SHERIFFDOM OF NORTH STRATHCLYDE AT KILMARNOCK

FATAL ACCIDENT INQUIRY

Under the
Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976
Determination by Sheriff Desmond J Leslie, Esquire,
Sheriff for North Strathclyde
following an Inquiry held at Kilmarnock
into the death of Jason Ritchie

KILMARNOCK: 16 October2009.

The Sheriff, having resumed consideration of the cause, Determines in terms of Section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976.

(a) That Jason Ritchie, born on 25 March 1976 and who ordinarily resided at 2 Goodbushill, Strathaven, died between 28 and 29 October 2006 at an indeterminate time, but before 7.45 am on 29 October, when he was pronounced dead. The place of death is HMP Kilmarnock, Bowhouse, Kilmarnock.

(b) That the cause of death was an overdose of the drug zopiclone, resulting in postural asphyxia.

(c) There were no reasonable precautions whereby his death may have been avoided.

(d) That there was a failure in the system of medication prescription to prisoners within HMP Kilmarnock whereby reviews of the medication prescription

requirements of prisoners were infrequent and subject to self supervision and not subject to a regular monthly programme of review by the prison medical staff.

(e) That there are facts pertinent to the circumstances of his death which are relevant in the wider public interest, namely: a) the provision of training for prison custody staff in awareness and recognition of drug and alcohol intoxication; b) the provision of cautionary notices within the prison as to the dangers of drug and alcohol misuse particularly in combination with each other; and c) the requirement to analyse and monitor the information obtained from cell search drug audits..

The Facts.

(1) Jason Ritchie, born at 23 March 1976, was a prisoner within HMP Kilmarnock (Bowhouse), serving a sentence of five years three months in respect of a conviction for assault to severe injury and permanent disfigurement. His earliest date of release was 8 May 2009. He had previously served a sentence of ten years imprisonment from which he had been released in May 2002. His licence had been recalled in respect of the unexpired portion of that sentence. He had transferred to HMP Kilmarnock (Bowhouse) on 13 September 2005 from Barlinnie Prison in Glasgow.

(2) Jason Ritchie was known to the prison medical team as a drug abuser.

(3) His admission record disclosed that, prior to his sentence, he abused heroin, methadone and cannabis. It was also recorded that he had been prescribed diazepam, temazepam, dihydrocodeine and venlovaxine. Whilst in prison, he requested assistance with detoxification.

(4) Mr Ritchie was seen by a consultant psychiatrist whilst in HMP Kilmarnock (Bowhouse) on 3 January 2006 and on 7 February 2006. He had complained of low moods and was recorded as not coping well with life. It was also noted that he had been abusing heroin within the prison.

(5) Mr Ritchie was housed within Cell 27, within A Wing, House Block One, which is a block reserved for long term prisoners. Cells are for single occupancy. Each cell has an emergency buzzer which can be activated by prisoners for assistance from prison staff during periods when prisoners are locked in their cells.

(6) Mr Ritchie was in receipt of prescribed medications namely, naltrexone at 100 mgs three times weekly, zopiclone 7.5 mgs daily and citalopram 40 mgs daily. Naltrexone is an opiate blocker, zopiclone is a sleep inducer and citalopram is an antidepressant. These drugs were prescribed to Mr Ritchie on a weekly basis and were retained by him to be used as prescribed.

(7) Mr Ritchie attended upon the prison doctor on 18 May, 8 June and 7 July 2006. No review of his prescribed medication was carried out between 7 July 2006 and 29 October 2006.

(8) At 10 pm on 28 October 2006, Mr Ritchie was locked in his cell for the night. A roll call was conducted by prison custody officers who recorded that he was alone in his cell. Neither of the two custody officers recorded that Mr Ritchie demonstrated any behaviours symptomatic of drug misuse.

(9) At 6.45 am on 29 October 2006, Mr Ritchie failed to respond to the morning roll call. His cell was entered by prison custody officers Sandy Ross and Alex McConnachie. Mr Ritchie was found positioned in a chair with his back to the door. His body was flexed, or slumped, forward. One arm lay loose and the other was between his legs. There was vomitous fluid on the floor between his legs and to which his head was facing. He was noted as being rigid and cold. His pupils were dilated and fixed and there was no pulse. No resuscitation procedures were considered appropriate. Life was pronounced extinct at 7.45 am.

(10) A search of Mr Ritchie's person and of his cell subsequent to his removal disclosed (after laboratory analysis) (a) a half tablet, a fragment of tablet and twelve loose tablets of zopiclone, (b) a piece of tablet containing quetiapine (an anti-psychotic drug), (c) five partial blister packs containing one, three, four, two and three tablets respectively, which were found to contain naltrexone, (d) three

sealed plastic bags stapled together, one of which was empty and one containing a blister pack containing six tablets bearing a manufacturers legend "nalorex" which is a branded form of the generic drug naltrexone, (e) a self-sealed plastic bag containing a blister pack of six tablets of ranitidine (a medical preparation for the treatment of ulcers), (f) a plastic bottle containing thirty seven brown tablets and six yellow tablets found to contain the vitamin B1 thiavem, (g) five blister packs containing a total of fourteen pills, seven pills within one blister pack which bore the manufacturers name, citalopram. The seven remaining pills contained within the four remaining blister packs were not identified.

