SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2026] FAI 37

EDI-B1392-24

DETERMINATION

BY

SHERIFF ALISTAIR W NOBLE

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

into the death of

STUART CAMPBELL GOVAN

Edinburgh 8 April 2026

The sheriff, having considered the information presented at an inquiry under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act") determines:

1. in terms of section 26(2)(a) of the Act, that Stuart Campbell Govan (hereinafter "the deceased"), born on 25 June 1962, a prisoner held in legal custody at HMP Edinburgh, died within Cell 68, Level 4, Ingliston Hall, HMP Edinburgh, on 25 July 2021 between 0359 and 0504 hours, life being pronounced extinct at 0526 hours on said date.

2. in terms of section 26(2)(c) of the Act, that the cause of death was multi-drug intoxication, in particular multi-drug intoxication resulting from ingestion of medication prescribed to him, most of which was kept by him in his cell.

3. in terms of paragraphs (b) and (d) of section 26(2) of the Act, that no accident took place.

4. in terms of paragraphs (e), (f) and (g) of section 26(2) of the Act, that no findings fall to be made.

NOTE

Introduction and parties represented at the inquiry

[1] This inquiry was held under section 1 of the Act. It was a mandatory inquiry in terms of section 2(1) and (4)(a) of the Act as the deceased was in legal custody at the time of his death.

[2] Four parties were represented at the inquiry. Ms Webb, procurator fiscal depute, appeared for the Crown; Mr Roach, solicitor, appeared for the Scottish Ministers on behalf of the Scottish Prison Service; Mr Rodgers, solicitor, appeared for the Scottish Prison Officers' Association; and Mr Holmes, solicitor, appeared for Lothian Health Board. The deceased's family took no part in the proceedings, although there was communication with the Crown.

[3] The notice of an inquiry was lodged by the procurator fiscal on 30 September 2024. (I discuss below the terms of the notice.) There was a preliminary hearing on 25 November 2024 and a further preliminary hearing on 13 January 2025. Oral evidence was led from one witness on 25 August 2025 (the witness having failed to appear due to reported illness on 9 May 2025). The inquiry ostensibly concluded with submissions on 1 October 2025, but prior to the issue of my determination, the procurator fiscal sought

to lodge a further documentary production, a standard operating procedure ("SOP") regulating *inter alia* the procedure to be followed at HMP Edinburgh when a prisoner who was allowed to keep medication in his cell was found under the influence of a substance, which in my view was a significant issue in the case. (The SOP came into operation in 2023, but as discussed below, one of the principal purposes of a fatal accident inquiry is to consider what steps, if any, might be taken to prevent the occurrence of similar events in the future. On that basis, the SOP, albeit it regulates procedure from 2023 onwards, is an important document.) At a procedural hearing on 16 February 2026, without objection from any of the other parties, I allowed the additional production to be received and heard further limited submissions on it, from the Crown only.

[4] At the hearing on 1 October 2025, all the parties to the inquiry, apart from the Crown, proposed only the making of formal findings. Ms Webb did not take issue with the terms of the formal findings proposed by the other parties, but also sought the finding of a relevant fact in terms of section 26(2)(g) of the Act and the making of a recommendation in terms of section 26(1)(b) and (4) of the Act.

[5] At the procedural hearing on 16 February 2026, following my allowance of the additional production, Mr Morrison, procurator fiscal depute, who then appeared for the Crown, intimated that the recommendation proposed by the Crown was no longer sought. (The relevant fact sought by the Crown was also redundant.) None of the other parties sought to add to their original submissions. I understood from what was said that Mr Holmes had provided the additional production to the Crown after he became

aware of its existence in another case. He apologised for its late appearance. (That was obviously not something for which he was responsible, and I express my thanks to him for bringing it to the court's attention.) The determination reflects the contents of the new production.

[6] Mr Holmes did not specify the other case in which he learned of the SOP's existence. On 23 January 2026 the determination in the case of James Stevenson was issued at Hamilton Sheriff Court. Mr Stevenson was a prisoner in HMP Shotts at the time of his death on 13 October 2021. It bears some similarities to the present case. Mr Stevenson died as a result of multi-drug intoxication. While I think it likely that some of the drugs found in his body, such as gabapentin and pregabalin, could have been prescribed to other prisoners (although they were not prescribed to Mr Stevenson), the focus of the inquiry was on the entry of illicit drugs into prison. That distinguishes it from the present inquiry. As set out below, with the exception of a trace amount of the illicit drug etizolam, all the drugs identified in the deceased's body were drugs of a kind prescribed to him. None of the parties to the inquiry challenged the obvious inference that the drugs which the deceased had taken were the actual drugs provided to him. I discuss the various issues below.

The legal framework

[7] Section 1(3) of the Act provides:

> "The purpose of an inquiry is to—
>
> (a) establish the circumstances of the death, and

(b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances."

[8] Section 29 of the Act provides:

"(1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out—

(a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and

(b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.

(2) The circumstances referred to in subsection (1)(a) are—

(a) when and where the death occurred,

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

(c) the cause or causes of the death,

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

(e) any precautions which—

(i) could reasonably have been taken, and

(ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided,

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

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

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

(a) if the precautions were not taken, or

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

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

(a) the taking of reasonable precautions,

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

(c) the introduction of a system of working,

(d) the taking of any other steps,

which might realistically prevent other deaths in similar circumstances."

