rapiscan Operation", which is undated (SPS Production number 10);
11. Copy of SPS GMA document "GMA 016A/16", which sets out revised requirements during locking and unlocking procedures in prisons and is dated 28 March 2016 (SPS Production number 11);
12. Copy of the SPS SOP for "Residential Numbers Check" dated July 2022, with a review date of July 2024 (SPS Production number 12);
13. Copy of the Course Descriptor for the "Locking & Numbers" Session on the SPS Residential Officer Foundation Programme, approved on 15 February 2022 (SPS Production number 13);
14. Copy of the PowerPoint presentation that is used during the "Locking & Numbers Session" on the SPS Residential Officer Foundation Programme, and is undated (SPS Production number 14);

15. Copy of the Session Plan for the "Locking and Numbers Session" on the SPS Residential Officer Foundation Programme, and is undated (SPS Production number 15);

16. Copy of SPS PRL Standards 1.3.2.5 on "Locking Policy/Management of Security Keys", and 1.3.3.3 on "Population Counts/Number Checks", contained within the Prisons Resource Library (SPS Production number 16);

17. Copy of SPS "GMA 014A/23" dated 21 March 2023 which was introduced with immediate effect to inform Governors and Managers of a new policy to ensure that Operations Officers acting up in a residential (prison officer) role have sufficient knowledge to commence duties within residential areas (SPS Production number 17);

18. Copy of the formal response submitted on behalf of SPS to recommendations made by Sheriff MacRitchie following the publication of his determination in relation to a mandatory Fatal Accident Inquiry held in relation to the death of Gary Ross, who died in custody at HMP Perth in March 2020 (SPS Production number 18);

19. Copy of compulsory annual online training "Mylo Training Package on Locking and Unlocking" dated April 2024 in respect of locking and unlocking procedures (SPS Production number 19);

20. Copy of the SPS training "Session Plan" on locking and numbers checks, which was introduced in January 2023 (SPS Production number 20);

21. Copy of SPS records regarding cell searches carried out in cells occupied by Mr Gorrie during his time in prison covering the period from 22 May 2019 to 11 July 2021 (SPS Production number 21);
22. Extract from the Attendance Record for the Numbers Check Awareness Refresher training held by HMP Perth in 2020/2021 (SPS Production number 22); and
23. Copy of the SPS SOP for "Residential Numbers Check" dated April 2020 (SPS Production number 23).

Findings in fact

Background information

[15] James Russell Gorrie was born on 29 July 1975 and was aged 45 years old at the time of his death.

[16] Mr Gorrie was a convicted prisoner at HMP Perth, 3 Edinburgh Road, Perth.

[17] In 2011, Mr Gorrie was sentenced to 7 years imprisonment with a 3-year extension period for assault to severe injury, permanent disfigurement and danger to life.

[18] On 13 September 2016 he was recalled to custody for further offending, namely contraventions of section 47(1) of the Criminal Law (Consolidation) (Scotland) Act 1995 and section 90(2)(a) of the Police and Fire Reform (Scotland) (Act) 2012. On 24 November 2017, Mr Gorrie was sentenced at Edinburgh High Court to a concurrent sentence of 12 months imprisonment for these offences.

[19] On 14 June 2018 at Perth Sheriff Court Mr Gorrie was sentenced to a concurrent sentence of 6 months imprisonment for a contravention of section 5(2) of the Misuse of Drugs Act 1971 (as documented in Crown Production number 5, at page 57).

[20] Mr Gorrie's death took place in cell 8 within C block, Level 4 at HMP Perth. This was a single occupancy cell which Mr Gorrie occupied alone.

Medical history

[21] On admission to HMP Perth, on 30 August 2016, it was recorded that Mr Gorrie had a history of depression but he denied thoughts of self-harm or suicide at that time. He reported a drug use problem in relation to heroin, cocaine and diazepam which was confirmed by drug urine sample. He had suspected asthma and was prescribed inhalers.

[22] On 2 July 2020 Mr Gorrie was admitted to Ninewells Hospital, Dundee, complaining of shortness of breath. He admitted to having taken medicines that were not prescribed to him at that time. He was diagnosed with drug toxicity and community acquired pneumonia, and remained in hospital for 2 days. He had further hospital admissions during August and October 2020, and in January 2021 in relation to pneumonia and respiratory issues.

[23] Mr Gorrie had contact with the HMP Perth Substance Misuse Team from February 2018. He was initially prescribed methadone, and was moved to Espranor, and then latterly had Buvidal treatment administered weekly by the Substance Misuse

Nursing team. Staff recorded that his attendance was excellent and he engaged openly with staff.

[24] In the month before his death, Mr Gorrie disclosed to members of the Substance Misuse Team that he was using illicit substances. On 14 June 2021 he discussed recent episodes of MORs in the hall and use of Benzodiazepines, and on 24 June 2021 he further disclosed that he had recently been using illicit Espranor for a few days due to a family bereavement, but had now stopped. Harm reduction was discussed with him.