(11) No records were maintained or retained in relation to random cell searches or drug audits carried out by prison staff prior to 29 October 2006.

(12) A post-mortem examination on 31 October 2006 by Dr Margaret Balsitis and Dr Jane Lang attributed death, pending toxicological investigation, to pulmonary oedema. Toxicological examination of a blood sample received from Mr Ritchie provided the following reading:

i. 31 milligrams of alcohol per 100 millilitres of blood;
ii. 0.59 milligrams of zopiclone per 100 millilitres of blood;
iii. 0.08 milligrams of desmethyldiazepam per 100 millilitres of blood;
iv. 0.03 milligrams of naltrexone per 100 millilitres of blood;
v. 0.017 milligrams of morphine per 100 millilitres of blood;
vi. 0.0051 milligrams of total morphine per 100 millilitres of blood.

The findings of morphine and total morphine were consistent with the use of morphine or heroin. Desmethyldiazepam is a metabolite consistent with use of diazepam, chloraxzepate, medozepam, prazepam or chlordiazepoxide. None of these drugs were prescribed to Mr Ritchie. On receipt of the toxicological findings, the cause of death was revised to "drug overdose (zopiclone)". This resulted in respiratory depression, leading to postural asphyxia.

(13) Subsequent to Mr Ritchie's death, the prescription of medication to prisoners was made subject to monthly review of each prisoner. Routine and random cell search procedures were formalised and records kept for audit scrutiny.

Note

This Inquiry related to the tragic death of Jason Ritchie whilst a prisoner in HMP Kilmarnock, Bowhouse, Kilmarnock. Mr Ritchie's mother and family were in attendance throughout the Inquiry. Mr Ritchie's mother raised a number of issues of some importance which were explored in the course of the Inquiry and which focussed principally on how it could come to pass that a prisoner under the protection of the prison authorities and in a carefully controlled and restricted environment, could die in circumstances which were neither accidental nor suicidal.

The purpose of a Fatal Accident Inquiry is to establish the facts surrounding a death. It is not to apportion blame.

Evidence and submissions were heard over four days. The Crown were represented by Mr Bell, procurator fiscal depute. SERCO, who are contracted by the Scottish Government to operate HMP Kilmarnock, was represented by Miss Irvine. The Scottish Prison Service was represented by Mr Watt, and Miss Glancy, advocate, represented the family of Mr Ritchie. I am grateful to all parties for their sensitive and thorough examination and cross-examination of the witnesses.

Evidence was led from Mrs Grace Ritchie, mother of the deceased. DC John Salisbury, James Meek, a Prison Officer based at Bowhouse, Kilmarnock, Derek Niven, a Prison Custody Officer based in Bowhouse, Kilmarnock, Alan McConnachie, Health and Safety Officer at Bowhouse, Kilmarnock, Sandy Ross, a Prison Custody Officer, Bowhouse, Kilmarnock, Alan Thornton, Staff Nurse, Bowhouse, Kilmarnock, Miss Hazel Torrance, Toxicologist, Dr Margaret Balsitis, Consultant Pathologist, Crosshouse Hospital, Kilmarnock, Miss Hilary McGilligan, Head of Security and Operations HMP Kilmarnock, Dr Hamad Kopal, Bowhouse Prison, Kilmarnock, Mr James Dougan, Performance and Improvement d

Director, SERCO, Miss Sinead McConnachie, Health Care manager, HMP Kilmarnock and DC Alexander Clark, Strathclyde Police, Kilmarnock.

A Joint Minute of Admissions was prepared and lodged in respect of photographic evidence, chemical analysis, the recovery of documents, and the identification of Mr Ritchie.

The History.

Mr Ritchie was a long term prisoner serving a sentence of five years three months within HMP Kilmarnock otherwise known as Bowhouse Prison. He had previously served a ten year sentence and had been subject to a Section 16 order under the Prisoner and Criminal proceedings (s) Act 1993 whereby an unexpired portion of that sentence fell to be served following upon the commission of a further offence which had resulted in a second sentence. It was not clear from the evidence to the Inquiry what the terms of Mr Ritchie's sentence were and I rely solely on the testimony of his mother as to the duration of that sentence. What is clear, however, is that Mr Ritchie was familiar with the prison environment and had spent considerable time within most of the institutions within the Scottish Prison Estate, including Barlinnie, Shotts, Glenochil and Bowhouse. Whereas his record of offending was for crimes of violence, he was noted as presenting no hostility to the prison authorities. He was considered obedient and respectful of the prison regime. He was transferred to Kilmarnock from Barlinnie on 13 September 2005. His earliest date of liberation was given as 8 May 2009.