Evidence

[9] As noted, parole evidence was led from one witness, Ovidiu Calinoiu, at the time of the deceased's death a prison nurse at HMP Edinburgh. (He was identified in documentation as both Ovidiu Calinoiu and Calinoiu Ovidiu. I understood from his evidence that his personal name was Ovidiu and his family name was Calinoiu, and accordingly I describe him as Nurse Calinoiu or Mr Calinoiu in this determination.) Two police statements made by Mr Calinoiu were also lodged as productions, the first (Crown Production 17) taken in person at HMP Edinburgh at 1014 hours on the date of the deceased's death, the second (Crown Production 22) taken by telephone on 18 April 2025. Statements from the following persons were also lodged:

- Dr Peter Maskell, forensic toxicologist, Crown Production 14, dated 21 March 2025
- David Haggie, prison officer, Crown Production 15, taken at HMP Edinburgh on 25 July 2021 at 0837 hours
- Jason McAndrew, prison officer, Crown Production 16, taken at HMP Edinburgh on 25 July 2021 at 0915 hours
- Marta Klajman, prison officer, Crown Productions 18 and 19, respectively taken at HMP Edinburgh on 25 July 2021 at 0617 hours and on 30 October 2023 at Corstorphine Police Station
- Jill Dollard, hall manager, HMP Edinburgh, Crown Production 20, taken at Corstorphine Police Station on 9 December 2023

- Maya Walker, paramedic, Scottish Ambulance Service, Crown Production 21, taken at HMP Edinburgh on 25 July 2021 at 0609 hours
- Dr Barbara Mundweil, prison GP, HMP Edinburgh. Lothian Health Board Productions 1 and 2 and Crown Production 23, dated respectively 21 January 2025, 12 September 2025 and 6 May 2025

As can be seen, with the exception of the Prison Officer Klajman's second statement, all the prison officer statements were taken within a few hours of the deceased's death, as was the case with Nurse Calinoiu's first statement and Paramedic Walker's statement. With the exception of Nurse Calinoiu's statements, presumably because he was actually giving parole evidence, the statements were agreed to be the equivalent of the parole evidence of the witnesses. In addition, an affidavit dated 7 May 2025 from Steven McCann, head of operations of the Scottish Prison Service, was lodged, and it was also agreed in the joint minute that this affidavit fell to be treated as Mr McCann's parole evidence.

[10] It is unnecessary to narrate all the evidence in detail. It was substantially agreed and uncontroversial, and it largely suffices to express its import in the findings below. In the discussion thereafter I will set out so much of the evidence as I think requires to be considered more fully. The findings repeat much of what is said in the joint minute, but also deal with some additional matters.

Findings

[11] The deceased Stuart Campbell Govan was born on 25 June 1962.

[12] He was a prolific offender, spending much of his life from 1995 onwards in prison.

[13] In addition to other categories of offending, he committed a number of serious offences of violence. He was convicted *inter alia* in the High Court in 1995 and 2003, the former conviction being one of assault to severe injury, permanent disfigurement and danger to life with intent to rob, the latter being one of assault to injury and danger of life.

[14] On 13 February 2014, the deceased pleaded guilty in the High Court to a charge of hamesucken (the crime of assaulting someone in their own home). He had been remanded in custody for this offence since 24 June 2013. On 21 May 2015, an order for lifelong restriction was imposed, with a punishment part of four years' imprisonment. The sentence was backdated to the date of the deceased's remand, and accordingly the expiry date of the punishment part was 23 June 2017.

[15] Following sentence, the deceased spent his whole period in custody within HMP Edinburgh, for most of the time in Cell 70, Level 4, Ingliston Hall. Following a period of two days spent in the segregation and rehabilitation unit ("SRU") in June 2021, after matters described in subsequent findings, he occupied Cell 68, Level 4, Ingliston Hall.

[16] In the initial years of his imprisonment, the deceased incurred a number of governor's reports and multiple breaches of prison rules, but thereafter settled down. The last misconduct report he received, prior to those incurred in June 2021, as mentioned hereafter, was in 2017.

[17] There was no indication, throughout the deceased's time in custody, that he entertained thoughts of suicide. He was never made subject to any suicide prevention strategy. He was popular with the other prisoners. He socialised with other prisoners in the morning of 24 July 2021. Although she did not visit him in prison, his mother kept in regular telephone and letter contact with him, and regularly topped up his prison personal cash account.

[18] On 1 November 2011, the responsibility for the provision of healthcare to prisoners transferred from the Scottish Prison Service (SPS) to the NHS. Since then, individual regional NHS health boards have been responsible for the delivery of health care services within prisons in Scotland which fall within their geographical ambit for the provision of medical care.

[19] The deceased suffered from Perthes disease which was diagnosed when he was a child. Said disease affects the hip joint, in particular the femoral head. In the case of the deceased, both hips were affected. The deceased was prescribed several medications to help with the management of the severe pain which he suffered.

[20] The deceased was also diagnosed with paranoid schizophrenia. On 26 August 2013, during the time that he was remanded, he was admitted to Carstairs State Hospital and remained there until 13 February 2014, the date of conviction. The deceased was prescribed with medications in relation to his mental health.

[21] The deceased's last review with the prison's mental health team was in October 2015 where he stated that he was happy with his current medication, was able to control his symptoms and would refer back to them should he have any concerns.

[22] The deceased refused to engage in a mental health review in December 2015 and then again in January 2016, stating he was fine and did not need mental health. The deceased declined to be seen in the psychology clinic on 4 April 2018, 11 April 2018, 13 March 2019 and 27 March 2019.

[23] On 4 June 2021 at a GP consultation, the deceased stated that he was struggling with pain and mobility and suggested changing his gabapentin medication to pregabalin as he believed pregabalin worked better. On 8 June 2021 the deceased's gabapentin medication was changed to pregabalin.

[24] On 9 June 2021 the deceased was found to be under the influence of a substance or substances. No gabapentin medication was left in his cell. The deceased was placed on Management of an Offender at Risk due to any Substance ("MORS").

[25] On 21 June 2021 the deceased was again placed on MORS due to concerns he was under the influence of an unknown substance. The deceased threatened the prison staff with violence, smashed his cell and covered the floor of the cell in faeces and other bodily fluids. As a result of his behaviour, the deceased was made subject to his last misconduct reports.

[26] On 23 June 2021 following several reviews from the nurse and advanced nurse practitioner, it was agreed that the deceased's pregabalin would be changed to supervised.

