SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE IN PERTH

[2020] FAI 8

B209/19

DETERMINATION

BY

SHERIFF GILLIAN A WADE QC

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

into the death of

MARK ALLAN
Born 4 July 1971
Latterly a prisoner at HMP Perth, 3 Edinburgh Road Perth

Act; Whyte, PF Depute
Fairlie; Tayside Health Board
Fairweather; Scottish Prison Service
Wallace; Prison Officers Association

Perth, 6 February 2020

The Sheriff, having considered all the evidence adduced,

Determines

1. In terms of section 26(2)(a) of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016, that Mark Allan, born 4 July 1971 died at some point during the night of 18 July into the morning of 19 July 2018 and life was pronounced extinct on 19 July 2018 at 0931 hours at her Majesty's Prison Perth, Edinburgh Road, Perth after his body had been discovered.
2. In terms of section 26(2)(b) of the said Act, makes no finding.

3. In terms of Section 26(2)(c) of the said Act, that the cause of his death was:

   I (a) a combined adverse effect of Buprenorphine and Chlordiazepoxide.

4. In terms of section 26(2)(e), that there were no precautions which could reasonably have been taken to prevent the death.

5. Makes no findings in terms of sections 26(2) (d), (f) and (g).

NOTE

[1] The fatal accident inquiry into the death of Mark Allan was initially held on 19 September 2019. The Crown was represented by Mrs Whyte, Procurator Fiscal Depute, Dundee. At that time Ms Stronach, solicitor, appeared to represent Tayside Health Board. Mr Shand, solicitor, appeared to represent the Scottish Prison Service. Ms Wallace, solicitor appeared to represent the interests of the Prison Officers' Association Scotland.

[2] A preliminary hearing had taken place on 20 August 2019 at 2 pm.

[3] Under reference to a draft joint minute of agreement I was advised that a number of matters had been agreed and a joint minute would be provided in due course. The Crown indicated that due to the extent of the matters agreed there would be no requirement to hear any oral testimony and that at the conclusion of the proceedings all parties would be inviting me to make formal findings only.

[4] I reminded the parties of the observations of Sheriff Foulis in a recent fatal accident inquiry which is reported under reference *[2018] FAI 40.* In that case there were no contentious matters and parties also sought to proceed by way of joint minute in terms of section 18 of the Act under reference to the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. In that case the learned sheriff observed that:

> "It should not, however, be lost sight of that the role of the sheriff at an inquiry is different from that played in adversarial proceedings. This is made clear by reference to the provisions of section 20(2) of the 2016 Act. It accordingly appeared to me that the parties entering a joint minute and intimating to me that this dealt with the matters which were to be the subject matter of the inquiry did not constrain me from seeking certain information to ensure that there were not

> matters upon which I should consider evidence in an appropriate form to be presented to me."

[5] In that case the learned Sheriff ordered the Crown to lodge a list of witnesses and a synopsis of the matters to which they spoke in order that he could determine whether there were indeed any matters upon which he required further information.

[6] In this case I was advised at the preliminary hearing that on 9 July 2018 the deceased was sentenced to 4 years and six months imprisonment at Dundee Sheriff Court; the sentence was imposed in relation to an assault to severe injury and permanent disfigurement. After sentencing the deceased was transported to HMP Perth, where he occupied Cell 13 in C Hall.

[7] On 19 July 2018 at 9 am the deceased was found to be unresponsive within his bunk bed in his cell in C Hall. On examination no signs of life were detected and life was pronounced extinct by the prison health care doctor on 19 July 2018 at 09:31 hours.

[8] The procurator fiscal advised that it was anticipated that the Inquiry would consider and examine the search procedures then in place within the prison and, although no obvious failings or issues had been identified, there was a requirement to fully consider the cause or causes of the circumstances resulting in the death of the deceased, any of the reasonable precautions which might realistically have prevented his death and any defects in the system of working which may have contributed to the deceased's death.

[9] This was the stated issue for the Inquiry in terms of Form 3.1.

[10] The application had been intimated on the Scottish Prison Service, The Prison Officers Association Scotland, NHS Tayside, and the deceased's sister and brother Victoria and Garry Laing.

[11] I indicated at the preliminary hearing that as matters stood I was not content with the terms of the joint minute and that I required evidence of the protocols and procedures which were in place at the time of the deceased's death in relation to the prevention of the introduction of drugs into the prison estate and also the measures which ought to have been taken to search prisoners and their cells for banned substances and items.

[12] I would have thought that standing the Crown's assessment of the issues and the discussion which took place at the preliminary hearing it would have been obvious that it would not simply be enough to lodge the policies and protocols and agree their provenance and content in a joint minute.

[13] What this Inquiry requires to examine is whether the policies, which were not in fact being criticised, were properly followed and applied in this particular case.

[14] Unfortunately when the case next called a final joint minute had been produced, which included 26 paragraphs, but which did not address this issue at all. Members of the deceased's family were present in court and understandably would be expecting examination of the evidence pertaining to the circumstances of their relative's death rather than a bland assertion that he died of a drugs overdose but that certain documents which they had neither seen nor heard of contained procedures which ought to have been followed.

[15] I afforded the parties an adjournment to ascertain whether any additional documents or information could be obtained quickly to address this gap in the evidence but it appeared that this could not be provided in such a short time scale.

[16] Accordingly I required to continue the proceedings until the 17 December 2019 in order for further enquiry to be made and for affidavits to be produced with supporting documents to satisfy me that the procedures had been adhered to in this case.

[17] In October 2019 I was provided with an affidavit by RR and dated 27 September 2019. This is in short compass. It simply explains in a little more detail, between paragraphs 5 and 10, what ought to have happened to the deceased when he was received at the prison and what the purpose of the operational policies and procedures, referred to as "SOPs", were.