Whilst in Bowhouse, he was housed in Cell 27, within House Block One, which is exclusively for long term prisoners. Cells are of a single occupancy only.

Mr Ritchie was a known drug abuser. It is recorded in his admission records to Barlinnie in August 2005, whilst on remand, that he had used heroin only whilst in jail. It was also noted at that time that efforts were being made by him to reduce his dependency on sleep promotion medication in line with the approach being taken by his GP whilst at liberty. He was not considered a suicide risk and did not demonstrate any suicidal tendencies. That his brother had committed suicide appeared to be a factor which he had used to counter any such similar thought in his own mind. However, conversely, that event appeared to have prompted within him the need for certain medications and, in particular, a sleep inducement prescription. The

medical records of Mr Ritchie are demonstrative of a prisoner who has had an active involvement with his medication requirements, who was quick to lodge formal complaints when medication was varied, or when that medication was provided in a form dissimilar to his expectations.

On 3 January and 7 February 2006, Mr Ritchie was seen by the prison psychiatrist, Dr Flowerdew who, in the first instance, recorded a preliminary diagnosis of potential depression. On Mr Ritchie's second appointment, Dr Flowerdew records Mr Ritchie as "not coping well with life" and that he suspected Mr Ritchie was abusing "heroin in significant amounts". Between the second psychiatric appointment and his death, Mr Ritchie was not subject to any follow-up consultation. I found this a matter of some surprise given this information however, fortunately, no subsequent medical appointment with the prison doctor evidenced any suggestion of "clinical depression" which may have warranted further psychiatric intervention.

Mr Ritchie was seen by Dr Kopal, the prison physician on 18 May, 8 June and 7 July 2006. I heard no evidence from Dr Flowerdew, but assume that any monitoring required of Mr Ritchie's condition was delegated to Dr Kopal and that a further psychiatric referral would have been at Dr Kopal's discretion. On the date of Mr Ritchie's last attendance with Dr Kopal, namely on 7 July 2006, he was prescribed 100 mgs naltrexone to be taken three times per week, 7.5 mgs of zopiclone to be taken daily and 40 mgs of citalopram also to be taken daily. Naltrexone is an opiate blocker *ie* it blunts the euphoric effects of opiates, zopiclone is a sleep inducer, and citalopram is an antidepressant. Mr Ritchie was a participant in a programme of "Medication in Possession" whereby prisoners are prescribed medication at weekly intervals. That medication is then self-administered.

On 28 October 2006, Mr Ritchie was reported to have spent most of his day with Robert Williamson, a prisoner with whom he was familiar, having spent periods of time with that individual in Glenochil and Shotts prisons. Mr Williamson, in a statement made by him to the police, recounted that Jason Ritchie had asked him and another prisoner, James Clark, if they had had any drugs. Mr Williamson declared that his response had been negative, but reported Mr Ritchie producing seven or eight pills from a blister pack that he had concealed in one of his socks and consuming these along with an anti-depressant pill he had produced from elsewhere. This was at approximately 7.30 pm. At 9.15 pm, Mr Ritchie was playing snooker

with Mr Williamson, but it was evident, at least to Mr Williamson, that Mr Ritchie was under the influence of an intoxicant and that "he was not himself" and that "he was hallucinating". Thereafter, Mr Williamson stated that he had requested of the prison custody officers an early lockdown. By that he meant that he wished to retire to his cell earlier than the designated time for such. Mr Williamson failed to present himself to the Inquiry to give evidence and I have therefor made no findings in fact based on his statement. However, Mr Williamson's account of Mr Ritchie's drug consumption is not entirely inconsistent with the subsequent toxicological findings.

Mr Derek Niven, the custody officer, gave evidence that the lockup of prisoners for the evening of 28 October 2006 took place at quarter to ten. His practice was to commence that process by 9.30 pm and have all prisoners return to their own cells. It is stated in evidence that he encountered Mr Ritchie in a cell, possibly Cell 35, on an upstairs landing. After a brief conversation, Mr Ritchie returned to his own cell where he awaited lockdown and the final roll call. Mr Niven recounted that Mr Ritchie's demeanour gave him no cause for concern and recalled that when in his cell and when called upon Mr Ritchie, who was sitting in a chair facing his desk, turned and looked in the direction of Mr Niven in acknowledgement of the roll call. At 6.45 on 2 October, the morning roll call took place. Prison Custody Officer Sandy Ross, accompanied by Prison Custody Officer Alex McConnachie, attended upon Cell 27. They encountered no response from Mr Ritchie. They entered his cell and found Mr Ritchie slumped forwards in his chair. One arm lay by his side and the other lay between his legs. A pool of congealed liquid was at his feet. Mr Ritchie was described as being blue in colour, rigid, and cold. His pupils were fixed and dilated and there was no pulse. No resuscitation was attempted as it was obvious Mr Ritchie was dead and had been so for some time. His life was declared extinct at 7.45 am by Dr Kopal. Mr Ritchie's body was later removed to Crosshouse Hospital for post mortem examination. His cell was searched and a substantial quantity of various medications was recovered, as has been set out in finding in fact ten.