[27] Following a period of supervised medication and a review on 16 July 2021 by the prison GP, Dr William Smith (who died prior to the present inquiry), the deceased was issued with a week's supply of pregabalin and carbamazepine on 22 July 2021 and a

week's supply of mirtazapine on 23 July 2021. Given his death, Dr Smith's reasons for restoring the deceased's ability to keep medication in his cell are unknown. The explanations given by the deceased for his condition and behaviour on 9 and 21 June 2021 were respectively noted to be that he was spiked and that his kettle was spiked.

[28] The deceased was on the following medications at the time of his death:

- Omeprazole 20mg once a day
- Quetiapine 150mg in the morning and 600mg at night
- Mirtazapine 30mg once at night
- Carbamazepine 200mg once a day
- MST - Morphine 30mg twice a day
- Tramadol 400mg once a day
- Pregabalin 300mg twice a day
- Arthrotec 75mg twice a day
- Sodium D3 tablets one 3 times a week.

The deceased received the MST and tramadol under supervision. This would be the case with any prisoner in receipt of such medications. He was allowed to keep the remaining medications in his cell.

[29] The deceased undertook 25 mandatory drug tests while in custody between October 1997 and January 2020. He provided three positive tests, in October 1997, September 2012 and September 2017, and 20 negative tests, the last being in January 2020. He refused to take the test on two occasions in 2017.

[30] At around 1350 hours on 24 July 2021, Prison Officers Jason McAndrew and David Haggie along with Prison Manager Jamie McGarry observed that several prisoners on Level 4, Ingliston Hall were under the influence of an unknown substance. Officer Haggie attended at the deceased's cell to check on the deceased and found him lying face down on the floor. Officer Haggie shouted the deceased's name and received a mumbled response.

[31] Ovidiu Calinoiu, a primary care nurse within the prison, attended the section to check on the condition of the prisoners. The deceased's condition was the worst of the prisoners he checked. Other prisoners were less affected, sometimes to the point of almost full recovery. Nurse Calinoiu's entirely incorrect understanding was that the deceased was only prescribed MST, not kept in his cell. He was aware of at least the second occasion in June 2021 in which the deceased had been found under the influence of a substance. By the next day the deceased had recovered, and Nurse Calinoiu was expecting something similar on this occasion.

[32] The deceased and another five prisoners were placed on MORS observations. In the case of the deceased, the arrangement was that he would be checked every 15 minutes for the first hour, every 30 minutes for the second hour and hourly for the remainder of the 24 hour period of observation. In the case of the other prisoners, they were initially to be checked every 30 minutes.

[33] Due to being placed on MORS, the deceased remained within his cell.

[34] Observations on the deceased from mid-evening onwards were carried out by Prison Officer Marta Klajman, an officer who had joined the prison service four months

before. She commenced duty as a night shift officer on Levels 3 and 4 Ingliston Hall at 1930 hours. She checked the deceased's cell at the following times: 2038 hours, 2148 hours, 2243 hours, 2343 hours, 0043 hours; 0154 hours; 0257 hours; 0359 hours and 0504 hours. Her duty was to obtain visual and verbal confirmation of the deceased's condition. When she checked the deceased at 0359 hours, she saw through the cell door hatch that the deceased appeared to be sleeping in a chair. She detected that the deceased was breathing and she obtained a verbal response from him when she kicked the cell door.

[35] When Officer Klajman attended at the deceased's cell at 0504 hours on 25 July 2021 to conduct the hourly check, the deceased was lying face down on the floor and did not provide a verbal response. Officer Klajman immediately radioed for assistance. Although she did not use the words "Code Blue" to indicate an unresponsive prisoner, as required by the Code Red Code Blue protocol in place in the prison, she otherwise imparted all the necessary information. By 0509 hours, several prison staff had attended at and gained entry to the deceased's cell, including the Nightshift Manager Jill Dollard and Prison Officer David Corcoran, the night shift officer working on Levels 1 and 2 Ingliston Hall.

[36] At 0509 hours the control room was alerted and at 0510 hours a blue light ambulance was requested. On the advice of the ambulance service, cardio-pulmonary resuscitation was commenced by Officer Corcoran and another officer who had arrived at the cell, Officer Bradley Dickson. Prior to the ambulance service's request, it had not been commenced because the deceased was exhibiting bodily signs of having been dead

for some time. The ambulance staff did not take over resuscitation when they reached the deceased's cell because it was apparent that the deceased had indeed been dead for some time. Paramedic Maya Walker pronounced life extinct at 0526 hours.

[37] A search of cell 68 was conducted by Detective Constable Derek Schulz of Lothian and Borders Police on 25 July 2021.

[38] The medication and packaging removed from the deceased's cell was as follows:

- Fultium (the D3 tablets) – 12 tablets present issued on 15 July 2021
- Pregabalin – no tablets recovered, 2 empty blister packets present (28 tablets used)
- Arthrotec – 14 tablets present issued on 15 July 2021
- Omeprazole – 1 tablet present and 6 used, 7 tablets issued on 15 July 2021
- Quetiapine – no tablets recovered, 1 empty blister pack present (14 tablets used) issued on 15 July 2021
- Mirtazapine – no tablets recovered, 1 empty blister pack with 7 missing tablets issued on 23 July 2021
- Carbamazepine – no tablets recovered, 1 empty blister pack with 7 missing tablets, issued on 15 July 2021.

[39] A post-mortem examination of the deceased was conducted on 28 July 2021 by consultant forensic pathologist Dr Kerryanne Shearer at the Edinburgh City Mortuary. The deceased's liver and lungs had suffered chronic damage, but this had no bearing on his death. One major artery of his heart had focal severe atheromatous narrowing, to such an extent that he could have died suddenly, but this also had no bearing on his

death. He had some rib fractures in the area of his sternum and where the ribs met cartilage, but these were due to the cardio-pulmonary resuscitation measures undertaken. At that stage the cause of death was recorded as unascertained, but three peripheral blood samples and a urine sample were retained for subsequent analysis. Following that analysis, a final post-mortem report was issued, recording the cause of death as: 1a. Multi Drug Intoxication.