[18] I had made it quite clear at the FAI that the Inquiry was not satisfied in relation to the evidence which it was being invited to accept at that time and why. The existing Joint Minute refers to the SPS policies (SOPS) which were in place at the time of the deceased's death. There does not appear to be any issue with the policies which were in force at the time, their suitability, appropriateness or whether they are robust enough to deal with the problem of drugs being introduced into the prison estate. To be frank I am not sure that the Crown has even sought to explore this issue.

[19] What concerns me is that even if the policies were fit for purpose the Inquiry requires to be satisfied that the policies were followed in relation to the deceased,

Mark Allan. It does not matter how fit for purpose the system of checks is if it is not applied rigorously.

[20] The additional affidavit at point 4 seems to say that the witness cannot confirm that the SOPs were applied in respect of the deceased as "only the member of staff carrying out the task could say it was complied with."

[21] I would have thought that this would immediately have triggered the obvious further enquiry with the said member of staff who was supposed to have carried out the task. If that member of staff cannot be identified then the Inquiry may well require to explore issues regarding how compliance with the SOPs can be monitored and should be monitored going forward.

[22] It was clear to me, as it was at the previous hearing, that in this case parties conducting the Inquiry have not properly applied their minds to the evidence which will be required to address the issues which had been identified in the original "Notice of an Inquiry" or Form 3.1, and were treating the proceedings as something of a formality. This is not a practice which can be allowed to develop and parties are reminded of their duties both to the Court and in terms of the Act to ensure that adequate evidence is furnished to support any findings which the Inquiry might ultimately be asked to make.

[23] I had expected and indeed requested that the Inquiry be furnished with considerably more detail and affidavits which were appropriately cross referenced to the documentary productions. What was produced did not meet these requirements. At the hearing I checked and double checked that parties understood a) the reason for the further evidence being required b) what should and should not be included in a joint

minute c) that the Inquiry would require to be satisfied that everything that could have been done to avoid the death of the deceased was in fact done. It is no good simply to produce documents to the Court and ask the Sheriff to make of them what he or she will. If I am to be invited to find that there were no failings or issues which may have caused or contributed to the deceased's death and that there are no reasonable precautions which might realistically have prevented his death and there are no systemic defects which have been identified or require to be addressed then I require this to be properly evidenced. I therefore issued a note to parties making clear that I expected these matters to be addressed before the case next called. I also requested sight of any draft joint minute which parties propose to rely on in advance of the hearing and indicated that those acting for the Scottish Prison Service required to undertake more thorough investigation into how the SOPs were implemented in this case. I made clear that should it transpire that this cannot be evidenced the Inquiry should be told how the Prison Service intends to address this in future.

[24] When the case called again on 3 February 2020 the court was furnished with considerably more detail and affidavits which were appropriately cross referenced to the documentary productions. In particular the affidavits of A J, the current Head of the Intelligence Management Unit (IMU) which provides support to Governors and Management Teams in Prisons at an operational level, and Prison Officer D A contained helpful and pertinent information relevant to the Inquiry. I had an opportunity to consider these affidavits in detail in advance of the continued hearing.

[25] Following production of these affidavits the Prison Officers' Association also obtained and lodged additional evidence by way of affidavits from Prison Officers S D and H F. I was advised that these had been considered necessary because the SPS had now lodged the "Death in Prison Learning Audit and Review" (DIPLAR), dated 20 August 2018. In this report, Prison Officer H F comments on "feelings of guilt" about whether her colleagues may have been spared distress had she adopted a different course of action (pages 21 and 22 of the DIPLAR). Prison Officer S D comments on feeling guilty and upset at not getting a verbal response from the deceased when she conducted the numbers check (page 22 of the DIPLAR).

[26] The affidavits provided by Prison Officers H F and S D provide background and further explanation in relation to the comments made by them during the DIPLAR.

[27] At the continued hearing the Crown did not lead any witnesses. The hearing proceeded by way of a minute of agreement as had been anticipated, although this had been amplified and expanded in light of the additional evidence available. The Procurator Fiscal also read out the affidavit of DC E B which related to the police investigation into the alleged supply of controlled drugs to the deceased.

[28] The Scottish Prison Service lodged in process the affidavits referred to above and relied upon those in their submissions.

[29] I also had the benefit of the affidavit of SF, the charge nurse at HMP Perth, and of course the affidavits of the Prison Officers referred to above.

[30] Prior to the hearing I had considered the list of witnesses and the relevant witness statements. The Crown had also lodged the following productions.

1) Intimation from Registrar

2) Post Mortem Examination Report

3) Toxicology Report

4) Death in custody folder

5) Book of photographs

6) Medical records.

[31] I had also had sight of the protocols and standard operating procedures referred to in the joint minute and produced by the Scottish Prison Service.

The evidence

[32] Mark Allan ("the deceased") was born 4 July 1971.

[33] The deceased's date of death is 19 July 2018. At the time of his death he was an inmate at HMP Perth, Edinburgh Road, Perth where he shared cell number 13, Level 4, C Hall with one other male prisoner (J L).

[34] On 9 July 2018 the deceased was sentenced to 4 years 6 months imprisonment at Dundee Sheriff. Crown Production number 4 page 56 is a copy of the Warrant relating to said sentence. His earliest date of liberation was calculated as 8 July 2022.

[35] On admission to HMP Perth on 9 July 2018 at 1905 hours the deceased was assessed by reception and healthcare staff and asked a number of welfare questions which indicated that the deceased was not at risk of suicide or self-harm. Crown Production number 4 pages 71 to 73 is the "Talk to Me" prevention of suicide in Prison Strategy paperwork which has been in place since 5 December 2016. The content of the

document was agreed. The affidavit of S F was also referred to and agreed to be a true account of the healthcare assessment carried out as part of the admission to Perth Prison procedures.

