SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY AT HAMILTON

[2025] FAI 36

HAM-B449-23/HAM-B447-23/HAM-B450-23

DETERMINATION

BY

SHERIFF LIAM MURPHY

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

into the deaths of

THOMAS THOMPSON, JAMES GARSCADDEN AND MARIUS BAUBA

Hamilton, 7 August 2025

DETERMINATION

The Sheriff, having considered all the information presented at the inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland Act 2016 (hereinafter "the Act") that:

1. In terms of section 26(2)(a) (when and where deaths occurred):

(a) Thomas Thompson died on 17 April 2021 at 0815 hours at HMP Shotts, Newmill and Canhill Road, Shotts. At the time of his death the deceased was in legal custody.

(b) James Garscadden died on 27 June 2021 at 0825 hours at HMP Shotts, Newmill and Canthill Road, Shotts. At the time of his death the deceased was in legal custody.

(c) Marius Bauba died on 24 July 2021 at 1908 hours at University Hospital Wishaw, 50 Netherton Street, Wishaw ML2 0DP. At the time of his death the deceased was in legal custody.

2. In terms of section 26(2) (b) (where and when any accident resulting in the death occurred):

The deaths of Mr Thompson, Mr Garscadden and Mr Bauba did not result from an accident.

3. In terms of Section 26(2) (c) (cause or causes of death):

(a) Mr Thompson's cause of death was 1a: Methadone, etizolam, tramadol and pregabalin intoxication.

(b) Mr Garscadden's cause of death was 1a: Cocaine and etizolam intoxication with coronary artery atheroma.

(c) Mr Bauba's cause of death 1a: Global ischaemic brain Injury due to 1b: Cardiac arrest due to 1c: Buprenorphine, etizolam and pregabalin intoxication.

4. In terms of section 26(2) (d) (cause or causes of any accident resulting in death):

The deaths of Mr Thompson, Mr Garscadden and Mr Bauba did not result from an accident.

5. In terms of section 26(2) (e) (the taking of precautions):

There are no precautions which could reasonably have been taken and which, had they been taken, might realistically have resulted in the deaths of Mr Thompson, Mr Garscadden and Mr Bauba being avoided.

6. In terms of section 26(2) (f) (defects in any system of working):

There were no defects in any system of working which contributed to the deaths of Mr Thompson, Mr Garscadden and Mr Bauba.

7. In terms of section 26(2) (g) (any other facts relevant to the circumstances of the death):

(a) Scottish Prison Service staff should ensure that their First Aid at Work and Emergency Response training is up to date and the training followed by staff when dealing with an unresponsive individual;

(b) Scottish Prison Service managers should robustly manage the system for alerting staff that refresher training is due and ensure that the training is completed timeously.

RECOMMENDATIONS

No recommendations are made under section 26(4) of the Act.

NOTE

The legal framework

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

[2] A fatal accident inquiry is held under section 1 of the 2016 Act and its purpose in terms of section 1(3) is to establish the circumstances of the deaths and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

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

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

Introduction

[5] This inquiry was established as a result of the deaths of three prisoners with HM Prison Shotts within a period of approximately 14 weeks.

[6] This inquiry took place at Hamilton Sheriff Court on 11 March 2024, 11 and 12 November 2024.

[7] Following the evidence on 11 March 2024 it was made apparent that Mrs Irina Bauba, the mother of Marius Bauba who had attended all hearings had raised issues which resulted in the inquiry being paused to allow her to enter proceedings as a

participant and make attempts to secure legal representation and funding for representation at the inquiry. Mrs Bauba was not able to secure funding to enable her to be legally represented and it was agreed that her partner, Mr Bates would represent her.