[25] Mr Gorrie's last consultant review with the substance misuse psychiatrist was on 28 April 2021, and he was last seen by a member of the Substance Misuse Team on 7 July 2021.

[26] Mr Gorrie was not on the mental health team caseload at the time of his death. He had previous contact for low mood, anxiety and some cognitive concerns that resulted in a referral to the Department of Clinical Psychology at Ninewells Hospital. He was assessed there on 25 October 2019 and 22 November 2019, with no findings of organic cognitive decline evident from CT head scan and clinical assessment. He also had contact with Psychiatry, and had several consultations during 2019. He was discharged from the Mental Health caseload on 28 August 2020.

[27] At the time of his death, Mr Gorrie was prescribed Buvidal treatment, which is a Buprenorphine prolonged release solution, weekly in the form of subcutaneous injections. He received the last dose on 7 July 2021. He was also prescribed medication for other medical issues including 900mg of Gabapentin, administered twice daily on a supervised basis, and 30mg Mirtazapine to be taken at night which was prescribed on a

weekly in-possession basis. Mr Gorrie was not prescribed Etizolam, Amitriptyline or Pregabalin at the time of his death.

Circumstances of the death

[28] At around 0800 hours on Saturday 10 July 2021, witness Michelle McLean, Prison Officer at HMP Perth, helped open the cells on C block.

[29] At around 0915 hours, same date, NHS nurses attended at C block to administer medication. Mr Gorrie attended at the hatch and obtained his medication.

[30] At about 1000 hours Mr Gorrie and all other prisoners were locked back in their cells.

[31] At about 1020 hours, witness McLean attended at Mr Gorrie's cell and provided him with food items.

[32] At about 1045 hours, Mr Gorrie was allowed out of his cell earlier than some other prisoners on the same landing because he held a "passman role". In his capacity as passman Mr Gorrie carried out light duties on the landing outside his cell. Passman duties permitted Mr Gorrie to leave his cell early to clean the tables, floors and empty the bins on the landing.

[33] Witness McLean unlocked Mr Gorrie's cell and he was thereafter served lunch. He sat at a table on the hall landing with a group of other prisoners.

[34] At about 1200 hours, Prison Officers McLean and Goligher locked the prisoners back in their cells after lunch.

[35] At about 1415 hours the cell doors were opened for association time.

[36] Throughout the afternoon, Mr Gorrie was on the hall landing with other prisoners. At about 1530 hours, nurses attended to provide medication and Mr Gorrie again attended to receive his medication.

[37] At about 1600 hours, prison staff served dinner to prisoners on the South Side of C block. Mr Gorrie exited his cell and sat at a table in the middle of the hall landing.

[38] At approximately 1645 hours Prison Officers Goligher and McLean entered the hall and began locking prisoners in their respective cells.

[39] There was nothing unusual about Mr Gorrie's presentation over the course of the afternoon prior to his death.

[40] At approximately 16:55:31 hours Mr Gorrie returned to his cell. He did not carry out his passman duties before doing so. Items were left on the tables which he should have removed.

[41] Over the days preceding his death Mr Gorrie had not carried out his passman duties to an appropriate standard. He had also been dismissive towards staff.

[42] At about 16:56:43 hours Officer McLean went to the door of Mr Gorrie's cell to lock him in for the night. Whilst there she spoke with him about his passman duties. Mr Gorrie was dismissive of her complaint but did not argue with her. At the end of this conversation Officer McLean locked the door to Mr Gorrie's cell for the night. When Mr Gorrie was last seen by Officer McLean he was alive and well. He was sitting watching television.

[43] At about 0730 hours on Sunday 11 July 2021 Officer McLean again commenced duty at HMP Perth.

[44] Prison Officers McLean and Hutt started to open up the cells on C block. At approximately 07:37:46 hours, Officer Hutt opened up the door of Mr Gorrie's cell.

[45] Officers McLean and Officer Hutt observed Mr Gorrie lying on the floor of his cell, partially under his bed with his feet nearest the cell door. Officer Hutt shouted Mr Gorrie's name and tried to rouse him by shaking him. He could not find a pulse and Mr Gorrie was cold to touch. There were no signs of injury.

[46] Officer Hutt requested that witness McLean put a "Code Blue" alert over the radio, and an ambulance was contacted. A Code Blue alert indicates a medical emergency without blood.

Medical response

[47] A prison officer advised Alexandra Oswald (also known as "Sandra"), Staff Nurse at HMP Perth, of the Code Blue alert in C Hall. She picked up emergency equipment and made her way to Mr Gorrie's cell.

[48] On her attendance, Staff Nurse Oswald's initial assessment was that Mr Gorrie appeared dead due to his mottled colour. She checked his pupils for a reaction. They were non-responsive. He was not breathing. She checked his carotid and radial pulses which were absent. Mr Gorrie was cold to touch and she noticed that rigor mortis had started to set in. Mucus had formed around his nose and mouth. The checks confirmed her first assessment that Mr Gorrie had passed away. The attending health care staff agreed not to carry out CPR in the circumstances.