[36] D G is a prison officer at HMP Perth. He first met the deceased on 16 July 2018 and did not consider him to be under the influence of any substances and described him as "a nice quiet lad".

[37] On 18 July 2018 the deceased and another prisoner, A H, were given permission to visit the library to collect audio books and were subsequently outwith C Hall between 1500 hours and 1530 hours. Dinner/Tea time was between 1630 and 1700 hours that day and checking prisoner numbers and lock up for the night occurred at 2030 hours after which all prisoners were secured for the evening.

[38] J L had provided a witness statement. He began sharing a cell with the deceased around 2130 hours on 9 July 2018.

[39] The Joint Minute records that over the next 10 days he witnessed the deceased sniffing white powder regularly and the deceased stated that he had a drug debt. J L did not disclose this information to members of SPS staff until after the deceased's death. It is also recorded in the Joint Minute as a matter of agreement that the deceased "kept his drugs on a window ledge outside the cell." On 17 July 2018 the deceased was seen using a razor blade to cut up the powder before snorting it. The razor blade was kept on the window ledge outside the deceased's cell.

[40] On 18 July 2018 the deceased told Mr L that he was missing his girlfriend and had a visit booked for Saturday. Later that day Mr L returned to the cell after exercising

and found the deceased within their cell with M A (a prisoner) and his cellmate (A H) who left shortly afterwards. The deceased's and Mr L's cell was locked at 2030 hours on 18 July 2018 and they began watching a movie at around 2045 hours. The deceased was seen by J L to snort white powder before getting into his bed. At approximately 2145 the deceased began snoring loudly. On 19 July 2018 witness L woke up and left the cell to get breakfast, he did not check on the deceased as he believed that he had already left the cell to shower.

[41] M A is a prisoner within HMP Perth and had known the deceased for around 40 years as they came from the same area. He described the deceased as "a nice quiet guy who never got into trouble". He confirmed that the deceased liked a drink but had never seen him take drugs. The deceased returned a borrowed book to Mr A on 18 July 2018 just before lock up time, at that time he did not appear to be under the influence of any substance. At around 0800 hours on 19 July 2018 Mr L (the deceased's cellmate) and Mr A joked about the deceased's loud snoring during the night which had prevented him from sleeping.

[42] Around 0900 hours Ms M (a prison officer) asked Mr A to accompany her into the deceased's cell to wake him for his medication. On entering the deceased's cell Mr A found the deceased within his bed. He noticed the deceased's legs were "a funny blue and his whole body was a funny colour". Mr A felt for a pulse on the deceased's neck but could not find one and asked Ms M to get assistance.

[43] C M is a Prison Officer at HMP Perth, on 19 July 2018. At around 0900 hours, two nurses were engaged distributing medication within C Hall. The deceased was

scheduled to receive medication and Ms M shouted for him a number of times. Believing the deceased to be sleeping Ms M' s witness statement also records that she entered the deceased's cell with M A, to wake Mr Allan for his medication. On entering Mr Allan's cell M A approached the deceased and stated that he thought "he was away." Ms M attempted to shake the deceased but found his skin to have a blue tinge and be cold to the touch. Ms M then shouted for assistance from the nurses (S B and E M) who were still close by distributing medication to other prisoners.

[44] S F is a Prison Officer at HMP Perth. On 19 July 2018 between 0700 and 0900 hours, he was directing prisoners to the nursing station to get their prescribed medication. He heard C M shout for assistance and entered the deceased's cell where he touched the deceased's calf and found him to be cold and clammy and immediately called "Code Blue" over the radio. Nursing staff arrived very quickly as they were nearby issuing medication within the hall.

[45] E M and S B are Nurses at HMP Perth. On 19 July 2018 at 0858 hours said witnesses were within C Hall, Level 4 dispensing medication when they responded to the "Code Blue" call and arrived immediately at the deceased's cell. They found the deceased to have signs of *rigor mortis* and observed that he had no colour to his skin.

[46] Dr Martindale is a General Practitioner who provides medical cover at HMP Perth, Edinburgh Road, Perth. On 19 July 2018 hours at 0925 hours she examined the deceased and found him to be lying prone, having vomited, *rigor mortis* and post mortem lividity were present and life was pronounced extinct at 0931 hours.

[47] On checking the deceased's medical records on 10 July 2018 Dr Martindale confirmed he had been prescribed a 9 day course of chlordiazepoxide on a reducing dose from 30mg twice a day to 10mg twice a day which completed on the evening of 18 July 2018. Chlordiazepoxide is a benzodiazepine used to treat alcohol withdrawal in those with a dependence on alcohol. The deceased was also prescribed 5 mg of aripirazole daily which is an antipsychotic medication, and 20 mg citalopram daily which is an antidepressant, thiamine three times daily which is used to prevent nerve problems related to alcohol abuse and omeprazole for acid reflux.

[48] On 19 July 2018 at around 1410 hours Cell 13, Level 4, C Hall was searched by officers of the Police Service of Scotland. Nothing of note was found within said cell but a rusty and dirty razor blade, an empty food bag, lighter and a straw were seen on the external window sill. These items were not seized as the window only opened about 1 to 2 inches meaning that the searching officers were unable to recover these items. During the search a single blue pill was recovered from under the fixed shelving unit (no further examination was carried out in respect of this pill).

[49] The deceased's prescribed medication was also seized and found to be Omeprazole, Citalopram and thiamine tablets.

[50] A H was a prisoner at HMP Perth who arrived at HMP Perth on 12 July 2018 and was allocated a cell in C Hall on 12 July 2018 which he shared with M A. On 18 July 2018 Mr H was within the deceased's cell with M A just after tea time when the deceased showed them both some white powder and stated that he had already snorted some the previous evening and he believed the powder to be speed and base which he had

obtained from "a Dundee boy called W" who he had been introduced to by M A. The deceased stated that he intended to take more of the white powder that night. On 19 July 2018 Mr H passed the deceased's cell on his way to the showers; at that time he believed that the deceased was asleep in his bunk. After his shower he became aware of activity in the deceased's cell. Mr H told police that the deceased told him that he had taken Subutex. Mr H provided all this information to Police on 26 July 2018 by which time he was accommodated in another Prison.