[8] As a result, representation at this inquiry was as follows:

- The Crown: Ms Guy, Procurator Fiscal Depute;
- Lanarkshire Health Board: Ms Ritchie solicitor;
- Scottish Prison Service: Ms Phillips, solicitor.
- Prison Officers' Association Scotland: Mr Rodgers / Miss McIlwham
- Solicitor for Joanne Garscadden: Ms Miller
- Representative for Mrs Bauba: Mr Bates

[9] The court is grateful to those solicitors and to Mrs Bauba and her partner, Mr Bates. The solicitors carried out further enquiries and investigations timeously and provided Mr Bates and Mrs Bauba with the relevant disclosure to ensure the inquiry could continue hearing evidence without unnecessary delay. In addition, six Joint Minutes of Admissions were lodged. One Joint Minute each in relation to the deaths of Mr Thompson, Mr Garscadden and Mr Bauba and the fourth, fifth and sixth Joint Minutes in relation to all three deaths. It was also agreed that a number of affidavits and witness statements should be admitted as the evidence of the witnesses and all productions lodged were agreed as true and accurate.

[10] Affidavits were lodged from;

- Mitchell Baillie, Acting Head of Operations, Scottish Prison Service;
- Elizabeth McNamee, Head of Legal Services, Scottish Prison Service;

- Dr Craig Sayers, Clinical Lead for the National Prison care network;
- Trudi Marshall, Nurse Director Health and Social Care, North Lanarkshire;
- Frank Wilson, Compliance Manager, HM Prison, Shotts;
- Suzanne Calder, Head of Health, Scottish Prison Service;
- Kirstie McIntyre, Learning and Development Manager, HM Prison Shotts.

[11] I heard evidence from Mitchell Baillie on 11 March 2024.

[12] I heard evidence from Steven Smith, Adam Lang and Sean McCracken on 11 November 2024.

[13] I heard evidence from David Wood, Claire Fitzgerald and Yvonne Kanjewe on 12 November 2024.

[14] Following the conclusion of evidence I directed parties to lodge written submissions which were submitted prior to hearing additional oral submissions on 27 January 2025. I do not intend to narrate all of the submissions made, but have taken them into account and thank all parties for their assistance in this regard.

Thomas Thompson

[15] At the time of his death Mr Thomson was serving a 4 year custodial sentence imposed at Greenock Sheriff Court, having pled guilty to a contravention of Section 49(1) of the Criminal Law Consolidation (Scotland) Act 1971. The sentence was backdated to 29 January 2018. Mr Thompson was considered for release by the Parole Board of

Scotland on two occasions during his sentence; on 17 December 2019 and 17 September 2020. On both occasions parole was not granted. Mr Thompson's earliest date of liberation was calculated as 28 July 2021, with a sentence expiry date of 28 January 2022.

[16] At the date of his death on 17 April 2021 Mr Thompson was a prisoner of HM Prison, Shotts. He was accordingly in legal custody as at the date of his death.

[17] Mr Thompson had a significant number of previous convictions dating back to 1991, when he was first detained within a young offenders institution. These include drug possession and supply. The Criminal Justice Social Work (CJSW) report prepared in advance of his sentencing noted that he reported suffering from chronic intravenous arterial damage, depression, and that he was also permanently blind in his left eye. It was noted that records indicated that his health difficulties were linked to his drug and alcohol misuse. The CJSW report also indicated that he had reported using cannabis from the age of 13 years old, progressing to heroin at around the age of 20 years old; subsequently using heroin intravenously. Mr Thompson reported that he had been drug free for a period of around 8 years at the time of his sentence and was prescribed methadone 30ml daily.

[18] Following his sentence, Mr Thompson was imprisoned within HM Prison Greenock until his transfer to HM Prison, Shotts on 18 June 2018.

[19] In April 2018, whilst on remand at Greenock, Mr Thompson was placed on MORS (Management of an Offender at Risk due to any Substance) following an incident when he attended at the prison healthcare centre in relation to another matter but was observed to be increasingly drowsy and suspected to be under the

influence of a substance. Prison healthcare staff requested attendance of an ambulance and the deceased was conveyed to hospital, before being returned to the prison on the same day following assessment.

[20] At the time of his transfer to HM Prison, Shotts it was recorded on Mr Thompson's healthcare transfer form that he was suffering from "poor vascular sufficiency to legs", varicose veins, and ulceration to the lower left leg. It was also recorded that he was suffering from ongoing pain to his right knee, hypertension, and depression. It was noted that Mr Thompson had had previous contact with mental health services, but no history of self-harm or suicide.