[49] At about 0840 hours, Kirsty Hosie attended in her capacity as a paramedic with the Scottish Ambulance Service. She saw that rigor mortis had started to set in and Mr Gorrie was cold to touch. She pronounced his life extinct at 0840 hours on 11 July 2021 and completed the relevant paperwork.

Police involvement

[50] At about 0830 hours on 11 July 2021, the Police Service of Scotland received notification that a male had been found deceased within HMP Perth. There were no signs of blood or violence on Mr Gorrie's body, or any obvious signs of drug misuse.

[51] Detective Constables of the Police Service of Scotland attended at the locus and carried out an initial assessment. Mr Gorrie's cell was found to be cluttered and untidy, with many personal effects within, but there were no signs of a disturbance having taken place.

[52] Mr Gorrie was found to be lying in the recovery position on the floor next to the bed, on his right-hand side. He was wearing black shorts with grey boxers underneath, and a blue zip up top with a black T-shirt underneath. There were various stains on Mr Gorrie's clothing which appeared to be from food.

[53] Mr Gorrie had fluid or mucus emanating from his nose. On partially removing his clothing it was noted that he had a scar on his left abdomen and his right cheek, consistent with old injuries. Mr Gorrie also had a smaller scar on his lower right forearm.

[54] Mr Gorrie was cold to touch and there was post mortem staining down his right side and his back, consistent with the position he had been found in on police attendance. There was more pronounced angular post mortem staining to his upper left shoulder blade, consistent with pressure against furniture or similar.

[55] Detective Constable Dale Hendry and Scene Examiner Anne Cheeney attended the locus and seized the following:

i) 3 pieces of small, blank white paper within the pocket of Mr Gorrie's shorts, one bearing a red ink mark but with no obvious signs of residue or notations;

ii) A white tablet within the pocket of Mr Gorrie's shorts; this was a large oval shape and appeared to have a marking on it which had worn off;

iii) Half a tablet, found on the floor within the cell next to Mr Gorrie's head, under the bed; this was half a white oval pill with a pink or orange coating.

[56] Detective Constables Carl Dyson and Mark Ross attended at HMP Perth and carried out a search of Mr Gorrie's cell. They recovered and seized the following items:

i) 6 x Mirtazapine tablets;

ii) 3 x yellow tablets + 9x white tablets;

iii) A vape and pieces of vaping equipment;

(iv) Medication in Mr Gorrie's name;

(v) Eye drop medication in the name of another person.

[57] Further items were recovered when prison staff finished searching Mr Gorrie's cell and were also provided to police officers. This included:

i) An iPhone from a DVD player;

ii) A charger from a DVD player;

iii) A square of paper found inside an alarm clock;

(iv) 2 x Etizolam tablets found inside an alarm clock;

(v) Traces of a sticky brown substance found inside a remote control, which later tested positive for Cocaine;

(vi) 2 x tablets, which later tested positive for Buprenorphine;

(vii) An SPS-issued SIM card; and

(viii) An "illicit", non-SPS issued SIM card found inside an SPS-issued mobile phone.

[58] Forensic analyses were performed on the items recovered from Mr Gorrie's pockets and his cell, with the following results:

i) 3 x white pieces of paper - ADB-BUTINACA (a Class B drug);

ii) White Tablet - Gabapentin (a Class C drug);

iii) 3 x yellow tablets, 9 x white tablets, 3 x yellow capsules - Gabapentin (a Class C drug);

iv) 7 white tablets - Gabapentin (a Class C drug);

v) 2 white tablets - Levetiracetam (not a controlled substance); and

vi) Half a pink or orange tablet - Mirtazapine (not a controlled substance).

[59] Mr Gorrie's body was formally identified by prison officers and conveyed to the Police Mortuary, Dundee, by police officers.

[60] No fingerprints or DNA were found on the recovered drugs, and no suspects were identified regarding the supply of the controlled drugs found at the locus.

Post Mortem Examination and Toxicology Analyses

[61] On 12 July 2021 the Crown Office and Procurator Fiscal Service received the death report from the Police Service of Scotland. A post mortem examination was instructed to take place, along with toxicology analyses.

[62] On 12 July 2021, Dr David William Sadler carried out a post mortem examination in relation to Mr Gorrie.

[63] External examination of the body revealed no injuries and gave no cause for concern. Autopsy revealed moderate enlargement of the heart (cardiomegaly), deemed likely to be a complication of obesity.

[64] Mr Gorrie's stomach contained undigested food and fragments had passed up the oesophagus, with two chipped potatoes partially occluding the larynx. There was partially digested solid food at the vocal folds, and slightly below this level in the upper larynx. The presence of food at that location may have represented agonal movement during resuscitation, or may have represented choking due to occlusion of the airways in life.