[40] The results of the analysis were:

Blood:

- Tramadol – 1.6mg/L
- Morphine – Less than 0.025mg/L
- Etizolam – 0.025 mg/L
- Alpha-hydroxyetizolam (a metabolite of etizolam) – present
- Pregabalin – 43 mg/L
- Mirtazapine – 1.1 mg/L
- Carbamazepine – 10 mg/L
- Quetiapine – 16 mg/L

Urine:

- Morphine – 0.73 mg/L.

[41] The level of quetiapine was high, within the reported fatal range. The level of tramadol was high, within the reported toxic and fatal ranges. The levels of pregabalin,

carbamazepine and mirtazapine were high, in each case within the reported toxic range. The levels of morphine and etizolam and its metabolite were low.

[42] Apart from etizolam and its metabolite, all the drugs found on analysis were drugs prescribed to the deceased. Etizolam is not licensed for medicinal use in the UK and therefore the deceased could not have obtained it as a result of its prescription to another prisoner in HMP Edinburgh. It must have been introduced into the prison illicitly. Following the deceased's death, enquiries were carried out with staff at the prison, however no information became available to suggest where the deceased sourced the etizolam.

[43] Prison officers and nursing staff engaged with various inmates who presented as under the influence on 24 July 2021. These individuals did not disclose what substance they had consumed or where they had acquired it.

[44] On 26 November 2024 forensic toxicologist Dr Peter Maskell advised that it was not possible to give any sort of realistic timings as to when the drugs detected in the post-mortem samples were taken.

[45] In 2023 a new MORS SOP was promulgated, authored by Caroline Kenny, Lead Nurse for Prison Healthcare. Its effective date was 5 July 2023, with a review on 5 July 2025. As at the date of this determination, it continues in operation, with no material change relative to matters of significance in this inquiry. At section 2.0, its purpose is defined as "to ensure that a robust process is in place so that there is a consistent approach to the clinical assessment, escalation and monitoring of patients who are at

risk due to any substance. In section 3.0, it is said that the SOP applies to all patients, registered nurses and medical staff within HMP Addiewell and HMP Edinburgh.

[46] Sections 4.0 to 9.0 are in the following terms:

> "4.0 Nursing response
>
> Patients who present as appearing to be under the influence of a substance will be assessed by a registered nurse as soon as possible.
>
> • Nursing staff will be alerted by either a phone call or a radio call.
>
> • On arrival to the hall the nurse should take a brief handover from the officer including what the initial concerns are and how the patient is/has been presenting.
>
> • If possible, the patient should be reviewed in the treatment room on the hall. Where possible, nursing staff should not enter the cell.
>
> • If the patient cannot attend the treatment room, they should be asked to take a seat outside the cell.
>
> • If there is an immediate concern that the patient warrants emergency response – management of the acutely unwell patient policy should be followed.
>
> • If opioid overdose is suspected –administer Naloxone 400 micrograms every 2– 3 minutes, each dose given in subsequent resuscitation cycles if patient not breathing normally, continue until consciousness regained, breathing normally, medical assistance available, or contents of syringe used up; to be injected into deltoid region or anterolateral thigh. (British National Formulary)
>
> • The purpose of the nurse attending is to obtain clinical observations and be part of the multidisciplinary team to discuss the frequency of SPS/Sodexo Justice Service (SJS) observations.
>
> **Observations**
>
> • The Nurse should obtain a full set of observations as per the NEWS2 chart. This should include AVPU/GCS and pupil size. If possible, the nurse should obtain a blood glucose level.
>
> • The nurse should observe the patients overall demeanour, speech and gait.

• Physical observations are to clinically assess the patient – if the observations are within normal range, it does not negate the requirement for the MORS policy to be initiated i.e., if the clinical observations are within normal range but SPS/SJS/NHS staff have raised concerns – the policy should still be initiated

• The frequency of SPS/SJS observations should be a joint decision – it is not the sole decision of NHS staff.

5.0 Documentation

Document findings in the patient's care plan within the SPS/SJS MORS paperwork:

• Clearly state what general observations you expect prison officers to undertake and how often i.e. visual observations, verbal observations – patient states name, SPIN etc.

• Clearly state in the care plan a worsening statement, i.e. if no improvement after a specific time what action to take e.g. phone out of hours police cell nurses, or an ambulance.

• Clearly state how frequently nursing staff will review

• Clearly state when the case conference is to take place (24 hours) Document consultation and clinical observations using SBAR on vision record. SPS/SJS are responsible for commencing the paperwork.

6.0 Review

The patient will be reviewed as frequently as clinically required however will not be removed from MORS or receive medication until after the case conference and not before 24 hours. If the patient is presenting as not being under the influence at 24 hours and their clinical observations are satisfactory, they can be removed from the MORS policy if this is agreed with both SPS/SJS and NHS. If there is still concern that the patient is under the influence after the first case conference, they will remain on MORS for a further 24 hours until another case conference takes place. This pattern of 24 hour case conferences will continue until all parties are satisfied that the patient is safe to be removed from the policy.

The frequency of clinical observations by trained nurses is a dynamic process with the regularity increasing or decreasing depending on the previous assessment, NEWS2 score and the patient's clinical presentation. If there is clinical concern, the

patient will be reviewed more regularly and should be escalated to ANP or GP in working hours and LUCS (Lothian unscheduled care service) out of hours. The clinical escalation policy should be followed at all times. See Appendix B for escalation information.

If the patient has refused observations a refusal form must be signed (Appendix A). If the patient refuses to sign this, a second person should sign to witness.

The patient should be reviewed at later time and observations offered again.

7.0 Prescribed Medication

Consider the patient's prescribed in-possession or supervised medications and whether they should be withheld while they are acutely unwell or suspected of being under the influence of an unknown substance.

Advice should be sought from the GP or ANP within working hours. Out of working hours LUCS will provide advice.

Remove in-possession medication from the cell immediately following the commencement of the MORS policy. Should the in-possession medication be incorrect, follow spot check procedure. Removal of medications is to ensure patient safety. Review in-possession medication removed and check if any essential life-saving medication requires administered that day (for example cardiac and diabetes medication).