[51] Crown Production number 1 is the Intimation of Death from the Registrar. Said production confirms that the deceased died at 3 Edinburgh Road, Perth on 19 July 2018 at 0931 hours. The content of the certificate is agreed to be true and accurate.

[52] Crown Production number 2 is a report containing the findings of a Post Mortem Examination of the deceased which was carried out on 25 July 2018 by Dr Tamara McNamee and Dr D William Sadler. The deceased's cause of death was established as "Combined Adverse effects of Buprenorphine and Chlordiazepoxide. On page 4 of 5 of the report the authors state "Although the concentration of chlordiazepoxide is below the expected fatal levels, it is recognised that taking sedative drugs together, in this instance, buprenorphine and chlordiazepoxide can have an additive or "cocktail effect" which may exceed the effects of each drug when taken individually and these enhanced effects may result in a fatal combination. These drugs share common potentially fatal side effects which include sedation, respiratory depression and coma via depression of the central nervous system. The combination of these drugs and their side effects have

resulted in death in this instance". The content of the report was agreed to be true and accurate.

[53] Crown Production number 3 is a toxicology report containing the findings of analysis of samples of the deceased's blood, urine and vitreous humour which were taken during said post mortem examination. The findings are considered and interpreted by Drs McNamee and Sadler in their report (Crown Production number 2.) The content of said report is agreed to be true and accurate.

[54] Crown Production number 4 is the Death in Custody Folder prepared by Scottish Prison Service. The content of said records is agreed to be true and accurate.

[55] Rachel Aiken is a Scene Examiner with the Scottish Police Authority. At 1342 hours on 19 July 2018 she took a number of photographs of C Hall, Level 4, Cell 13, HMP Perth which are contained within Crown Production number 5.

[56] The photographs therein are more particularly described as follows:-

`1-16' show general views of cell.

`17-19' show general views of window.

'20-22' show views of blade on left hand side of external window sill

`23-25' show views of items on right hand side of external window sill

`26-48' show views of the deceased.

[57] Crown Production number 6 is the healthcare records of NHS Tayside pertaining to the deceased.

[58] The SPS have procedures for detecting and preventing drugs and other prohibited articles from entering and circulating within HMP Perth. SPS Production 1 is the Standard Operating Procedure document which details Admission Procedures.

[59] The SPS carries out targeted and routine searches of visitors to HMP Perth. SPS Production 2 is the Standard Operating Procedure document which details Visits Procedures.

[60] The SPS carries out targeted and routine searches of incoming and outgoing mail. SPS Production 3 is the Standard Operating Procedure document which details how suspicious mail is dealt with.

[61] The SPS carries out targeted and routine searches of prisoners. SPS Production 4 is the Standard Operating Procedure document which details Searching Prisoners.

[62] The SPS carry out routine drug tests of those prisoners within custody at HMP Perth. SPS Production 6 is the Standard Operating Procedure for Compulsory Drug Testing Procedures.

[63] The SPS carry out routine searches of prisoners' cells. SPS Production 8 is the Standard Operating Procedure for routine cell searches.

[64] Production 9 of the Scottish Prison Service's Inventory of Productions is the Death in Prison Learning Audit and Review (DIPLAR), completed by SPS and NHS Tayside on 20 August 2018. This was referred to in more detail in the oral submissions made on behalf of SPS.

[65] Production 10 of the Scottish Prison Service's Inventory of Productions is a record of the occasions on which Cell C4/13 at HMP Perth was searched by SPS in the

year 2018. Production 11 of the Scottish Prison Service's Inventory of Productions is a record of the occasions on which Cell C4/13 at HMP Perth was searched by SPS in the years 2017 and 2018.

[66] Production 12 of the Scottish Prison Service's Inventory of Productions is an intelligence record dated 31 July 2018, held by the SPS in respect of prisoner P W.

[67] Production 13 of the Scottish Prison Service's Inventory of Productions is an SPS Tasking Form dated 31 July 2018, which records the outcome of a search of prisoner P W's cell on 3 August 2018.

[68] Production 16 of the Scottish Prison Service's Second Inventory of Productions is an affidavit by A Johnson; SPS Intelligence Management Unit Manager at HMP Perth dated 13 January 2020. Production 17 of the Scottish Prison Service's Second Inventory of Productions is an affidavit by D A, SPS First Line Manager at HMP Perth, dated 13 January 2020.

[69] All of the documents lodged on behalf of SPS were agreed to be true and accurate in their content.

[70] In addition to the evidence produced in the Joint Minute the Crown made reference to the affidavit of DC E B. This was specifically related to police investigations following the death of the deceased. On the 30 October 2019 the procurator fiscal had contacted the police asking for further information arising from the content of A H's statement. In that statement he had noted that on the evening before his death the deceased had told him that he had sourced drugs from a person identified as "W". Further investigation disclosed that this was a man called P W. It is clear from the crime

sheet relating to the deceased's death that intelligence suggested he may have been the source of the non-prescription drugs which the deceased had ingested. This intelligence was only made available after the deceased's death.

[71] The Intelligence Management Unit at Perth prison further informed the police that Mr W was serving a sentence of four years and nine months for assault to injury and robbery and that his earliest release date was 8 June 2021. Between the date of provision of this affidavit and the date of the continued hearing it was ascertained that Mr W had been arrested on suspicion of being concerned in the supply of drugs to the deceased. He was cautioned at that time and made no reply. He was conveyed to Perth police station and was interviewed following a private consultation with his solicitor. He provided a predominantly no comment interview but denied having any physical or mental health issues and advised that due to previous drug abuse he was prescribed a drug known as "Espranor" which, he claimed, was like Subutex. He indicated that this was intended to dissolve straight away on a person's tongue when it was administered to them. Mr W initially said he had been prescribed this for about 2 ½ years but then changed his mind and became confused regarding the length of time over which this had been prescribed.