[21] Mr Thompson underwent mandatory drugs tests in October 2018, October 2019, and January 2021. All tests provided negative results.

[22] In May 2020 Mr Thompson was placed on MORS following an incident when he attended at the prison healthcare centre and was suspected to be under the influence of a substance. Mr Thompson denied having taken any illicit substances, instead stating that he had taken only his prescribed pain medication but had taken two pills instead of one. The prescribed medication was discontinued the following day, as per practice within the prison, and he was offered an alternative pain relief which he refused to take.

[23] On 22 February 2021 Mr Thompson presented to healthcare staff as increasingly sleepy and short of breath. His observations were taken and he was commenced on oxygen. An ambulance was requested by healthcare staff. Mr Thompson denied having taken any illicit substances however was given naloxone 400 micrograms in the

presence of paramedics. His condition improved thereafter, however he refused to attend at hospital.

[24] At the time of death Mr Thompson was prescribed a large quantity of medication, including Pregabalin, Mirtazapine, Tramadol, and Methadone. Both the Methadone and Tramadol were prescribed daily under supervision by healthcare staff. He was entrusted to self-administer all other prescription medication and this was stored within a safe box in his cell

Circumstances of the death of Mr Thompson.

[25] At the time of the Mr Thompson's death Covid-19 restrictions were in place in HM Prison Shotts. As a result of these restrictions, prisoners were locked in their cells at approximately 1700 hours and a final numbers check was conducted. Mr Thompson was last seen alive at around 1645 hours on 16 April 2021 when he was locked within his cell following the evening meal by Prison Officers. Mr Thompson was located within cell 3/13, being a single occupancy cell on level 3 of Lamont Hall. He was described as being "in good spirits" throughout the day and shortly before lock-up he had requested some bags of cereal from the store cupboard which he was given.

[26] At approximately 0730 hours on 17 April 2021 Prison Officers began carrying out a numbers check. At around 0750 hours they unlocked the deceased's cell, and Officer Murphy entered. At this time Mr Thompson was observed to be unresponsive on the cell floor in between his bed and the desk unit. He was observed to be lying on his left side with vomit around his head area and his extremities were white in colour

and cold to touch. Mr Thompson's bed did not appear to have been slept in. Officer Murphy immediately called a "code blue" using her radio.

[27] Prison nurse MacPherson attended at Mr Thompson's cell between 0750 and 0755, alongside first line managers, officers Williams and Robertson and other staff who were working on Lamont Hall that morning. Mr Thompson's body was found to be very stiff and rigid. An ambulance was requested to attend. Prison nurse MacPherson checked the deceased's temperature with a tympanic ear thermometer which indicated a very low temperature and advised that Mr Thompson appeared to be dead. Paramedics arrived at around 0810 hours and at 0815 hours Mr Thompson's life was pronounced extinct. The cell was thereafter locked and secured with Mr Thompson within. Police Scotland were contacted and CID officers attended. A private ambulance arrived at around 1306 hours and Mr Thompson was removed from the cell and conveyed to the mortuary at Queen Elizabeth University Hospital, Glasgow for post mortem

The Cause of Death

[28] A post mortem examination was conducted by Consultant Forensic Pathologist, Dr Julie McAdam on 12 May 2021. The cause of death was: 1a. Methadone, etizolam, tramadol and pregabalin intoxication.

[29] The conclusion of the examination was:

> "Post mortem examination confirmed the presence of large ulcers on both legs, but there was no convincing evidence of systemic infection. The heart was heavy as compared to height but was within the normal range as compared to