Prior to any medication being stopped there should be a multidisciplinary discussion involving as many disciplines as possible. The original prescriber of the medication should be involved in this discussion where possible, if not they should be made aware of any decisions that have been made relating to the prescription.

All medication removed must be recorded on administration sheet. Indicate on the patient's drug kardex that medication is withheld.

Return medication when it is safe to do so and when the patient has been removed from the policy.

Following the case conference - if the patient is removed from the MORS policy, their observations are within normal range and they are presenting as no longer being under the influence, they can receive their supervised medication.

If nursing staff have completed the administration of medication in the hall before the case conference has taken place then arrangements should be made to bring the patient to the health centre for their supervised medication - if operationally possible i.e. when and if NHS/SPS/SJS staff can facilitate this

8.0 Follow up

If the patient is receiving:

• Opiate Replacement Therapy - notify the addictions team who will review.

• Psychotropic medication - notify the mental health team who will review.

• Other medication – primary care will follow up and discuss medication and frequency of clinical review with the GP or ANP.

If the patient is expressing suicidal ideation, particularly paranoia or psychotic symptoms, instigate 'Talk to Me'. If persistent delusions or hallucinations occur, arrange a psychiatric review

9.0 Responsibilities

Staff undertaking and recording clinical observations should have a sound knowledge of the normal range of physical observations and be confident about taking appropriate action to escalate care if results are abnormal. Staff must have completed an appropriate programme of education and be deemed competent in the use of Vision, NEWS2 and SBAR-D. The minimum standard is the NEWS2 elearning module appropriate to role. In addition, face to face NEWS2/SBAR-D training can be provided. All clinical staff will complete annual training in basic life support at a minimum. Practice must always be in accordance with local policies and procedures. All staff are accountable for their practice. Hardware must be available to record and view patients' information related to observations and management e.g. Computers on PCs A stock of NEWS2 paper charts should be stored in the health centre."

Discussion

[47] In terms of the initial notice of an inquiry lodged by the Crown, reference was made to three issues which might arise for consideration at the inquiry. The first of these was the availability of illicit drugs in HMP Edinburgh, how they entered prison,

the practices and procedures to prevent entry and manage the situation where entry was gained, and whether these practices and procedures had been followed in the deceased's case. The productions included a number of SOPs setting out various measures devised to deal with the many potential routes whereby such drugs might be introduced. It bears emphasis, however, that in this case the deceased died from the consumption of medications prescribed to him, much of which he was allowed to keep in his cell. A trace of an illicit drug, etizolam, was found on analysis of his body samples, but the drugs involved in his death by way of multi-drug intoxication were drugs he had been prescribed and which he was largely allowed to keep in his cell. The proliferation of illicit drugs in HMP Edinburgh is a relevant circumstance to the extent that it underpinned some of the assumptions made about the deceased's overdose, and the approach taken to it, but the efficacy of the measures taken to prevent the entry of illicit drugs into prison was not something explored in evidence.

[48] Two other subsidiary matters were mentioned in the application, the fact that the prison officer who discovered the unresponsive deceased in his cell did not declare a Code Blue, and the fact that when entry was gained to the deceased's cell by that and other officers, no resuscitation measures were undertaken until the ambulance service which had been contacted requested that that be done. They were not covered at all in the joint minute. I have, for the sake of completeness, mentioned them in my findings, but it is evident, for the reasons stated in the findings, that they had no significance in relation to the deceased's death. Although the words "Code Blue" were not used, the officer concerned immediately radioed for assistance, imparting what she had

discovered. As to why the officer did not say the words, she had only been employed as a prison officer for 4 months, but in her second statement the reason she appears to give is that there were no nurses in through the night to respond to a Code Blue. In any event, within a very few minutes, a number of other officers attended, and entry was gained to the deceased's cell. Turning to the second subsidiary matter, no resuscitation measures were attempted because it was apparent that the deceased had been dead for some time. Although cardio-pulmonary resuscitation was commenced at the request of the ambulance service, the ambulance personnel who attended at the deceased's cell likewise formed the view that the deceased had been dead for some time. They themselves did not pursue attempts at resuscitation. I do not mention these matters further.

[49] Another matter which did not receive specific attention was the deceased's motivation in consuming the majority of the drugs within his cell. No party suggested that the deceased was intending to take his own. life, and on the basis of the evidence, I consider it extremely unlikely that that was the deceased's intention. The deceased was subject to an order for lifelong restriction, and had been in custody since the date of his remand in 2013 (and indeed almost continuously in custody since 1995), and there was no likelihood of his imminent release, but no suicidal ideation had been expressed by the deceased during his time in custody. He had never been made the subject of any suicide prevention strategy. No significant change is his circumstances is apparent in the period immediately prior to his death. He had been moved from the cell he had occupied for many years, cell 70, to cell 68, and he also had worries about Covid, but

these do not appear to be significant matters. Although she did not visit, his mother kept in regular telephone and letter contact with him. He was well liked by the other prisoners. He had socialised with other prisoners in the morning of 24 July 2021. In all the circumstances, it would appear highly likely that the deceased did not intend to die and was not expecting to die as a result of ingesting the drugs he did. As noted in the findings, and a matter to which I now turn, he had been found under the influence of one or more substances on two occasions in June 2021, from which he made a full recovery.

[50] The first of these occasions was on 9 June 2021. Afterwards no gabapentin was found in his cell. (I have identified the drug as gabapentin because that is the drug named in the joint minute. In the DIPLAR report, it is identified as pregabalin. For present purposes, it is not material which it was.) It appears that at a later stage, when the deceased successfully sought the return of his in-possession medication, he told the doctor, Dr Smith, that one tablet was missing; there is no indication in the papers whether or not that was correct. His explanation for being under the influence of a substance, as noted, was that he had been spiked. The deceased's medication had just been changed from gabapentin to pregabalin, at his request, on the stated basis that he was struggling with pain and mobility. It cannot now be known if this was the deceased's true or only reason. It would appear that pregabalin was subject to misuse. In her statement of 21 January 2025, Dr Mundweil indicates that since 2021 it has become known that pregabalin had been involved in a significant number of drug deaths in Scotland, and that its use in prison has been significantly reduced, with gabapentin

generally substituted. In her later statement of 6 May 2025 she indicates that where pregabalin is still prescribed, it is no longer held in-possession i.e. retained by the prisoner in his cell.