[65] Histopathological examination of the tissues confirmed a small amount of aspirated gastric material in one section of the lung, suggesting that aspiration may have

occurred in life, possibly associated with a terminal episode of choking. This is likely to be due to acute drug intoxication.

[66] Cardiomegaly, likely the result of obesity, was likely to have made Mr Gorrie's heart more susceptible to terminal cardiac arrhythmia and was a significant contributory factor to his death. Such cardiomegaly may result in sudden death at any time due to disturbance in the electrical rhythm of the heart (cardiac arrhythmia).

[67] Autopsy revealed no further acute natural disease which could have contributed to Mr Gorrie's death.

[68] Dr David William Sadler, pathologist, certified Mr Gorrie's cause of death as:

I. (a) Acute and Chronic Adverse Effects of Buprenorphine and Etizolam AND Possible Choking on Food;

II. Cardiomegaly, Obesity.

[69] Upon being asked by the Crown to comment further in relation to the cause of Mr Gorrie's death Dr Sadler opined that although the Mr Gorrie's stomach contained undigested food including recognisable chips, the presence of two large intact and unchewed chips at the level of the vocal folds suggested aspiration in life and consequent choking, rather than passive port-mortem regurgitation which usually occurs with more fluid digested gastric contents. He also opined that the presence of gastric material localised to one section of the lung on histological examination supported aspiration occurring in life.

[70] Toxicology analyses were performed on the bodily fluids of the deceased which detected:

i) Amitriptyline (an anti-depressant drug which was not prescribed to Mr Gorrie);

ii) Etizolam and its active metabolite (a drug not currently licenced for medical use in the United Kingdom);

iii) Mirtazapine (an anti-depressant drug prescribed to Mr Gorrie);

iv) Pregabalin (a drug not prescribed to Mr Gorrie at the time of his death); and

v) Buprenorphine, an opioid analgesic, and its metabolite Norbuprenorphine

[71] Upon being asked by the Crown to comment further in relation to the cause of Mr Gorrie's death Forensic Toxicologists Fiona Wylie and Peter Maskell opined that on balance Mr Gorrie had taken buprenorphine additional to the Buvidal injection he received on 7 July 2021.

Accommodation

[72] Prisoners generally have a kettle and a television in their cells. They are allowed food in their cells. They can take food from the landing into their cells when they wish and can purchase snacks and soft drinks.

[73] During the course of the night prisoners are not checked whilst in their cells. It would not be reasonable to do so. Prison officers conduct patrols on the landing. Within the cells, prisoners have an intercom system and an emergency button which are

monitored 24 hours a day. The intercom system is within close proximity to the bed in each cell.

[74] Prisoners also have access to a telephone. Mobile telephones were issued to prisoners during the Covid pandemic. Since Mr Gorrie's death in-cell telephones have been introduced instead.

Passman duties

[75] Mr Gorrie held the position of a passman on the hall. Passmen are hand selected by the residential staff on the hall. In selecting prisoners for passman duties regard will be had to a prisoner's general behaviour towards other prisoners and staff, and also to whether a prisoner has recently been placed on MORS or "on report" for an infraction of prison rules.

[76] A prisoner tasked with passman duties has no greater freedom within the prison estate than other prisoners.

[77] Passmen are supervised and monitored by residential staff on an ongoing basis.

Drugs

[78] Buprenorphine is available in two forms, namely Buvidal as a subcutaneous injection and Espranor as a tablet which dissolves on the tongue.

[79] At the time of his death Mr Gorrie was prescribed 32 mg of Buvidal every 7 days. He last received a dose by way of a subcutaneous injection in his left arm on 7 July 2021.

[80] At HMP Perth Espranor is administered daily on a supervised basis. Nurses observe the patient taking the tablet and check as best they can that the tablet has dissolved. If a patient is found to be concealing the tablet, or there is a suspicion of this then the patient is given an appointment with the Substance Use Team consultant to discuss other treatment options such as Buvidal or methadone.

[81] Mr Gorrie was not prescribed Espranor at the time of his death.

[82] At HMP Perth Amitriptyline may be prescribed on an "in possession" basis for a week or on a supervised basis depending on the prisoner's risk profile. Prisoners who are prescribed Amitriptyline on an in-possession basis should store the drug in the in-cell safe provided.

[83] Mr Gorrie was not prescribed Amitriptyline at the time of his death.

[84] Etizolam is an unlicensed drug in the UK and is not prescribed in HMP Perth.

[85] Pregabalin is prescribed at HMP Perth. It is not prescribed as an "in-possession" drug and is only dispensed on a supervised basis.

[86] Mr Gorrie was not prescribed Pregabalin at the time of his death.

[87] At HMP Perth Gabapentin is a supervised drug and is never dispensed on an "in-possession" basis.

[88] Mr Gorrie was prescribed Gabapentin at the time of his death. He was prescribed 900mg twice a day, dispensed in the morning and evening on a supervised basis. He was last issued with prescribed Gabapentin by nursing staff at HMP Perth on 10 July 2021 in the morning and in the evening.