> body weight and appeared of normal configuration and there was no evidence of natural disease to account for death.
>
> The history of drug abuse is noted and analysis of post mortem blood revealed a level of methadone which would be consistent with therapeutic use, but no information provided regarding this man's prescribed medication. Also present in the blood was etizolam (illicit benzodiazepine) with a higher than therapeutic level of pregabalin (anticonvulsant, analgesic), a level of tramadol (opioid analgesic) within the fatal range, a higher than therapeutic level of mirtazapine (antidepressant), a higher than therapeutic level of amitriptyline (antidepressant) and therapeutic levels of chlorphenamine (antihistamine) and gabapentin (anticonvulsant/analgesic) and quetiapine (antipsychotic). Although the level of amitriptyline is higher than would be expected with therapeutic use, it is well-recognised that this drug can undergo post mortem redistribution, i.e. the levels can rise in blood after death and this could explain the level detected in this case.
>
> In summary, methadone and etizolam with the high levels of tramadol and pregabalin would have acted in combination to depress breathing, induce coma and eventually cause death. It is unlikely that any of the other drugs present would have significantly contributed to sedation.
>
> The cause of death is therefore regarded as methadone, etizolam, tramadol and pregabalin intoxication."

Investigation by Police and Scottish Prison Service into the Death of Mr Thompson

[30] On 17 April 2021 an inspection of the cell was carried out by Prison Officer Murphy in the presence of other staff, prior to the attendance of paramedics and it was noted that there did not appear to be any obvious drug paraphernalia within the cell.

[31] Police Scotland were notified of the death at around 0835 hours on 17 April 2021. DS Lawrence attended at HM Prison, Shotts at approximately 1054 hours with his colleague police witness Orr and a scenes of crime officer. DS Lawrence coordinated initial enquiries within the prison which included a search of the cell, seizing items and

liaising with prison staff on duty at the time. DS Lawrence found no obvious signs of injury on Mr Thompson and no apparent suspicious circumstances from his observations within the cell. DS Lawrence noted medication, mirtazapine, in the name of a fellow prisoner during the cell search. DS Lawrence was advised by prison staff that this prisoner had been transferred to another prison the day before.

[32] Following confirmation that Mr Thompson's death was due to drug intoxication, DS Lawrence carried out an investigation to identify the source of the drugs. As part of his investigation, DS Lawrence made a request to prison staff to speak to friends of Mr Thompson in the prison and was informed that no prisoner wished to speak to the police. He also reviewed CCTV showing Mr Thompsons movements on the afternoon and evening of 16 April 2021 until he was discovered deceased in his cell on 17 April 2021. He observed nothing of evidential value on the CCTV to assist with his investigation. DS Lawrence reviewed the content of Mr Thompson's mobile phone handset and his prison calls and found no information to assist in his investigation to identify the source of the drugs. DS Lawrence's interrogation of intelligence systems did not provide any information. DS Lawrence took a statement from Mr Thompson's next of kin who could not provide any information in relation to the source of the drugs.

[33] Mr Thompson's prison issue mobile telephone was analysed by police witness Lawrence and nothing of evidential value was found on the device in relation to drug misuse. The deceased's recent telephone calls were also reviewed following his death by DS Lawrence. Between 13 April 2021 and 17 April 2021 the deceased made 20 calls; 18 of these calls were unsuccessful, either ringing out or the call failing to

connect to the recipient. The two calls which were successful, one to the deceased's father and one to his sister, also contained nothing of evidential value in relation to the deceased obtaining or misusing drugs.

[34] At the conclusion of his investigation, DS Lawrence was unable to identify any suspects who had provided the drugs to Mr Thompson.

James Garscadden

[35] At the time of his death Mr Garscadden was serving a sentence of 4 years, 9 months and 10 days. This sentence was made up of multiple cumulative sentences imposed at various courts for dishonesty and road traffic offences, including 10 convictions for driving whilst disqualified. Mr Garscadden had been in custody since 12 August 2019, and his earliest date of liberation was calculated as 21 November 2023.

[36] At the date of his death on 27 June 2021 Mr Garscadden was a prisoner of HM Prison, Shotts. He was accordingly in legal custody as at the date of his death.

[37] At the time of his death, the deceased was placed within cell 37, Lamont Wing.

[38] Following his appearance at Glasgow Sheriff Court on 12 August 2019 Mr Garscadden was remanded in custody at HM Prison Barlinnie. He was transferred to HM Prison, Low Moss on 11 June 2020 and remained there until his transfer to HM Prison, Shotts on 13 May 2021.