Post mortem and toxicology.

The post mortem examination of Mr Ritchie's body did not identify the processes that culminated in Mr Ritchie's death. The preliminary findings substantiated some form of respiratory depression. The lungs were oedematous. There was significant anterior lividity

consistent with Mr Ritchie dying whilst slumped forward. His lungs were severely oedematous (excess fluid on the lungs which is consistent with terminal cardiac failure). A supplementary post mortem report following on toxicological examination established an overdose of the sleep inducement drug zopiclone as the most likely form of death. "Zopiclone" could have produced severe sedative effects on Mr Ritchie. If he was unconscious for a number of hours after ingestion, the maximum concentration of the drug achieved from his ingestion would have been significantly higher than that found in the analyses of the post mortem blood. Doctors Balsitis and Lang concluded that the circumstances of Mr Ritchie's seated and slumped position on a chair combined with the post mortem findings of conjunctival haemorrhage and perricardial haemorrhage that "the possibility exists that the terminal event was postural asphyxia. The cause of death was set out as "drug overdose (zopiclone)"." The toxicological findings are set out in finding in fact twelve. It is clear that Mr Ritchie had consumed a cocktail of drugs which had been combined with alcohol.

Of the drugs detected within his system, only zopiclone and naltrexone were consistent with his prescribed medication. Desmethyldiazepam is a metabolite of *inter alia* diazepam and was not prescribed to Mr Ritchie. The traces of morphine and total morphine were consistent with the abuse of heroin. Alcohol within the prison is a prohibited substance. The Inquiry heard that zopiclone is generally considered a safe medication and that consumption in significant quantities is necessary to result in a fatality. In general terms a normal two week supply or a supply in excess of two weeks, if consumed at once, could possibly have fatal consequences. The other substances detected in Mr Ritchie's blood were not at toxic levels and were not in themselves characteristic, alone or in combination, of causing death; however they may have had, with the exception of naltrexone, a marginal or "additive" effect in intensifying the process of respiratory depression brought about as a result of Mr Ritchie's ingestion of zopiclone. Miss Torrance described the quantity of zopiclone taken by Mr Ritchie as within the range of dosages which could give rise to fatalities albeit, in her view, Mr Ritchie's toxicology revealed a dosage towards the lower end of the scale of dosages considered perilous. However Miss Torrance emphasised that it was necessary, in any computation of dosages likely to have been consumed, to factor into that equation the process. whereby the drug would have broken down in the blood by the time of the post mortem examination and that the likelihood was that the level of consumption was higher than that disclosed by the post mortem toxicological analysis.

Essentially zopiclone works as a respiratory depressant, slowing down the breathing process to a point where breathing can terminate. The drug was described by Miss Torrance as an ”hypnotic” *ie* a genus of drug recognised for its sedative effect. It had been known to have been used as a “date rape” drug. Consumption in excess of prescribed dosage might lead to nausea, sedation and eventually respiratory depression which could bring about cardiac failure which, in turn, would be evidenced by pulmonary oedema or excess fluid in the lungs. I quote from Dr Balsitis that the effect of a fatal dose of zopiclone would be “depression of the function of the central nervous system which … … … appears to have caused depression of the cardio respiratory function to cause the heart and lungs to stop working properly. Such a situation could be exacerbated if a person was unable to move themselves from an uncomfortable position due to the effect of the drugs, whereby the position they are in compresses the chest and does not allow normal respiratory movement. If the drug level is such that a person is in a position that they are unable to move out of, the process of reduction of respiration may occur, thereby reducing the supply of oxygen to the brain and bringing about cardiac and respiratory failure”. This is the process known as positional or postural asphyxia and is consistent with the forward slump position of Mr Ritchie found by the prison custody officers and which was supported by the post mortem findings of anterior lividity, namely the rushing and settling of blood to the front of the body. It would therefor appear that a chain of events was initiated by the ingestion of the drug zopiclone which would not necessarily be of a toxicity to cause death, but was within a range of volume whereby fatality could result if the circumstances were appropriate. In this case, the postural position of Mr Ritchie, his loss of consciousness and his inability brought on by intoxication to remedy his position progressed the sedation caused by his ingestion of zopiclone to a point where respiratory and cardiac failure occurred. However, Dr Balsitis was clear in her view that even if Mr Ritchie had been prostrate, he may not necessarily have escaped the fatal consequences of his overdose.