[72] It was put to him that he had been seen in the company of Mark Allan on CCTV at 0813 hours on 18 July 2018 outside the deceased's cell. He denied being associated with him beyond exchanging pleasantries. Of importance Mr W made clear that he had not been prescribed Subutex and that Subutex and Espranor differed. He was thereafter released without charge.

[73] The information management unit was updated regarding the outcome of this interview and M B from that unit advised that Espranor was indeed used instead of Subutex but enquiries were ongoing as to when the change was made.

[74] As I understand matters at present it seems unlikely that there will be criminal proceedings against anyone based on the quality and sufficiency of the evidence currently available but it is clear that on the balance of probabilities the deceased appears to have sourced the buprenorphine which was found in his system from within the prison itself.

[75] On behalf of the SPS evidence was then provided by way of affidavits provided by officers A J and D A.

[76] A J is currently the manager of the intelligence management unit and is responsible for the collection, analysis and dissemination of prison related intelligence. He confirmed that Hall staff within the prison carry out cell searches which can be either routine or intelligence based. Records disclosed that the cell in which the deceased was accommodated was searched on 5 July 2018, 40 days prior to Mr Allan coming into custody. No prohibited articles were founded during that search. It was searched again on 11 October 2018 which of course is some time after the deceased's death and nothing of note was found. The cell was not searched during the deceased's short time in custody.

[77] The officer also indicated that searches are routinely carried out if intelligence demands it. There is no record of any such search having taken place in the days prior to the deceased's death.

[78] A rub down search occurs on a daily basis. It involves patting down a prisoner's arms, chest, back, torso and legs. The prisoner's pockets are also emptied. Such searches take place each time a prisoner leaves his hall to go to the gym or to a work party. He is also subjected to such a search when he returns to his hall. This is routine and no records are kept of such searches.

[79] Prisoners are strip-searched when they are admitted to prison. They have their clothes taken from them at that time and are offered an opportunity to shower. They are then issued with prison clothing. Again because this is part of the admission process no specific record would be kept but the deceased would have gone through this process on 9 July 2018.

[80] Visitors are also searched when they come into the prison in a process similar to that which takes place in an airport. There was information that the only visit which the deceased had was with his lawyer on 16 July 2018. Prison officers would not routinely strip search a prisoner after a visit from his solicitor as they treat lawyers as trustworthy and professional.

[81] Prisoners are tested for drugs while in custody. This might be part of a risk assessment or due to the suspicion of drugs use. The decision to test is made by the manager of the hall. There is no record of any specific concerns in relation to Mr Allan during his period in custody. There was no suspicion that he was involved in the use of drugs and over his previous periods in custody throughout his life he has been tested in excess of 40 times all of which have produced a negative result.

[82] Evidence was also provided regarding the way in which mail received into the prison is checked for anything suspicious. However there was no record of any incoming mail for the deceased during his period in custody.

[83] A J also provided evidence about intelligence received after the deceased's death regarding the source of the drugs. On the basis of this evidence arrangements were made to search P W's cell. This took place on 3 August 2018 but no illegal drugs were found. NHS staff did notice that he had fewer prescription drugs in his possession then he should have had and they carried out checks into his medication. It should be noted that the intelligence provided was uncorroborated and from an untested source.

[84] The evidence of D A was also of assistance. He held the position of first line manager in C Hall. He is in charge of 56 members of staff and around 377 prisoners. His recollection of the deceased's death was limited and his evidence related to the procedure for searching cells. He confirmed that there was no longer a team dedicated to drug testing but that tests were still carried out at random intervals.

[85] He was unable to assist with information as to how the deceased obtained the drugs which led to his death but confirmed that the various searching procedures in place were aimed at preventing drugs entering the prison. He stated that

> "prisoners have 24 hours a day to think up new ways to get round that these procedures, such as concealing drugs inside their bodies. They can also soak mail in drugs which might not always be detected. It's impossible to catch every drug that a prisoner might try to introduce into the prison. As soon as we close a door on a route for drugs to enter the prison, we find out later that another door has opened."

[86] Finally Mr Fairweather submitted that regard should be had to the death in prison learning, audit and review or (DIPLAR) report. It is clear from this report that a comprehensive review was carried out after Mr Allan's death. Previous reports from his times in custody in the past have indicated that he was a compliant prisoner and presented no difficulties while in the custodial setting. Any concerns about self-harm or suicidal ideation date back 12 years or more. There is no indication of a history of drug misuse although there were concerns regarding alcohol abuse for which the deceased was medicated on his admission. Of significance it is noted that the drug screen on admission was negative.

[87] The report indicates the effect which the deceased's death had on members of staff and at paragraph 10 it is noted that the post-mortem toxicology report indicates that the deceased had buprenorphine in his system which is a medication "only administered within the prison setting supervised by nursing staff".

[88] The second part of the report is a learning plan. Not unsurprisingly it identifies that staff unfamiliar with the residential function are to be fully supported and informed of policy and procedure relevant to the role. This is a direct reference to the concerns regarding obtaining a verbal response on the numbers check.

[89] There are various action points identified at point 4 but those were not specifically relevant to this Inquiry.

[90] In conclusion on the evidence available it was submitted that the deceased was receiving care during his time in custody. What emerges is a biography of a man who

was struggling with mental health and alcohol issues and the drugs aspect of his life was not known to anybody until after his death.

[91] Finally reference was made to the Standard Operating Procedures simply because they give the detail of the references in the affidavits.