[39] Mr Garscadden was subject to an assessment by healthcare staff as part of the prison admission process on 12 August 2019 and was seen by the Prison General Practitioner on 13 August 2019. He was recorded to be no apparent risk of suicide and

to have no thoughts of deliberate self-harm. It was recorded that Mr Garscadden was misusing drugs, notably cocaine, including recent use four days prior to his admission to HM Prison Barlinnie and that he spent £300 weekly on this habit. Medical records also note a past medical history of anxiety and depression, with the deceased reporting he was diagnosed by his GP 6 months earlier and was prescribed mirtazapine.

[40] On 11 December 2019 Mr Garscadden was seen by the prison GP. The consultation noted that he was not suicidal but he stated he had suffered childhood trauma and was requesting a single cell. The GP advised the deceased to self-refer to the Mental Health Team (MHT) and prison staff advised that if a single cell became available that could be allocated to Mr Garscadden. Mr Garscadden was seen by healthcare staff on 19 December 2019, who reiterated to prison staff to move the deceased to a single cell if one became available. During his time at HM Prison, Barlinnie Mr Garscadden saw Prison healthcare staff for minor ailments including warts on his fingers, fungal infections, rashes related to psoriasis and an injury to his left heel sustained playing football.

[41] On 31 August 2020 Mr Garscadden completed a self-referral to the MHT making childhood disclosures and advised that he required a single cell due to suffering from depression and anxiety, stating that he if had a cell mate he would end up assaulting them. On 1 September 2020 Mr Garscadden completed another referral to the MHT and stated he was "starting to feel violent towards other prisoners". He was seen by a nurse, on 7 September 2020 and it was noted he was well kempt and engaged well with staff. He reiterated his need for a single cell and was noted to be very focussed on this. The

nurse checked prison records for the deceased, which noted he was marked for a single cell until March 2020, after which he agreed to share a cell. Mr Garscadden was notified of this by letter and that Prison staff were aware of the deceased's request and his threats to assault other prisoners.

[42] A further self-referral to the MHT was completed by Mr Garscadden on 15 September 2020 where he cited that he was suffering from low mood and that he was distancing himself from other prisoners, which was causing him distress. He was seen by healthcare staff on 18 September 2020 in response to his self-referral. It was noted that he was struggling to share a cell and his mental health was suffering as a result. Consequently, a single cell was provided to the deceased. On 22 September 2020 his referral was discussed at a MHT allocation meeting. It was noted that his request for a single cell had been granted and that his mood was low. He was to be given self-help literature in the first instance.

[43] On 13 December 2020 Prison staff requested that Mr Garscadden be seen by healthcare staff as he was suspected to be under the influence of a substance. He disclosed to a nurse that he had taken five tablets of mirtazapine the previous evening. Consequently, he was placed on MORS with 15 minute observations. The following day, 14 December 2020, Mr Garscadden was reviewed by the GP where he stated he took the tablets as he was in pain, regretted taking them and denied any intent of self-harm or suicide. It was noted that he was speaking in sentences and was coherent, alert and oriented. His vital observations were checked and were normal. He was removed from MORS and given fusidic acid to be applied to his wound and dressing.

[44] Mr Garscadden was placed on MORS on 10 January 2021, following concerns from prison staff that he had taken an illicit substance, with 15 minute observations to be carried out. Prison staff were advised to remove his vape and any medications in his possession from him. At a review with a GP the following day he denied any substance misuse but at a further review with a GP on 12 January 2021 he admitted he "drank something" which was diluted in his coffee but stated he felt well and the medical records note he appeared alert, oriented and not under the influence. He was removed from MORS.

[45] Mr Garscadden made another self-referral to the mental health team on 19 January 2021 when he requested to speak with someone after he had suffered two family bereavements over the weekend and cited suffering from low mood. He was referred to chaplaincy for support.