[51] On 21 June 2021, a more serious incident occurred. The deceased was found substantially under the influence of a substance. He had caused damage to his cell, threatened prison officers with violence and smeared faeces and other bodily fluids in his cell. His subsequent explanation was that his kettle had been spiked. The deceased's pregabalin medication was thereafter given under supervision, rather than held in-possession. The deceased repeatedly sought its return, and following a meeting between him and Dr William Smith on 16 July 2021, Dr Smith authorised the return of the deceased's medication to his cell.

[52] In relation to the events leading up to the deceased's death, as noted in the findings, the deceased was one of several prisoners found under the influence of one or more substances at about 1.50pm on 24 July 2021. Assistance was summoned from a prison nurse, Ovidiu Calinoiu. Nurse Calinoiu was born in Romania and obtained a nursing qualification there. After he came to this country, he initially worked as a nurse in care homes. He then joined the NHS and worked in HMP Edinburgh from February 2021 until May 2024, when he left both HMP Edinburgh and the prison estate. In July 2024 he ceased working for the NHS. At the time he gave evidence, he was working as a joiner. It appeared to me that he did not enjoy his time as a nurse in prison, at least as regards those aspects of his work to which he referred in evidence. When he attended on 24 July 2021, he found a number of prisoners under the influence

of drugs. They were affected to varying degrees. The worst affected was the deceased. In terms of the short statement he provided on the day of the deceased's death, he stated that the deceased "was medicated on daily basis. He was prescribed with MST 30mg twice a pain as a pain relief I believe." MST was only given under supervision.

[53] In his second statement, taken by telephone on 18 April 2025, he referred at the outset to the time that had passed and to the fact that he no longer had access to NHS systems or notes. Beyond that, he stated the following:

> "As I recall it, the MORS procedure would require any prescription medication to be removed from a prisoner's cell once the procedures were initiated. As a nurse I would remove any of the medication that was in plain view or left out, but it wouldn't be part of my role to search a cell or search a prisoner.
>
> It's a bit of a grey area between the NHS and the prison officers, if I knew the prisoner had medication then I would ask the prison officers to search the cell and the prisoner in order to remove this when the MORS procedure was initiated. If that was the case for Mr Govan then that would have been the action I would have taken.
>
> Generally, the officers would search the cell and the prisoner, and they would be aware if a prisoner was on medication and they would be aware that the MORS procedures had been initiated.
>
> In terms of Mr Govan he wouldn't have possession of medication himself, he was prescribed MST 30mg twice a day. And this would have been given to him at the hatch of the medical room on level 3 and a mouth check would have been done to ensure the medication was administered and swallowed properly, that was our standard procedure.
>
> If it was suspected by the prison officers that Mr Govan was under the influence he would not have been sent down to the hatch for his medication.
>
> I've been asked if Mr Govan was prescribed Gabapentin, and if he would have had access to it himself within his cell.
>
> I do not recall this, I can only remember him being prescribed MST and I don't think he was prescribed anything in his possession at that time."

[54] In his evidence, Mr Calinoiu repeated his understanding that the deceased was only prescribed MST, which he did not keep in his cell. He also testified in examination-in-chief that the prison officers would have known what drugs the deceased had been prescribed, and that the prison officers would have searched his cell. In relation to his former assertion, under cross-examination from Mr Roach, he accepted Mr Roach's suggestion to the effect that the prison officers would not know what drugs the deceased had been prescribed; they might have been able to infer from carrying out their duties that the deceased had been prescribed drugs.

[55] Mr Calinoiu's evidence clearly raised a number of issues. He obviously had no idea what drugs the deceased had been prescribed, nor that the deceased was able to keep many of them in his cell. There were agreed statements from Officers Haggie and McAndrew, the two officers who discovered the deceased under the influence on 24 July 2021. The statements were quite brief, as noted taken on 25 July 2021 by police officers who had attended at the prison in response to the deceased being found dead. Officer McAndrew told the police officer taking his statement that the deceased was medicated for his mental health on a daily basis. He refers to the deceased having been similarly intoxicated a few weeks back, and having recovered, the "word on the street" indicating that it could be etizolam. In terms of Officer Haggie's statement, he expressed the suspicion that the deceased had been under the influence of etizolam (on the basis of something found on another prisoner) and similarly expressed a belief that the deceased had been affected by etizolam on two occasions in June, he being aware of both of them.

In relation to medication, Officer Haggie said that the deceased "had very bad mental health problems but generally I believe he wasn't medicated for it. I'm not too sure about it.". There was obviously no search of the deceased's cell for prescribed medication.

[56] The MORS SOP introduced in June 2023 was in operation for almost a year before Mr Calinoiu gave up his employment. He did not expressly mention it, and neither the procurator fiscal nor the other agents were aware of its existence. It is impossible to know whether the SOP had any influence on aspects of his evidence. Some of the things he said appear to reflect its terms.