[89] On occasions prisoners attempt to conceal Gabapentin on their person. Nurses are not able to check this unless they see the prisoner do so. Nurses can ask prisoners to open their mouth so that they can check the drug has been taken, but nothing more. If a nurse suspects a patient of concealing a drug they will alert SPS officers. Only SPS officers have authority to search prisoners.

[90] Mr Gorrie was prescribed Mirtazapine at the time of his death, at a dose of 30mg taken at night. This was prescribed on a weekly "in-possession" basis.

Storage of medication

[91] There is a controlled drug cupboard for each hall at HMP Perth. Nurses carry out a stock check of supervised medication and controlled drugs every morning and maintain a controlled drug book in which this information is recorded.

[92] Locked medical trolleys are used to dispense drugs in each flat of the prison. The key to each trolley is kept on a nurse's keychain. Drug trolleys are signed in and out of the controlled drug cupboard so that the identity of the nurse holding the keys to the trolley is known at all times.

[93] Medication rounds are carried out by two members of staff, a nurse and a witness. The witness is either another nurse, or a health care support worker or pharmacy technician who has completed prescribed training.

[94] The nurse dispensing medication decants drugs from the drug cupboard to the drug trolley for the medication round and will document what is removed from the drugs cupboard and what is returned in the presence of the witness.

[95] The locked medication trolley is taken to the hall by the nurse and escorted by a prisoner officer. There is no prisoner movement at this time. The prisoner are locked in their cells or otherwise restricted from moving.

[96] At each flat the nurse will go to the medication room, from where drugs are administered to one prisoner at a time through a hatch. The prisoner is not allowed to leave the window until NHS staff are satisfied the prisoner has consumed the medication dispensed to him. Every effort is made to ensure this happens, but on occasions a prisoner will successfully conceal a drug or swallow a tablet and regurgitate it at a later time.

[97] At the end of the medication round the locked medication trolley is returned to the Health Centre. The nurse is escorted back by a prisoner officer and a further stock check is carried out before the medication cupboard is locked.

[98] Medication spot checks are generally carried out at HMP Perth twice a year. Additional checks are carried out on the basis of intelligence, with an aim to carry out 20 spot checks per week across all 6 flats within HMP Perth.

[99] Medication spot checks are unannounced. They take place 2 or 3 days after prisoners have received their weekly medication. An NHS member of staff will access information regarding the drug prescribed to each prisoner on an "in-possession" basis and how many tablets the prisoner should have of any drug on the day in question. An NHS member of staff will be escorted to a cell and will ask to see the prisoner's medication and count how many tablets the prisoner has in his possession.

[100] If a prisoner fails a spot check this is discussed at a medication management meeting attended by a clinical pharmacist, a senior nurse and a GP. A low level tablet discrepancy may be reasonable, depending on the level of risk, and the prisoner may be given the benefit of the doubt. In those circumstances it is likely a further unannounced spot check would take place within the next 2 weeks.

[101] A larger tablet discrepancy may lead to the prisoner's medication being discontinued, or to medication being dispensed on a supervised basis rather than on an "in-possession" basis.

[102] Mr Gorrie was spot-checked in relation to his prescribed "in-possession" medication on 10 January 2021 and 21 February 2021. On both occasions he had the correct amount of medication in his possession.

Urine sampling

[103] Prisoners are urine tested on admission to HMP and ongoing urine screening takes place as part of a prisoner's ongoing assessment and medicine compliance.

[104] A urine sample was taken from Mr Gorrie on 7 July 2021. The laboratory report was returned on 2 August 2021 and showed that the urine sample was positive for Buprenorphine, Gabapentin and Pregablin.

[105] Had Mr Gorrie still been alive it is likely he would have attended a meeting with a substance use prescriber in order to carry out a full medication review and determine what medication it would be safe to keep him on. It is likely his Gabapentin would have been stopped because it is unsafe to take Gabapentin and Pregabalin at the same time.

[106] Prior to 7 July 2021 Mr Gorrie's last drug test was in 2019 and tested positive only for Buprenorphine, which was prescribed to him.

Illicit drugs

[107] SPS has in place a number of measures aimed at preventing illicit drugs entering the prison estate and identifying and removing drugs when these are present.

[108] Internally SPS have an Intelligence Unit which constantly monitors prisoners in custody, including information regarding who is supplying or buying illicit substances. A monthly meeting is held with Police Scotland to discuss these issues.

[109] Prisoners often volunteer information regarding drug availability since some do not like the unpredictability caused by illicit drug use and may disclose their concerns to staff. If SPS become aware of a supply chain they will take steps to disrupt that. Depending upon information received SPS may lock down an area within the prison or carry out targeted searches. Prisoners can be moved. Drugs can be intercepted.

[110] If SPS receive intelligence about a prisoner being in possession of drugs then a targeted search will be undertaken.