[46] On 7 April 2021 Mr Garscadden was placed on MORS following concerns from prison staff that he was under the influence of an unknown substance. A nurse noted that his pupils were equal and reactive and he appeared flushed and was slurring his words. He was placed on 15 minute observations. Mr Garscadden later stated he had taken all of his mirtazapine tablets and this prescription was discontinued. He was reviewed the following day on 8 April 2021 by a GP who noted he was clearly under the influence and unable to stand still. He was continued on MORS with 15 minute observations until 12 April 2021. Following a search of his cell 14 etizolam tablets as well as a number of unknown white tablets, mirtazapine tablets and a loose razor blade were recovered.

[47] On 8 April 2021 the deceased was also involved in an incident with prison staff where he sustained injuries as a result of being restrained. He was seen by a nurse who noted his face was bloody with dried in blood while he stated he was kicked to the face by prison officers. He reported that his wrist was "broken", though there were no visible signs of injury on his body or arms or wrists. At a consultation the following day on 9 April 2021 to review his injuries and his MORS status, Dr Zahid Shah noted his speech was slurred, though he appeared oriented to space and time. Mr Garscadden denied taking anything unprescribed and maintained that he felt fine. Dr Shah continued him on MORS with 60 minute observations. He was also referred to accident and emergency due to the injuries he sustained the previous day. Mr Garscadden was admitted to the Emergency Department of the Glasgow Royal Infirmary on 9 April 2021 due to injuries sustained as a result of becoming violent and assaulting prison officers and thereafter being restrained. He suffered an injury to his right hand and ankle and was provided with a splint and sent back to the prison on the same date. As stated above, he was taken off MORS on 12 April 2021 following a review by the prison GP.

[48] Mr Garscadden was placed on MORS on 28 April 2021 by healthcare staff as prison officers suspected he had concealed drugs although it was noted that he appeared alert and orientated to time, place and person and he was steady on his feet. Given the suspicion that he was concealing illicit drugs he was placed on 15 minute observations with his vape and prescribed medications removed. He was reviewed by the prison GP on 30 April 2021 and denied taking any illicit substances and stated he felt "fine". He

was noted to be fully oriented to space and time with normal speech and gait. Accordingly, he was removed from MORS but a warning issued regarding drug use.

[49] On 1 May 2021 Mr Garscadden was placed on MORS following concerns from prison staff that he was under the influence of a substance. He was placed on 15 minute observations and his vape and all medications removed. Following a search of his cell an etizolam tablet was recovered from his kettle.

[50] Mr Garscadden did not have any significant mental health issues while in prison. However, he was placed on Talk To Me on 2 May 2021 after claiming to a prison officer that he had eaten pieces of metal because he was "sick of this place". He was placed on 30 minute observations and a case conference was arranged for the same day. At the case conference he denied any thoughts of suicide or self-harm but stated he was "fed up" of being on MORS as he was missing visits with his children and was angry. He was assessed as being 'no apparent risk' and was removed from Talk To Me. Mr Garscadden's medical records note that he admitted he had etizolam hidden in his cell (in his kettle) but did not intend to use it. This incident was the sole occasion Mr Garscadden was placed on Talk To Me. He was removed from MORS on 4 May 2021.

[51] On admission to HM Prison, Shotts on 13 May 2021 the admissions process noted that he had no thoughts of deliberate self-harm and was assessed as no apparent risk of suicide. The deceased's prescribed medication is noted as the tropical based creams Kardex and includes Zerobase 11% and Fusidic Acid 2%.

[52] The final contact that Mr Garscadden had with healthcare staff prior to his death was on 8 June 2021 when he reported an injury to his right foot from playing football when another prisoner stood on his foot. He was seen by a nurse, who noted that he had sustained some bruising and was prescribed Ibuprofen, advised to rest and apply ice.

[53] Prison intelligence recorded the deceased was involved in a number of incidents relating to illicit drugs during his incarceration. Six days prior to Mr Garscadden's death, mail intended for him was intercepted and tested positive for "spice".

Circumstances of the Death of Mr Garscadden

[54] At around 1700 hours on Friday 26 June 2021 prison officers attended at Mr Garscadden's cell to carry out a head count before locking prisoners in their cells for the evening. Mr Garscadden was eating his dinner and watching television and did not cause officers any concern.