[92] So far as the Health Service was concerned the evidence led came from the affidavit of S F, the charge nurse at HMP Perth.

[93] She was a Charge Nurse in the Primary Healthcare Team. Part of her role involved carrying out healthcare admission assessments. She would attend the prison reception and review people arriving into custody from the courts or other establishments. At the reception, once people are searched, they are put in a waiting area and then she would collect them for their healthcare assessment. She would check the Personal Escort Record and also check and complete the Talk To Me paperwork. Talk To Me is the prison suicide risk management policy. During the healthcare admission assessment, she would go through the patient's personal healthcare record. This involves asking the person about their physical and mental health, allergies and prescribed medications. She would then record their responses on the NHS computer system.

[94] She did not have any particular recollection of Mr Allan, the deceased. The only memory she did have was when he mentioned mental health challenges. On review of the records she recalled that she made the entries in Mr Allan's medical records on 9 July 2018 when he was admitted to HMP Perth.

[95] Significantly as part of the healthcare assessment, she asked the deceased whether he had taken any drugs. He told her he had and mentioned "base", which she recorded in the medical notes.

[96] In addition the deceased specifically said he had "mental health challenges" and that he had previously attended Carseview. She noted he had made historical attempts at self-harm or suicide but that the last time was 12 years ago. She would not put someone automatically on "Talk To Me" just because they told her they had self-harmed some time ago. She noted that he engaged fully at the interview, had good eye contact and was open and relaxed and that he presented "no apparent risk of self harm".

[97] She also noted his alcohol dependence syndrome, because there is detox medication available for that. She noted the medication which he was prescribed in the community and of importance carried out a urine test. She stated that,

> "all nurses in reception should always ask for a urine test on admission for all new prisoners. We do a drug urine test to see if there are any drugs in their system. With urine testing we need to get a sample before they go to the prison halls, in order to get a clear sample of what they have been using. The sample when they have just arrived in prison shows what drugs they had taken in the community."

[98] The deceased's urine test was negative for drugs. The drug test strip is dipped in the urine sample. The strip has five sections on it, each testing for a different kind of drug. The drugs tested for are: opiates, benzodiazepines, methadone, cocaine and buprenorphine. The deceased mentioned he had taken drugs in the past but that might not show up depending when he took the drugs.

[99] It is known from toxicology reports that although the deceased mentioned "base" there was no such drug in his system at the time of his death.

[100] The Management of Offender Risk Substance (MORS) policy was discussed. If a nurse, or other member of staff, suspects a prisoner is under the influence of a substance because of their presentation such as slurred speech, poor coordination or sleepy behaviour, then the prisoner would be placed on MORS. There was no such suspicion with the deceased.

[101] Following an adjournment in the course of the hearing additional information was provided in relation to the administration of buprenorphine as it was becoming clear that the most likely source of the fatal ingredient in the cocktail of drugs ingested by the deceased was internal rather than external to the prison.

[102] In particular Nurse F stated "If a patient is prescribed buprenorphine within HMP Perth it is prescribed in the form Espranor Oral lyophilisate which is a wafer tablet, white in colour. It is prescribed to be taken supervised by nursing staff. The patient drinks water and the wafer is placed on the patient's tongue to dissolve. The treatment agreement signed by the patient allows the nurse to ask to look into the patient's mouth to ensure that the wafer has dissolved. However this form of the medication was not in use in HMP Perth in July 2018.

[103] Subutex is another form of the drug, buprenorphine, which is also white and is prescribed and taken under the patient's tongue under the same agreement as above. This form of the medication was in use in HMP Perth in July 2018. Whilst every precaution is taken to prevent diversion of these medications it was acknowledged that

both prison and nursing staff were aware that this can happen. When taken illicitly patients or prisoners can take the drug in a different manner eg snorting. There is also the possibility of drugs, including prescription medicines, being introduced into the prison through other avenues."

[104] Finally I heard evidence from the Scottish Prison Officers' Association. As a result of requests for further information I was provided with additional affidavits from SPS staff. Prison Officer S D, who was and is currently employed as an Operations Officer at HMP Perth, explained that at the time of the deceased's death her responsibility was to ensure the safety and security of the prison and prisoners. Her role involves carrying out duties outwith the Residential Halls, including escorting prisoners to and from different locations within the prison, including the health centre, and carrying out patrols of the establishment. She also dealt with visitors coming in and out of the prison. It is part of her responsibility to search visitors and then to be present during visits between prisoners and their visitors. She confirmed that she would also be on the look out for anything suspicious or out of place.

[105] As an Operations Officer she is sometimes called upon to cover for Residential Officers if the prison is short staffed. This can be if someone is on annual leave, or has phoned in sick. Residential Officers are Band D Officers, whereas Operations Officers are Band C Officers. This means that Residential Officers are on a higher pay scale than Operations Officers.

[106] She explained that Residential Officers are based on the residential halls and have much more one to one time with the prisoners than Operations Officers. She

explained that the role of the Residential Officers required them to carry out a number of day to day tasks which were not part of the remit of the Operations Officers. This included cell searches, cell clearances, cell risk assessments, locking up and unlocking of the cells and checking prisoner numbers.

[107] On the morning that Mark Allan was found to be deceased, she had been asked to cover for a Residential Officer on C Hall, as the prison was short staffed. She had never been on an early shift before and had never been required to carry out a numbers check.

[108] It seems that there was no formal training provided to Operational Officers "acting up" as Residential Officers but as she would be assigned specific tasks by more experienced officers who would remain on the Hall she did not consider this to be problematic.