[111] If a residential wing has a spike in the number of prisoners placed on MORS then the area will be locked down and a mass search carried out.

[112] A mass spot check is carried out approximately monthly and will also involve members of the NHS nursing team. Annual searches also take place. A tactical dog unit is frequently used.

[113] Redacted prison intelligence record in relation to Mr Gorrie included a number of entries between August 2017 and June 2021 regarding Mr Gorrie's suspected involvement in illicit substances during his time in prison custody.

[114] Every cell within a prison is searched a minimum of four times each year.

[115] Prisoners are searched after visits on their return to the hall. Searches are carried out on a random basis. All prisoners leaving a residential area are x-rayed to scan for metal and weapons. Prisoners are searched when they leave a work shed. Rub down searches take place regularly and strip searches when appropriate.

[116] Visitors to the prison undergo searching similar to airport security. Mobile telephones are placed in a locker and not allowed into the establishment. Visitors are searched upon entry. Visits are supervised by Operations Staff.

[117] HMP Perth has outside patrols and internal patrols to monitor the prison and CCTV across the whole prison which is used to monitor hot spots which have been identified where illicit items can be thrown over the perimeter walls and fences. External grills have also been installed to prevent prisoners fishing packages over the walls.

[118] Targeted searches are undertaken with the assistance of Police Scotland. If a person is suspected of bringing an illicit substance into the prison they will be searched.

[119] All staff are searched upon entry to the establishment. Their property is x-rayed and no mobile telephones are allowed. Infrequent searching of staff takes place in conjunction with the National Tactical Tea, including a Dog Unit. On occasions a number of staff will receive a thorough search.

[120] All vehicles entering the establishment are also searched by SPS Operations staff. A vehicle search involves speaking with the driver, checking inside and outside the vehicle, any compartments within the vehicle and underneath the vehicle.

[121] Body scanners have been introduced to scan for concealed drugs. All prisoners are scanned upon admission to HMP Perth, including transfers from other sites, from court and other external appointments.

[122] Set procedures are in place for dealing with prisoners who provide a positive indication on the body scanner.

[123] HMP Perth has taken steps to mitigate the risk of illicit substances being introduced through general correspondence sent to prisoners using the prison mail system. All prisoner's mail is photocopied and prisoners only receive a photocopy of their mail. The only exception to this is legal correspondence.

[124] A formal process is also in place for prisoners to receive items other than correspondence in prison. The prisoner require to complete a pro forma form which is authorised by a First Line Manager and sent out to the prisoner's family. The requested item is then taken or sent to the prison and is assigned a unique reference number which links the item or package to the completed request form. Parcels arriving at HMP Perth without an assigned reference number are rejected and do not enter the prison. Introduction of this system has led to a significant reduction in illegal parcels being sent to the establishment.

[125] If a parcel is received with no unique reference number which contains drugs or mobile telephones then Police Scotland will be informed. On occasions enquiries may

lead to individuals responsible for sending illicit parcels being identified and prosecuted.

[126] On occasions drones are used to deliver parcels containing drugs and mobile telephones beyond the perimeter of HMP Perth. SPS are currently piloting technology to track drones in order to detect and deter the delivery of drugs into the establishment in this manner.

[127] All new clothing sent to residents from outwith HMP Perth is laundered to ensure that any item potentially soaked in illicit substances is washed out.

[128] Despite extensive efforts on the part of SPS it is not possible to eradicate the introduction of illicit drugs and prohibited items into the prison estate.

Lock up procedures

[129] Numbers checks and lock up procedures are carried out in prison multiple times each day in accordance with Standard Operating Procedures.

[130] When conducting numbers checks prison staff must ensure that they physically account for each prisoner. Prison staff must also ensure that they see the face of, and get a verbal response from all prisoners during lock up and unlocking periods, including patrol periods at lunchtime and in the evening. Revised guidance issued by SPS specifically states that this is to "reduce the risk of suicide and also identify someone with a deteriorating health condition".

[131] At HMP Perth the Standard Operating Procedure (both at present and at the time of Mr Gorrie's death) specifically requires that numbers checks and lock up procedures are carried out by prison officers in pairs.

[132] On the evening prior to Mr Gorrie's death Officers McLean and Goligher were working on the landing on C Hall where Mr Gorrie's cell was situated. They were both residential officers on the hall. It was their responsibility to carry out the lock up procedure for the night. They should have undertaken this duty together in a pair.

[133] When Officer McLean started carrying out lock-up procedure she was not accompanied by another officer. Officer Goligher had become involved in a conversation with another prisoner. By the time that conversation had ended Officer McLean had undertaken a large part of locking up duties on the landing alone. Officer McLean did not tell Officer Goligher she had carried out lock up procedures unaccompanied by another prison officer. Officer Goligher did not check Officer McLean had done so and did not suggest that they should both carry out a subsequent - and SOP compliant - lock up procedure before passing responsibility for the landing to patrol officers for the night.