[55] At around 0100 hours on Saturday 27 June 2021 the deceased was checked by prison officers due to complaints of loud music being played from his cell. The officers checked on him and requested that he turn down the volume of the music, which he was happy to comply with.

[56] At approximately 0740 hours on Saturday 27 June 2021 prison officers were opening the cells to carry out a morning check on prisoners and as per protocol required a visual and verbal response from all prisoners. On attendance at Mr Garscadden's cell, Officer Anderson spoke to Mr Garscadden but did not receive a response.
Mr Garscadden was noted to be lying on top of his bed fully clothed with his head

nearest the cell door and his arm and leg dangling from the bed. Officers Anderson and Clark entered the cell and attempted to obtain a response, however he remained unresponsive. Officer Clark shook Mr Garscadden's head while Officer Anderson shouted and shook Mr Garscadden's arm in order to obtain a response. Officer Clark then took a key and scraped this against the sole of the Mr Garscadden's foot, however he remained unresponsive.

[57] Additional Prison Officers entered the cell and Officer Murray used his radio to call a "Code Blue", to alert medical staff that urgent assistance was required. Mr Murray was informed by vestibule staff there was no nurse in the establishment at that time. Nursing shifts within HM Prison, Shotts at that time were 0800 hours to 1800 hours on weekends and 0700 hours to 1900 hours on weekdays. Officers Clark, Murray and Baillie lifted Mr Garscadden from his bed onto the cell floor. Thereafter, Officers Clark and Baillie administered Cardiopulmonary resuscitation ('CPR'). Nurse O'Brian, who was rostered to work from 0800 hours to 1800 hours arrived at HM Prison, Shotts at 0747 hours and was informed to attend immediately to Lamont Hall, arriving at Mr Garscadden 's cell at approximately 0755 hours in response to the "Code Blue" and provided assistance with CPR. CPR continued until the arrival of the ambulance crew at approximately 0805 hours.

[58] The ambulance crew consisting of a paramedic and ambulance technician took over CPR and noted that Mr Garscadden was asystole. They provided advanced airway support and adrenaline was administered, with no improvement. An additional paramedic attended and assisted with CPR. Mr Garscadden continued to be asystole,

with his pupils fixed and dilated with no respiratory effort. Around 20 minutes after the commencement of CPR, it was agreed that the CPR was ineffective and that efforts should cease as there remained no signs of life. Mr Garscadden's life was pronounced extinct at 0825 hours.

The Cause of Death of Mr Garscadden

[59] A post mortem examination was conducted by Dr Julie McAdam on 15 July 2021. The cause of death was 1a. Cocaine and etizolam intoxication with coronary artery atheroma.

[60] The conclusion of the examination was:

> "Post mortem examination revealed severe atheromatous narrowing of a major coronary artery with non-specific pulmonary oedema and congestion and mild fatty degeneration of the liver.
>
> Analysis of post mortem blood revealed evidence of recent use of cocaine and etizolam, with a low level of alcohol. Cocaethylene was present in blood indicating that alcohol has been used with cocaine, though some of the alcohol level detected could reflect post mortem production. Given that actual cocaine was detected rather than only the metabolites, this drug has been used soon prior to death.
>
> Etizolam is an illicit benzodiazepine type drug, the abuse of which is increasing, it often sold as Valium though is considerably more potent. There is little in the medical literature regarding post mortem and potentially fatal levels of etizolam, but the level detected in this case is higher than often encountered in our experience.
>
> Cocaine is a stimulant drug which most often causes death as the result of cardiac arrhythmia or seizure, whereas etizolam is a sedative drug, but the interactions between cocaine and etizolam are poorly understood.
>
> The presence of pre-existing coronary artery atheroma would have rendered this man more susceptible to the adverse effects of stimulant and sedative drugs.

> In summary, the cause of death is regarded as cocaine and etizolam intoxication with coronary artery atheroma."