In house medication policy.

Broadly speaking there are two categories of drugs available within prisons: drugs which are prescribed by the prison physician and non prescribed drugs. In the latter category, the drugs range from vitamin pills which are readily available to substances controlled under the Misuse

of Drugs Act 1971. The Toxicology report discloses use by Mr Ritchie of non prescribed drugs, but the critical factor in his death was the ingestion of a drug which was prescribed to him within the prison. HMP Kilmarnock operates a programme known as "Medication in Possession Policy". This allows a prisoner to self administer his prescription. A prescription is given on a weekly basis. Otherwise a prisoner is subject to supervised administration of his prescription by the prison nursing staff. Not all drugs fall within the Medication in Possession Policy and not all prisoners are deemed suitable for inclusion in the programme. The Medication in Possession Policy was initiated in HMP Kilmarnock in July 2006 and set up within national guidelines prepared by the National Prescribing Centre in conjunction with the NHS. The purpose of the Policy is manifold: it allows prisoners to take an active role in managing their own health care, it affords prisoners the opportunity to use medication at the appropriate time; it creates an environment leading to better management of long term conditions; it improves awareness and treatment of conditions; it frees up medical staff and reduces prisoner's time at treatment in queues at treatment times; and it reduces the likelihood of a prisoner missing his medication should he be at court or on a visit or in transit between prisons. It is a process whereby, so far as possible, the practice of dispensing drugs mirrors the experience of a person at liberty.

The Medication in Possession Policy applies throughout the prison service. The programme designed for HMP Kilmarnock was set out in a policy document prepared by Dr Kopal and Mr Dougan and revised by a second document implemented shortly afterwards. At the time of Mr Ritchie's death, the second revised policy for Medication in Possession was in place. That policy provided as its aim: "To encourage prisoners to be responsible for their own medication and self administration where reasonably practical in line with government policy and the National Prescribing Centre Guidelines". The document then goes on to set out the considerations which should be given to each prisoner/patient in an assessment of their suitability for the programme. These considerations are as follows:

(1) Does the prescription comply with the policy and is the medication allowed in possession?

(2) Can the prisoner understand the instructions contained on the package, the importance of complying with those instructions, and can it be reasonably assumed that the prisoner will follow these instructions?

(3) What is the prisoner's risk of self harm, taking into account knowing past behaviour and current circumstances?

(4) Is there any significant life event that may render the prisoner liable to an increased risk of self harm?

(5) Would the in possession of medication increase the risk of the prisoner being bullied to an unacceptable level?

(6) Are there other concerns that the medication is unsuitable for in possession issue?

The document then sets out the procedures for the issue of medications and goes on to highlight the risk considerations to be applied:

> "All drugs have the potential to cause harm if taken inappropriately. A considered risk assessment of the prisoner is essential when deciding whether to issue Medication in Possession and it is important to properly balance risk to the individual and to others within the need to empower the individual and to encourage self care. It is essential that the special context of the prison community must be taken into account in considering whether to allow drugs in possession and staff must remain aware of their overriding duty to take reasonable precautions to ensure the safety of all prisoners within the establishment".

The document lists those drugs which are not suitable for Medication in Possession, namely benzodiazepines (except zopiclone), procyclidine, controlled drugs and opiate medications. In line with the policy document, prisoners to be eligible for the Medication in Possession Policy are risk assessed and are required to sign an "IP Agreement" (In Possession Agreement). That assessment is made by health care staff and is ratified by the prison doctor. It determines whether the prisoner/patient has the capacity to understand his medication, can read any instructions on the use of the medication, has no history of self harm, has never overdosed or saved up medicine, has had no history of being bullied nor has suffered from depression requiring qualifying medications and that there are no other relevant considerations which should apply. If assessed positively and approved by the doctor, the

prisoner signs an agreement or contract, which is broadly to act responsibly with his medication and *inter alia* "not to hoard or save up medication".

The theory and practice of Medication in Possession was spoken to at some length by Dr Kopal and Mr Dougan. In my view, the policy aims are high and the objectives are worthy and respectful of the rights and dignity of prisoners. The policy has acknowledged the potential weaknesses and inherent risks while setting out an overarching strategy to deal with those risks.