[109] On the morning of 19 July 2018, she went in to the prison about 06.45 hours to start her shift and described carrying out duties with Officer F who was already on the Hall, unloading the prisoners' milk on to the trolley. The first task of the morning was to complete a numbers check of the hall. She and Officer F began to carry out the numbers check. Officer F went to the North Side of the hall to begin the numbers check, and she went to the South Side. Prior to this, no one had ever told her exactly what was required when carrying out a numbers check. She knew that there were boards which showed how many prisoners should be in each cell and knew that she required to visually check that the number of prisoners in each cell was correct but she did not know that she required to get a verbal response from each of the prisoners, as this had

not been explained to her. She therefore did not seek a verbal response from the prisoners when she was carrying out the check.

[110] Although she did not specifically remember going into the deceased's cell she did not notice anything untoward that morning. She was aware of the code blue and code red procedures at the time this happened, and would have been confident that she knew what to do if she had identified anything out of place.

[111] Once the numbers check for the hall had been completed she was relocated to another area of the prison to work for the morning. She was not made aware that Mr Allan had been found deceased until later that morning.

[112] After the deceased had been found there was a DIPLAR [Death in Prison Learning, Audit and Review] in which she took part. The SPS lodged that document in January 2020 and in response to its content the Prison Officers' Association felt it appropriate to provide further evidence. During the course of the DIPLAR, Ms D commented that she felt guilty for not trying to get a verbal response from the deceased when she carried out the numbers check that morning. During the DIPLAR there was extensive discussion about the circumstances of the deceased's death and Ms D remembered a comment having been made that it appeared that the deceased had died long before he was found, as *rigor mortis* had set in. She commented, "So whether he had been found at 7am or later would have made no difference in terms of his survival."

[113] This is correct and while it is understandable that Prison Officer D is reflecting on her actions particularly in not seeking a verbal response, it would have made no difference to the eventual outcome and did not cause or contribute to the cause of death.

[114] Prison Officer D also expressed regret that her colleague "C" found Mr Allan. She appreciated that this was difficult and felt that if she had sought a verbal response she would have spared C the ordeal of having to deal with the incident.

[115] I also had evidence by way of affidavit from H F who is now employed as a Residential Officer at HMPYOI Polmont. She was also employed as an Operations Officer at the time of the deceased's death. However she was acting up as a Residential Officer in order to gain experience while being mentored by other Residential officers.

[116] She knew the deceased as he was on her landing and had some interaction with him. She said,

> "he seemed like a genuinely nice person. He kept himself to himself and wouldn't be shouting or trying to draw attention to himself like some other prisoners. He was never in any bother with any of the prison officers".

[117] Officer F was working on the early shift on 19 July 2018. She arrived at work at about 6.55 am and found that Prison Officer S D was already carrying out the numbers count on the South Side of the hall. She began to carry out the numbers check on the North Side.

[118] She explained that after the numbers count, the morning proceeded as normal. Between 7am and 8am, there were only two Prison Officers working on the flat as a result of which they do not open the cells in the whole hall until other officers are in attendance at about 8.10am.

[119] Her recollection was that at about 9am, nurses were giving out medication to the prisoners. The deceased's name was on the list of prisoners who were due to obtain medication but he did not attend when his name was called. This resulted in another

officer (who we know to be C) going to check on him. She immediately identified that something was wrong and shouted "code blue".

[120] She, along with other Prison Officers who had responded to the Code Blue call, lifted the deceased off his bed as he was on the top bunk. Numerous nursing staff attended the scene and shortly after this, the First Line Manager, AH instructed all non-essential staff to leave the cell which Officer F then did.

[121] In relation to the DIPLAR she said that she "was carrying around guilt from the incident and wondered if differing my actions could have prevented my colleagues from the distress that they went through." In her affidavit she explained that the reason she made these comments was that she usually did the numbers check on the South Side of the hall but that Prison Officer S D was an Operations Officer and was just in to help that day. She was advised by nursing colleagues that it wouldn't have made any difference if she had discovered Mark Allan at 7am during the numbers check, as he had died during the night. It is clear however that the incident has affected her and the other prison staff who discovered the deceased.

Submissions

[122] At the conclusion of the evidence I invited submissions from all parties.

[123] The Crown sought formal findings. The Procurator Fiscal stated that in discussions with a family member present in court it was clear that even the family were unaware of the deceased's substance abuse.

[124] This is of course a mandatory inquiry as the deceased was in legal custody at the time of his death. Under reference to Section 26(2)(a) and (c) I was invited to make formal findings. I was not invited to make any recommendations or suggest any improvements which might prevent other deaths in similar circumstances.

[125] In terms of the prescribed medication there is no suggestion that it was abused. The cause of the death was "the cocktail effect" of taking his prescribed drugs along with buprenorphine.

[126] Touching on the police interview it was submitted that during his interview P W told the police he was prescribed Espranor. It seems that that was given in a different form at the time of Mr Allan's death and was most probably Subutex.

[127] The Crown referred to the additional evidence which had come to light regarding the new form of administering buprenorphine in a wafer thin, faster dissolving formula but conceded that while this might reduce risks of sharing medication it could not eliminate it altogether.

[128] On behalf of the SPS it was submitted that I should make formal findings about the time of death being overnight on the 18th, into the 19th July 2018. This was because the precise time of death was not known. All that was known for certain was that the deceased was found dead and life was pronounced extinct at 09.31 hours. However he had been alive when he went to bed and had been heard snoring loudly during the course of the night. This proposal was not opposed by any of the other parties and seemed to me to reflect the factual position.

[129] I was invited to find on the balance of probabilities that the white substance referred to was buprenorphine and indeed that it was Subutex. While investigation into P W has proved inconclusive and I cannot therefore make a finding into the source of the drugs, it was fair to say that on the balance of probabilities the drug which caused the death was sourced from within the prison. Whatever the source it was submitted that the SPS took reasonable precautions that were aimed at preventing the deceased taking the drug.