[134] When she had finished speaking with him Officer McLean locked the door to Mr Gorrie's cell for the night. When she last saw Mr Gorrie in his cell he was sitting watching television.

[135] As residential prison officers in C Hall both Officers McLean and Goligher were familiar with Mr Gorrie.

[136] Officer McLean did not have any knowledge of Mr Gorrie's involvement in illicit substances. She was not in any way concerned about his presentation on the night prior to his death.

[137] Officer Goligher had never seen Mr Gorrie under the influence of illicit substances in the prison. He was unaware of any current issues or the deterioration in Mr Gorrie's passman duties.

[138] The lock up procedure undertaken by Officer McLean was not compliant with SPS required practice. Officer McLean obtained a verbal response from Mr Gorrie but she was not accompanied by a second prison officer when she did so.

Findings

[139] The Notice of the Inquiry anticipated that the inquiry would consider and examine (i) the procedures for prescribing, dispensing, and storage of buprenorphine; (ii) the search procedures then in place within HMP Perth and what preventative measure are in place to stop drugs entering the prison system and to stop the misappropriation of prescribed substances such as buprenorphine; (iii) the impact of the role of "passman" and whether that role or similar provides additional opportunity to prisoners with drugs addiction difficulties to access and acquire illicit substances and ,if so, what measures can be put in place to limit such possibilities; and (iv) any reasonable precautions which might realistically have presented Mr Gorrie's death and any defects in the system of working which may have contributed to his death.

[140] SPS and NHS have appropriate procedures in place for the prescribing, dispensing and storage of buprenorphine.

[141] A raft of search procedures are in place at HMP Perth both to prevent illicit drugs entering the prison system and to stop the misappropriation of prescribed medication. It has not been possible on the evidence to identify how Mr Gorrie obtained the non-prescribed additional drugs or the illicit drugs which he consumed on the night prior to his death or which were found in his cell thereafter.

[142] Whilst I have noted some intelligence was held by SPS regarding Mr Gorrie's previous involvement with illicit drugs it is clear neither of the prison officers who gave evidence had any concerns in this regard at the time of his death.

[143] Furthermore, Officer McLean had a detailed conversation with Mr Gorrie when she locked him into his cell for the night and she had no concerns regarding his presentation at that time. There is no evidence to suggest that the additional supervision provided by MORS could or should have been invoked that evening.

[144] It will be apparent from Finding in Fact 76 above that Mr Gorrie's role as passman had no relevance to the circumstances of his death since it did not allow him additional freedom within the prison estate or contribute to his ability to source additional drugs.

[145] Mr Gorrie would not have been placed in the position of a passman had residential officers had any concerns regarding his non-compliance with the prison regime or knowledge of his ongoing consumption of illicit substances. Nonetheless

medication which had not been prescribed to Mr Gorrie was found in his cell after his death, together with illicit drugs.

[146] The SPS lodged a number of documents which outline the procedure for making regular checks of prisoners within their cells on a daily basis. These checks include numbers checks and welfare checks upon prisoners.

[147] In terms of Standard Operating Procedures in place at HMP Perth regular checks must be undertaken by two officers, who are required to ensure that they account for each prisoner. There is a specific requirement that an officer should unlock each cell door in order to see the face of, and obtain a response from the prisoner. Officers are required to engage in a dialogue with prisoners. These measures are designed to reduce the risk of suicide and to identify any person with a deteriorating health condition.

[148] It will be seen that at Findings in Fact [132] to [138] I have concluded that the SPS locking up procedures which took place on the night prior to Mr Gorrie's death was not undertaken in accordance with the relevant SOP. This is particularly disappointing given earlier FAI determinations in relation to persons in custody at HMP Perth have reached the same conclusion.

[149] However, notwithstanding her failure to comply with the lock up procedures in place, I was satisfied by Officer McLean's evidence that she is well aware of the correct procedure to be adhered to, and that she has subsequently attended and taken on board appropriate training.

[150] I was particularly impressed by the evidence of Officer Goligher. He is an experienced prison officer and as he watched the CCTV footage of the locking-up

process in court he was able to explain clearly what was going and demonstrated a good understanding of the correct procedures which require to be adhered to. He appeared genuinely surprised when it became apparent to him that only Officer McLean had carried the locking up procedure in relation to Mr Gorrie on this occasion.

[151] Unfortunately, but understandably given the passage of time, he could not recall exactly why he had been speaking to another prisoner on this occasion, or why that had taken so long. He readily conceded that he did not push his colleague to carry out a second lock-up process once he became available and volunteered that in hindsight he should have done so.

[152] Whilst it is regrettable that officers at HMP Perth did not adhere to the required locking up procedure on the night prior to Mr Gorrie's death it is apparent from the CCTV footage shown to the court that this was the only occasion throughout the day when two officers were not present when the check was done. I could identify no defects in other numbers checks and lock up procedures on the footage which was shown to the officers in court on a number of occasions, and which I had had the opportunity to view in full in advance of evidence being led.