Mr Dougan gave evidence that of the six hundred and fifty prisoners in HMP Kilmarnock, one third to half were on medication. Between thirty to fifty were taking anti-depressants at any one time and at least in 2006, approximately sixty prisoners had been prescribed zopiclone. The volume of prescribed drugs in the jail is such that vigilance against abuse is, in my view, paramount. For the Medical in Possession Policy to be effective and efficient, the prison staff must be alert continuously to the dangers inherent in the self administration of drugs in line with the IP policy. That is a consideration clearly identified within the policy document to which I have referred. Unfortunately, I heard no evidence on staff training in awareness of drug misuse and in the identification of symptoms or other indicators of either the misappropriation of drugs by prisoners or of the inappropriate ingestion of drugs, or of what procedures should be occasioned if drug misuse has been identified. I nonetheless consider that it is a matter that should be, if not already, addressed by the prison authorities. The statement obtained from Mr Williamson clearly and unambiguously presents a history of an intoxicated Jason Ritchie in the hours leading up to his death. Although that observation was untested in court due to Mr Williamson's non appearance, it was nevertheless a history which is consistent with the central finding of the post mortem report. Prison Custody Officer Niven, whom I did not consider to be lying to the Inquiry, gave an account of Mr Ritchie's presentation which was in contradiction of Mr Williamson's statement. Either Mr Ritchie was adept at concealing his intoxication or Mr Niven was blind to Mr Ritchie's condition or at least unattuned to the signs of Mr Ritchie's intoxication which may have been evident from any aberrant behaviour on his part.. Identification of Mr Ritchie's intoxication may have actioned a medical response.

Given the very considerable propensity for drug misuse where there is a Medication in Possession Policy which operates in tandem with a regime which allows for the freedom of

movement of prisoners within their accommodation wings, it is critical that the controls in place are compatible in equal measure with the objectives of the Medications in Possession Policy as with the prohibition of the supply, exchange, hoarding or bargaining of non prescribed drugs within the prison. It might be argued that where there is a density of drug abusers in prison, then drug misuse is an inevitable concomitant of the Medication in Possession Policy. Mr Ritchie was a known drug addict with an addiction stretching back several years. His assessment for the Medication in Possession Programme had to strike a balance between that condition and the rehabilitative purposes of his incarceration. His prison history did not disclose any factor which singled him as an inappropriate participant in the programme, however, that he had a history of drug abuse should have ensured regular scrutiny of his prescription requirements and consumption habits.

At the time of his death, Mr Ritchie was in receipt of 100 mgs of naltrexone three times weekly, 7.5 mgs of zopiclone daily and 40 mgs citalopram daily. In quantitative terms, he would receive weekly six naltrexone tablets, seven zopiclone tablets and seven citalopram tablets. That prescription would be received each Monday and if consumed in the prescribed manner, by Saturday he would be in possession of two zopiclone tablets and two citalopram tablets only. However, the search of his cell revealed six naltrexone tablets, an empty packet of zopiclone tablets and seven citalopram tablets. This was inconsistent with his prescription and when set against the toxicological findings and the totality of the drugs recovered from his cell, is indicative of a disregard of the Medication in Possession Policy by Mr Ritchie either by hoarding his medication or by obtaining medications from elsewhere. Overall, it suggested Mr Ritchie paid lip service to the contract or agreement entered into by him when subscribing to the Medication in Possession Policy. That agreement provided that:-

(1) He would present his ID card to the dispensary to enable collection of his prescription.

(2) Take all medications as prescribed.

(3) Not hoard or save up his medication.

(4) Not have in possession medication belonging to other prisoners.

(5) Not give or sell medications to somebody else.

(6) Not alter or tamper with medication in any way.

(7) Return all unused medications to the Health Care Centre as soon as possible.

(8) Immediately inform health care staff if medication was lost or stolen, or if there was difficulty in complying with instructions.

It should have been evident that a known drug abuser who was subscribing to In Possession programme requires a level of constructive monitoring and random auditing of the drugs in his possession. Alertness of prison staff to signs of intoxication is essential to the success of the IP programme. As I stated earlier, Mr Ritchie's medical history would suggest a very proactive engagement by him in his prescriptive requirements. He was seen by Dr Flowerdew, the prison psychiatrist, in February 2006, when he was described as being of low mood but with no follow up programme in place. There was no monitoring of his condition to determine improvement or deterioration or any programmed psychiatric examination to determine a prognosis. He was seen by Dr Kopal on three occasions, 18 May, 8 June and 7 July all 2006. No review of his medication took place thereafter. There is a clear context for regular review of the prisoner's requirements. In Mr Ritchie's case, it is evident that he has been identified in his prison record as being a drug abuser, that he has shown himself to be actively engaged as to the extent and scope of his medication, and that he was receiving a variety of drugs designed to assist him counter the effects of heroin, raise his mood, and help him sleep. Combined, these factors ought to highlight Mr Ritchie as a prime candidate for very regular reviews of his medication programme for no other reason than to enable the prescribing doctor to continuously monitor the therapeutic impact of that medication. At the time of Mr Ritchie's death, the absence of a regime of monitoring and reviewing the individual needs of prisoners on the Medication in Possession Programme would suggest the programme was largely dependent upon the prisoner's inclination to visit the physician rather than the doctor's engagement with the prisoner to ensure that the medication continued to stimulate the appropriate therapeutic responses or to determine whether the medication remains necessary or suitable. At the time of Mr Ritchie's death, such reviews were six monthly. I concur with Counsel for the family's submission that the length of such reviews constituted a failure in the system which operated within the prison in 2006 and which

contributed to Mr Ritchie's death. Fortunately, the prison management have since identified this weakness. Prisoners are now subject to a minimum monthly review of their medication needs by the prison doctor. Care should also be taken that there are no loose ends in a patient's treatment and that if a psychiatric referral has been made, that referral should continue until the psychiatrist has recorded that no further psychiatric input is required.