[130] Mr Fairweather highlighted 4 precautions which in his submission evidenced that the measures in place were reasonable:

i) The evidence of Officers A and J confirmed that prisoners are routinely searched for prohibited articles and on balance the deceased would have been searched routinely during his period in custody.

ii) Cells are searched around 3 times per year. Although the cell was not searched during his time in custody the deceased was only in prison for 10 days prior to his death so it was not unusual.

iii) Routine drug tests were carried out to identify those who would be misusing drugs in prison. Although no intelligence led tests were carried out during the deceased's time in custody he was tested on admission and there was no intelligence to suggest that he was using drugs. All intelligence we now have come to light after the event. There is of course a balance to be had between the human rights of the prisoner and the need to eliminate illicit drugs from the system.

iv) Prisoners are supervised when taking medication and challenged if there is an attempt to conceal it. It was submitted that this is a reasonable precaution to prevent misuse and circulation of prescription medication.

[131] The alteration of the form of the buprenorphine was referred to. However it was acknowledged that this could only reduce the risks of concealment and onward supply and not eliminate it. It was acknowledged that there may be ways round the systems which have been put in place but that did not detract from the fact that reasonable precautions have already been taken.

[132] Finally it was submitted that on the evidence it could not be said that there was a systemic failure. What happened was that a person deliberately circumvented the system. That risk can be reduced but not eliminated on the evidence of Nurse F and the prison officers.

[133] On behalf of Tayside Health Board I was also invited to make formal findings only. It was submitted that there is no evidence to support the conclusion that there were defects in the system attributable to the Health Service. The deceased's well recorded interactions with medical staff did not suggest that drug use or self-harm were immediate issues. He was prescribed appropriate medication. He was not at risk of an overdose. It would have been extremely difficult for medical staff to predict his death. Nurse F reported no concerns and supervised the administration of drugs to the deceased.

[134] In conclusion it was submitted that the circumstances of the deceased's death had been agreed and the Inquiry should therefore make the formal findings suggested.

[135] Prison Officers' Association adopted the Crown submissions and invited me to make formal findings. Further comment was advanced in relation to Section 26(2)(e) and any precautions which could have avoided the death. It was again submitted that there was nothing in the deceased's presentation which indicated risk.

[136] During the admissions procedure he tested negative for drugs. Intelligence was not received until after he had died that there was any issues with illicit drugs. It was of some comfort that all staff who interacted with the deceased said that he engaged well and was pleasant. There had been no cause for concern. There was no requirement for observations and no reason for a targeted search. Any further precautions would not have been reasonable.

Findings

[137] It is essential in approaching the Inquiry into any death in prison that it is not simply treated as a formality. At the outset the information available to me certainly did not satisfy the evidential tests which I am required to meet in order to make findings.

[138] It is clear that the finding initially proposed in relation to the time of death was inaccurate. We simply do not know when the deceased died. All we know was that he was found dead and declared to be so at 0931 hours. He was alive on the evening of 18 July 2018 and from the condition of his body it can be concluded that he died during the course of the night because *rigor mortis* had set in by the time he was found.

[139] What the prison service and the health service require to do is to take reasonable precautions to prevent deaths in prison. I am satisfied that the Operating Procedures are

fit for purpose and that they were followed in this case. Those working within the prison service are well aware that attempts will be made to circumvent the systems which are put in place and the evidence of the prison officers made clear that as soon as one supply scheme or route was shut down another route emerged. If prisoners are determined to obtain illicit drugs then they will find ever more inventive ways of doing so.

[140] Sadly in this case the mixture of drugs taken by the deceased proved fatal. It is most likely that, on the balance of probabilities, the drug was sourced from within the prison. That is so because buprenorphine is only available in the custodial setting. It is also most likely that the drug was Subutex because that was how buprenorphine was administered at the time of the deceased's death.

[141] While changes have been made and Espranor has replaced Subutex it is acknowledged that that can only minimise rather than eliminate all risk. There will no doubt continue to be a currency in prescription drugs within the custodial setting which the authorities must do their best to manage. The duty is not an absolute one however.

[142] I do not consider that there were any systemic failures in the administration of the prescription drugs at the time of the deceased's death and this sad loss is indeed due to prisoners taking steps to circumvent systems which are put in place for their health and safety.

[143] There was no intelligence or suspicion which would have resulted in the Prison authorities searching the deceased or his cell and nursing staff had made no

observations about the deceased's presentation which would indicate a risk of drug overdose. Even the deceased's family were not aware of his substance misuse.

[144] There was evidence to suggest this was not the first time the deceased had ingested buprenorphine in addition to his prescription medication. Having done so once without incident it is probable that he did not consider that he was putting himself at risk of fatality.

[145] There are some lessons to be learnt in terms of the training to be given to those acting up to roles with which they are not familiar. In particular it has been highlighted that it is important to obtain a verbal response in a numbers check but the failure to do so in this case would have made no difference as the onset of *rigor mortis* indicated death had occurred sometime before he was found.

[146] While I consider it important to have the fullest information available regarding the circumstances surrounding the death of Mr Allan it is clear to me that nothing Prison Officer D did or omitted to do caused or contributed to that outcome. I am satisfied that there are systems in place which are robust and while it should be observed that the procedure for obtaining a verbal response was not followed in this case that has already been identified in the DIPLAR and no doubt the appropriate training measures will be put in place.

[147] In this case that failing did not cause or contribute to the deceased's death.

[148] I was therefore satisfied that it was indeed appropriate for me to make formal findings in relation to the cause of death and the place of death only.

[149] I did not consider that any additional findings or recommendations in terms of the 2016 Act were required.

[150] It remains for me to extend sincere condolences on behalf of all parties and the court to the family of the deceased for their loss and to thank them for their patience in this Inquiry which, for a variety of reasons, has spanned some months.

[151] It is however important that the facts are fully explored in order that the appropriate findings can be made.