[153] Both Officers McLean and Goligher have been provided with appropriate training and refresher training and were clearly aware of the correct procedure to be followed. There is no suggestion from the CCTV footage I have viewed that Officer McLean appeared hurried or careless when she carried out locking-up on her own. In fairness, she did more than simply obtain a verbal response from Mr Gorrie. She had

clear sight of him and engaged in a conversation with him. Having done so, she had no concerns regarding his appearance or demeanour.

[154] In those circumstances, whilst this Inquiry has identified that the locking-up procedure was non-compliant on this occasion, I am unable to conclude that an SOP compliant lock-up would have prevented Mr Gorrie's death.

[155] Affidavits lodged by SPS from Andrew Hodge, Governor and Jane Brown, Learning and Development Manager at HMP Perth, detail the current arrangements in place for training in relation to locking-up procedures. Training is delivered to new recruits and to officers transferred to Perth. Both operational and residential staff receive training in this regard, and refresher training is also provided.

[156] Clearly the emphasis upon training has been effective, since both Officers McLean and Goligher were able to advise the court how locking-up procedures should be conducted and to identify for themselves the failings demonstrated from the CCTV footage placed in court.

[157] Accordingly, I am likewise unable to identify any defects in the system of working which may have contributed to Mr Gorrie's death. Further, I am unable to recommend any reasonable precautions which might realistically have prevented his death.

Statutory findings

[158] I have made no findings in respect of section 26(2)(b) of the 2016 Act. I am satisfied that Mr Gorrie's death was not caused by an accident. I was not invited to find otherwise by any of the parties to the inquiry.

[159] There is no evidence to suggest that Mr Gorrie had a desire to take his own life whilst I prison. He occupied a single cell and there is no suggestion of any kind of force being used against him. Mr Gorrie voluntarily ingested illicit drugs.

[160] There is no evidence to suggest that Mr Gorrie intended to kill himself or even to be physically incapacitated by these drugs. It is likely that the drugs ingested by Mr Gorrie impacted upon a subsequent episode of choking and rendered him unable to summon assistance.

[161] I accept the submission made on behalf of POAS that those who take illicit drugs must do so with an implicit acceptance of potentially serious consequences. This is particularly true of Etizolam, which is an unregulated drug and means that the composition of the drug taken is always completely unknown.

[162] I am satisfied that an unintended consequence of deliberate behaviour is distinct from "an accident" and that loosely speaking Mr Gorrie's unfortunate death was caused by misadventure. I accepted Dr Sadler's evidence entirely in this regard.

[163] Having made no finding in respect of section 26(2)(b) I have likewise made no finding in respect of section 26(2)(d) of the 2016 Act.

[164] I have made no findings in respect of section 26(2)(e) of the 2016 Act.

[165] I am satisfied there are no precautions which could reasonably have been taken that might realistically have resulted in Mr Gorrie's death being avoided.

[166] I accepted that submissions made by the Crown and on behalf of SPS that the SPS makes significant efforts to try and prevent illicit substances from entering the prison estate.

[167] I have made no findings in respect of section 26(2)(f) of the 2016 Act. Whilst I have identified a defect in the system of working, insofar as officers McLean and Goligher failed to carry out a lock-up procedure which complied with the relevant Standard Operating Procedure, I am not satisfied on the basis of my above findings that this in any way contributed to Mr Gorrie's death.

[168] In particular, I accepted Officer McLean's evidence regarding her verbal interaction with Mr Gorrie and her evidence regarding his presentation at that time. In those circumstances I am satisfied that this regrettable error in no way contributed to Mr Gorrie's subsequent death or amounts to a relevant factor in relation to his death.

[169] There is no evidence to suggest that a compliant numbers check would have led to a different outcome in the particular circumstances of this death in prison.

[170] Further, it was quite clear from their parole evidence that both officers were well aware of the SOPs in place regarding numbers checks and locking and unlocking procedures and I am satisfied from the affidavits lodged that appropriate training and refresher training is already in place for SPS residential officers.

[171] There were no systemic defects identified in the evidence which contributed to Mr Gorrie's death. The fact that Officer McLean concedes she departed from her

training and the SOP in place does not constitute a systemic defect in practice at HMP Perth and as I have already identified, an appropriate training regime has already been put in place and is ongoing.

[172] I have made no findings in respect of section 26(2)(g) of the 2016 Act. In my view there are no other facts which are relevant to the circumstances of Mr Gorrie's death.

[173] Mr Gorrie's role as a pass man on the hall was raised in the DIPLAR (Crown Production number 7) as a factor to be considered at the inquiry, but there was nothing in the evidence before me to suggest that was a relevant factor in relation to his death.

[174] I was satisfied that it was appropriate for me to make findings only in relation to the cause of death and place of death in this case.

[175] In light of the above I make no recommendations.

Conclusion

[176] All that remains is for me to express my sincere condolences to Mr Gorrie's family.