Cell Searches.

In conjunction with a programme of systematic medical review must also be a resourced, documented and comprehensive system of random and systematised auditing of prisoners on the Medication in Possession Programme. This is to ensure, insofar as possible, that at a particular point in time, the level of medication held by a prisoner is consistent with his prescription use. The Inquiry heard evidence that thirty spot checks were conducted each week by health care staff within the prison. The selection of prisoners was randomised and any inconsistency discovered between medications found and prescribed use, prompted a referral to the doctor for review of the prisoner's continuing suitability to continue on the Medication in Possession Policy or gave rise to review of the prisoner's prescription requirements. At the time of Mr Ritchie's death in October 2006, there were no records of the actual audits which were conducted by the health care staff at that time. That is regrettable. Mr Dougan advised the Inquiry that subsequent to the implementation of the Medication in Possession Programme which was set out in its final terms on 12 October 2006, the level of spot checks was at a "fairly low level". He indicated that there were between ten to fifteen spot checks per month throughout the entire prison. That was clearly inadequate given the surge in volume of drugs available within the prison as a result of the Medication in Possession Policy. Since then these spot checks on prisoner cells have increased significantly. Care should be taken by the prison management that the level of randomised audit should be continuously reviewed to minimise the risks of over or under consumption by prisoners of drugs prescribed to them. . Although I concede that the fact that there was any randomised checking done at all must have had some deterrent effect amongst prisoners to refrain from misusing medications, the pausity of checks at the time of Mr Ritchie's death may have contributed to an attitude that the risks of discovery for each prisoner were risks worth taking by him.

The analysis of the information obtained from the cell search audit records is of some relevance to the Inquiry. In the sample of such records as were produced as being illustrative of the bookkeeping now in place it was recorded that there were twenty three failures of the IP programme amongst prisoners within a sample of thirty audits. In other words, in twenty three out of a total of thirty searches, there were quantities of drugs within prisoners' possession which were inconsistent with the prescriptive use of medications as at the time of the search. Of these failures, the drug of preferred misuse was zopiclone. It is imperative that patterns of medication misuse are properly identified and that remedial action is taken. That remedial action may be to withdraw the drug most often misused or to prescribe it for shorter periods or to prescribe it under supervision. Mr Dougan indicated that the use of zopiclone within the prison is in decline, but nonetheless it remains in my view incumbent upon the prison authorities to identify any patterns which emerge from the audit records and deal with them as appropriate. That level of analysis does not appear to have been carried out either currently or at the time of Mr Ritchie's death.

Drugs and Alcohol in Prison.

Mr Ritchie's death was as a result of an overdose of zopiclone. The toxicology reports, however, disclose that he also ingested a number of unprescribed substances and in particular, heroin and alcohol. I sympathise with Mrs Grace Ritchie's primary concern that if her son is in prison, then he should be protected against contact with either of these substances. The Inquiry heard evidence of the security measures which the prison deploys to prevent the ingress of heroin into the prison and also to inhibit the production of alcohol within the prison. Neither of these substances contributed directly to Mr Ritchie's death. The alcohol within his bloodstream was low and although it may have had a minor contributory effect upon respiratory depression, it must be stressed that it was not in itself a fatal dose. I was satisfied that there is a rigorous programme of cell searches carried out within the prison. There is a minimum of ten individual cell searches carried out each day and special searches are carried out on a frequency dictated by other information available to the authorities. Each cell search is conducted in the presence of the prisoner who is strip searched but who is not subjected to any internal body search. Medications recovered in such a search are checked as they would be if found in a medications audit for IP compliance or otherwise. In addition, each cell is checked on a "lock, bolts and bars" basis daily, to ensure that the fabric of the cell is unaltered.