[57] As to the MORS SOP in force at the time of the deceased's death, Mr McCann said the following about it in his affidavit:

> "5. In the event an officer suspects a prisoner of being under the influence of an illicit substance, the MORS policy will be initiated. An NHS staff member will be called to assess the prisoner and make a decision about the frequency of observations the prisoner requires to be keep them safe and alive. The observations can also require to include a visual or the prisoner and obtaining a verbal response. All of the required MORS paperwork then requires to be completed reflecting when MORS was initiated and the frequency of observations in place.
>
> 6. Once a prisoner is placed on MORS, the prisoner should then automatically be placed on a Rule 95 to remove the prisoner from association. The prisoner should be separated from association for the safety of others and the prisoner themselves. This is in case the prisoner who is under the influence is behaving in a volatile manner. In addition, there might be bullying by other prisoners if a debt is due in relation to the drugs purchased and taken.
>
> 7. The prisoner's electronic record, PR2, is also updated to reflect the initiation of MORS and the frequency of observations. The PR2 is also updated to reflect referrals made on behalf of the prisoner and what addiction and recovery support has been taken up. The prisoner should then also be placed on report for taking an illicit substance and a disciplinary hearing should take place. The

> purpose of the disciplinary hearing in these circumstances should be supportive and helpful as opposed to punitive. A discussion should take place about addiction support available to assist the prisoner's recovery. The hearing should not be focused on establishing guilt or punishments being enforced against the prisoner.
>
> 8. In the event a prisoner is on MORS and it becomes clear during observations that their health is declining a nurse should be called immediately to assess the prisoner and decide if further medical assistance is required or if the prisoner requires to go to hospital. If during an MORS observation a prisoner is unconscious and not breathing, a Code Blue should be called by the prisoner officer and an emergency ambulance requested."

[58] The 2023 MORS SOP appears to me to demand more of the nurse who attends. Although not expressly stated when and how it is to be done, the acquisition of knowledge clearly plays an important part in the SOP's operation. Section 7.0, quoted in full in para [46] above, deals with the case of the prisoner who is prescribed in-possession or under supervision medication. It states *inter alia*:

> "Consider the patient's prescribed in-possession or supervised medications and whether they should be withheld while they are acutely unwell or suspected of being under the influence of an unknown substance.
>
> Advice should be sought from the GP or ANP within working hours. Out of working hours LUCS will provide advice.
>
> **Remove in-possession medication from the cell immediately following the commencement of the MORS policy. Should the in-possession medication be incorrect, follow spot check procedure. Removal of medications is to ensure patient safety.** [Emphasis mine] Review in-possession medication removed and check if any essential life-saving medication requires administered that day (for example cardiac and diabetes medication)."

If a nurse is to ensure the removal of in-possession drugs where a substance has been taken, then clearly the nurse will have to know what drugs the prisoner would have in his cell. Similarly, it would appear necessary for the nurse to impart that knowledge to

the prison officers undertaking the cell search, so that they would know everything they were looking for.

[59] I note that, appropriately, there is no requirement, where drugs are to be removed from a cell, that the prisoner concerned must be suspected of being under the influence of a drug prescribed to him. Indeed, the SOP would cover the situation where it was fairly clear that the prisoner had taken an illicit drug not prescribed to him. It is not said expressly why, but it would avoid the possibility of the prisoner thereafter overdosing on the drugs prescribed to him, or the possibility that even taking the medications in the manner prescribed might react with whatever illicit substance he had consumed. (In this case, it was the drugs prescribed to the deceased which were wholly responsible for his death.) The cell search would also of course establish whether the deceased had consumed more than he should of his prescribed medication.

[60] The previous paragraph leads on to one of the issues arising in relation to the drugs prescribed to the deceased. One of the things which particularly concerned me was when the deceased had consumed the drugs, and in particular whether he had consumed all of them by the time he was seen by Nurse Calinoiu and confined in his cell under MORS, or took further drugs in the hours between his confinement and subsequent death. In relation to that issue, the opinion of Dr Peter Maskell, the forensic toxicologist who had initially analysed the samples taken from the deceased, was sought, and he provided the following statement:

> "To estimate the time of consumption we would need to have specific information for all of the variables of the relevant equation. The main two variables that would be required for solving this equation would firstly be the

> dose of any drug consumed, and secondly how often that drug had been consumed in the week or couple of weeks prior to the death. Other variables (such as the length of time the specific drug would stay in the body) would also be required. These other variables would be unique to the deceased and would not be able to be determined following death. Due to the large number of unknown and unknowable variables it is not possible to give any realistic timing as to when the drugs detected in the post-mortem blood samples were consumed by the deceased."

As mentioned later, the view taken by the Crown was that this evidence precluded the making of findings under paragraphs (e) and (f) of section 26(2) of the Act.

[61] In relation to the deceased's medication, I have already noted Dr Mundweil's comments about pregabalin. Generally, she described the deceased's drugs regime as a well thought out package. In relation to tramadol, it and MST were the two drugs that the deceased was not allowed to keep in his cell. He took them under supervision. He last took tramadol on the morning of 24 July 2021. From Dr Maskell's initial report, attached to the post-mortem report, the level of tramadol in the deceased's body fell within the toxic and fatal ranges. In her statement Dr Mundweil indicated that the dose the deceased received was only one-third of the maximum dose. It is difficult to conceive that the deceased would be prescribed a dose which would be liable to harm or kill him. An explanation seems to me to lie in the nature of the data used by Dr Maskell, to which he himself added a caveat. The level of tramadol in the deceased's blood was 1.6 mg/L. In relation to tramadol, what he said in his report was:

> "A single 100 mg dose gave peak serum concentrations averaging 0.28 mg/L. Daily doses of 200-499 mg tramadol for 4 weeks gave serum concentrations ranging from 0.095-0.841 mg/L. Blood collected from 83 persons suspected of drug-impaired driving contained tramadol concentrations in the range 0.01-5.4 mg/L. In 17 fatal cases believed to have been due to unintentional overdose with tramadol plus other agents, an average post-mortem femoral blood

> concentration of 3.7 mg/L (range 1.1-12 mg/L). Individual tolerance to opioids should be considered when interpreting the significance of these findings."

The number of cases is limited, the individual circumstances are not disclosed, the figures cover a vast range, and there is the caveat added by Dr Maskell that individual tolerance to opioids should be considered. (Similar qualifications and caveats applied to the other drugs found in the deceased's body.) There may be other possibilities, for example that the deceased also obtained illicit tramadol, but these seem to me less realistic.

[62] Turning to the parties' submissions, as indicated all of them were prepared prior to the appearance of the 2023 MORS SOP. The submissions on behalf of the Scottish Prison Officers' Association and Lothian Health Board were brief. In the former, it was pointed out that no party sought to suggest that the deceased's death was avoidable, or that any prison officer or member of the POAS could or should have acted in a way which may have prevented the deceased's death, or acted in such a way so as to contribute to his death. The evidence had primarily focused on medical care, and the operation of the SPS MORS policy, each of which were issues for other parties to the inquiry to comment upon. Only formal findings were sought.