All visitors to the prison are scanned and x-rayed for the detection of drugs or prescribed items such as weapons or mobile phones. Dogs are deployed to assist in the detection of drug traces on visitors or their clothing. Prison staff are similarly searched. The perimeter of the prison is patrolled to deter the projection of drugs into the prison in missile form, whether that be in the cavities of dead birds or tennis balls. Notwithstanding the efforts by the prison management, there is undoubtedly a Canute inability to brace the tide of drugs into the prison. Evidence was heard from one prison officer that he had been approached by a prisoner to secrete the drugs into the prison for reward. It is clear that any weakness will be exploited to have drugs smuggled into the prison. However, I am satisfied that there is systematic vigilance in place to minimise the movement of drugs in the prison. Alcohol is brewed within the prison from indigenous ingredients such as bread and fruit. A simple fermentation process is carried out in receptacles available legitimately within the prison. An alcohol discovery is made approximately once a month . Prisoner ingenuity will always counter such resources as the prison authorities deploy to prevent and deter the production and distribution of alcohol within prison. Whereas deterrence should never be diminished, the reality is that alcohol as an illicit substance is likely always to have prevalence within the prison notwithstanding the counter efforts by the prison management. If the production of alcohol in itself is a problem, it is a problem compounded with that of the drug abuse whether a drug is prescribed or otherwise. Alcohol was thought to have had an “additive” effect to the effects of zoplicone by intensifying the process of respiratory depression. The level of alcohol in Mr Ritchie’s blood was low and in the absence of the more powerful sedative would not have induced a fatal consequence.

It was accepted that short of 24/7 incarceration, it is virtually impossible to eradicate drug and alcohol misuse within the prison. It is therefor important that at a practical level, prisoners are made aware of the potentially fatal consequences of combining drugs with alcohol. Any drug awareness programme within the prison should not discount or overlook the hazards of alcohol ingestion, either on its own of in combination with drugs .It is likely that this is a matter which would be raised with the PIAC (Prisoner Information and Activity Committee)for discussion with prisoner representatives but is a by-product of this Inquiry that the prison management may wish to ensure appropriate information is available within the prison generally as to the potentially lethal and fatal consequences of alcohol and drug combinations.

Overnight Security.

I lastly turn to the question of overnight security within the block where Mr Ritchie's cell was situated. There is no evidence before the Inquiry to suggest that Mr Ritchie had summoned assistance to his cell or that the prison custody officers on duty on the night of his death were negligent in their supervision of the cell area. Such evidence as there was identified Mr Ritchie at the point of the evening roll call positioned within his cell with his back to the cell door. No irregularity in his behaviour was identified by the prison custody officers. Each cell is equipped with a panel button which, when activated, alerts a central control room (The Bubble) within the block. If an alert is made, a light is activated outside the cell door and a buzzer sounds within the control room. These can only be deactivated manually. I do not doubt in any way the evidence of both prison custody officers on duty overnight on the night of Mr Ritchie's death that there was no alert emanating from Mr Ritchie's cell. Random cell inspection overnight is considered contrary to the prisoner's human rights. There is a balance to be struck between a prisoner's right to privacy and the prison's supervisory role of prisoners. It would be entirely inappropriate for prisoners throughout the night to be subjected to unwanted and unwarranted surveillance in the absence of a predetermined suicide risk. I am satisfied that any suggestion that Mr Ritchie may have alerted the prison staff overnight, is entirely speculative. I am also satisfied that neither overnight staffing levels nor the emergency alert system were are in any way deficient and that they contributed to Mr Ritchie's death.

Conclusion.

Mr Ritchie fell victim to his own drug misuse. The concerns of the Inquiry rightly focussed on the Medications in Possession Policy which was implemented in its revised form on 12 October 2006 and on the security measures within the prison to deter and prevent the misuse of drugs within the prison environment. I am satisfied that the dispensing regime integral to the Medication in Possession Policy is appropriate to prisoners' needs. However, the long term prescribing of drugs to prisoners without any frequency of review, was a deficiency in the system at the time of Mr Ritchie's death. That monthly reviews have been replaced since 2007 is a sufficient step, in my view, to remedy that deficiency within the system. Whereas drugs and alcohol are likely to be prevalent to a greater or lesser extent

within the prison, I am satisfied that there is continued vigilance on the part of the prison management and that sufficient security measures are in place to restrict, so far as possible, the ingress of illicit substances into the prison. However staff ought to be continuously vigilant and alert to the signs of intoxication and its potential consequences for prisoner safety. The dangers within a prison are likely to be more extreme due to the greater potential for unorthodox drug misuse than might be the case within the community at large and therefore appropriate training and protocols should be in place to assist custody officers to react appropriately to substance misuse. Whilst not undermining any prohibition of alcohol, sufficient publicity should be distributed within the Prison highlighting the hazardous nature of consuming alcohol with prescribed drugs. Patterns of drug misuse, where established, should assist in any review of the IP Policy.

I offer the sympathies of the Inquiry to Mrs Grace Ritchie and her family on the loss of her son. Though his life was troubled and no doubt the cause of great anxiety to her, Mrs Ritchie has endeavoured to draw some positive outcome from her bereavement which might assist in the future welfare of prisoners.

,Reported by me

Sheriff Desmond J. Leslie