[63] It was also submitted on behalf of Lothian Health Board that no findings in terms of sections 26(2)(e) to (g) were necessary. In particular it was submitted that there was no evidence available of any precaution which might reasonably have been taken by Lothian Health Board, which could have realistically prevented Mr Govan's death.

[64] In the Scottish Government submission, it was said (correctly) that Nurse Calinoiu's evidence that prescribed medication would be removed from the cell of a prisoner under the influence of a substance went beyond the requirements contained in the MORS policy (then current). Further to Nurse Calinoiu's (ultimate) evidence that officers would not be told what drugs had been prescribed to a prisoner, but would be able to infer if a prisoner was receiving prescribed medication, it was submitted that it would not be appropriate for the MORS policy to include a requirement for officers to remove prescribed medication from an individual's cell. In practice, officers were not privy to information relating to an individual's healthcare. Additionally, removal of certain medications might lead to a deterioration of an individual's health and officers were not trained to manage this risk. There was no evidence before the court that there was a defect in the operation of the MORS policy by SPS staff. (The 2023 SOP of course requires removal of in-possession medication, but the consequences of that removal have to be considered by medical personnel.)

[65] In relation to whether findings should be made under paragraphs (e), (f) and (g) of section 26(2), it was submitted that the affidavit evidence of Steven McCann should be accepted in full. (Reference was made to all aspects of his evidence, including matters such as preventing the entry of illicit drugs into prison, which had limited direct relevance to the circumstances brought out in the inquiry.) It was submitted that there was no evidence before the court suggesting that the substances identified in the final post-mortem report as causing the deceased's death were the result of a defect in the current drug prevention measures in place.

[66] Reference was also made to the agreement in the joint minute that on 1 November 2011, the responsibility for the provision of healthcare to prisoners transferred from the Scottish Prison Service (SPS) to the NHS. Since then, individual regional NHS health boards had been responsible for the delivery of health care services within prisons in Scotland which fall within their geographical ambit for the provision of medical care. In the circumstances, the Scottish Ministers were not privy to the medical records and conditions of individuals in their care. It was submitted that the evidence provided to the inquiry relating to the deceased's prescription medication was therefore outside of the Scottish Ministers' knowledge. The Scottish Ministers had not provided evidence in relation to these matters. It was submitted that whilst all deaths were tragic, in the circumstances of the deceased, nothing could have been done by the SPS or otherwise to prevent his death. There was also no evidence before the inquiry which indicated that there was a defect in a system of working which may have caused or contributed to his death.

[67] As noted, the Crown was the only party to suggest that more than formal findings should be made. In relation to section 26(2)(e) it was submitted that it set out a two-stage test. First, the court required to be satisfied on the evidence led that there was a precaution which could reasonably have been taken, and secondly, the court had to be satisfied, again on the evidence led, that if the precaution in question had been taken, then it might realistically have prevented the death. The Crown sought no finding in terms of this provision. In relation to section 26(2)(f), defects in any system of working which contributed to the death, the Crown also sought no findings in terms of this

provision. However, section 26(2)(g) allowed the court to make findings about any other facts which are relevant to the circumstances of the death. It allowed findings to be directed at such circumstances even if there was no finding that, on the balance of probability, they contributed to the death. Unlike section 26(2)(e) and (f) there was no requirement for a causal connection. As such, it was considerably wider in scope. During the course of the Inquiry, the court had raised the question of the retention of prescribed medication by a prisoner who was suspected to be under the influence. The Crown submitted that, given that the timing of the consumption of the drugs identified in the deceased's system could not be determined, a finding under paragraph (e) or (f) could not be made; reference was made to the statement of Dr Peter Maskell. However, the Crown submitted that the retention of prescribed medication was a fact relevant to the circumstances of the death and further submitted that a finding under section 26(2)(g) should be made. After extensive reference to Nurse Calinoiu's evidence, it was pointed out that the MORS policy had no requirement for a cell search and removal of medication from the cell, and further that while the timing of the consumption of the drugs could not be determined, the deceased might have consumed a quantity of his prescribed medication following being placed on MORS on 24 July 2021. In these circumstances, the Crown submitted that the following finding should be made in terms of section 26(2)(g):

> "The Scottish Prison Service Management of an Offender at Risk due to any Substance - Policy & Guidance does not contain a provision for the removal of prescribed medication when a prisoner is suspected to be under the influence."

In respect of section 26(1)(b) and (4), which required the court to consider whether a recommendation might be made that "might realistically prevent deaths in similar circumstances" the Crown pointed out that in terms of Nurse Calinoiu's parole evidence, while it might happen in practice, there was no requirement under the MORS process to remove prescribed medication from a prisoner's cell at the stage where they were found to be under the influence and placed on MORS. In the Crown's submission, a recommendation might be made that the Scottish Prison Service consider reviewing the MORS policy to include a provision that prison healthcare staff and prison officers should give active consideration to the removal of prescribed medications from within a prisoner's cell when they are placed on MORS.

[68] I accept Ms Webb's submission that Dr Maskell's evidence precludes the making of findings under paragraphs (e) and (f) of section 26(2) of the Act. The existence of the 2023 MORS SOP also overtakes the need for a relevant fact to be stated in terms of section 26(2)(g) of the Act, or for a recommendation as initially proposed to be made. The SOP only applies to HMP Edinburgh and HMP Addiewell, the prisons falling within the ambit of Lothian Health Board. I would understand the position held by its author, Lead Nurse for Prison Healthcare, to be a Lothian Health Board position rather than a national one. It may be that other health boards with responsibilities for other Scottish prisons have similar procedures in place, but if not, they might give consideration to introducing one.

[69] All those appearing before me tendered their personal condolences and the condolences of the parties they represented to the deceased's family and friends. I would add my own condolences.