Investigation by Police and Scottish Prison Service into the Death of Mr Garscadden

[61] Police Scotland were notified of the death of Mr Garscadden. Detective Constable's McMillan and Kerr attended at HM Prison, Shotts with a scenes of crime examiner at approximately 1010 hours. A systematic search of Mr Garscadden's cell was conducted. Two prison issued mobile phones and a smaller illicit mobile phone were found. A container of orange liquid was also noted and later tested to contain 10.4% alcohol.

[62] The three mobile telephones recovered were examined by Police Scotland with nothing of evidential value found. The next of kin of Mr Garscadden were contacted but they were unable to assist with any information as to where the deceased may have obtained drugs from.

[63] At the conclusion of his investigation, DC McMillan was unable to identify any suspects who had provided the drugs to Mr Garscadden.

Marius Bauba

[64] At the time of his death on 20 February 2020, Marius Bauba was serving a 9 year custodial sentence imposed at the High Court of Justiciary at Glasgow having pled guilty to culpable homicide and to an attempt to pervert the course of justice. The sentence was backdated to 20 February 2020. His parole qualifying date was 20 April

2024. Mr Bauba's earliest date of liberation was calculated as 18 August 2028 with a sentence expiry date of 19 February 2029.

[65] At the date of his death on 27 July 2021 Mr Bauba was a prisoner of HM Prison, Shotts. He was accordingly in legal custody as at the date of his death.

[66] Mr Bauba had a number of previous convictions. These included drug supply.

[67] Following his appearance at Ayr Sheriff Court on 20 February 2020 he was remanded in custody at HM Prison, Barlinnie. He was transferred to HM Prison, Kilmarnock on 6 November 2020 and remained there until his transfer to HM Prison, Shotts on 29 April 2021.

[68] Between June 2020 and April 2021, mail addressed to Mr Bauba was found to contain drugs on 3 separate occasions. The drugs were identified as cocaine and spice. On 3 October 2020 drugs were found in Mr Bauba's cell, identified as "spice". He had a cell mate and both prisoners denied ownership of the drugs. On 15 November 2020, drugs were found on pieces of paper within a newspaper which was slipped out of Mr Bauba's cell for another prisoner to collect, these drugs were identified as "spice". Mr Bauba was put on report. On 18 November 2020, Mr Bauba's cell and person were subject to an intelligence led search using drug detection dogs. Mr Bauba handed over pieces of paper, identified as spice. He was put on report. On 19 November 2020, the Mr Bauba's cell and person were subject to an intelligence led strip search. Officers recovered eight and a half pills, identified as morphine and diazepam, and thirty two stamp sized pieces of paper, identified as spice. Mr Bauba was not prescribed morphine or diazepam and was put on report.

[69] On 26 June 2021, Mr Bauba was found to be under the influence of an unidentified illicit substance and was put on report and MORS with 30 minute observations and he provided a verbal response at each of these. This continued until 28 June 2021. No referral was made to addiction services.

Circumstances of the death of Mr Bauba.

[70] At 1230 hours on 23 July 2021 Prison Officer Smith saw Mr Bauba at cell lock up in his single occupancy cell within Allanton Hall 4 in Cell 64.

[71] At approximately 1340 hours, Prison Officer Smith was unlocking the cells after lunch and found Mr Bauba unresponsive, lying on his bed with his feet hanging off his bed and his head fully back. Officer Smith states that he raised his voice to gain a response from Mr Bauba and when he did not get a response he entered the cell and tried to wake him. Officer Smith stated that he checked that Mr Bauba had a pulse using Mr Bauba's wrist, observed his chest rising and falling and concluded that he was breathing. Officer Smith called a code blue using his radio and confirmed over the radio that Mr Bauba was breathing and had a pulse but was unresponsive.

[72] Mental Health Nurse Wood arrived at Allanton level 4 at approximately 1346 hours in order to distribute medication and attended Mr Bauba's cell for a reported code blue. He entered the cell and noted that Mr Bauba was on his left hand side in the recovery position. Nurse Wood heard a snore / grunt type noise from Mr Bauba when he approached him. He tried to find a pulse on Mr Bauba but was unable to distinguish a clear pulse.

[73] At approximately 1347 hours Nurses Fitzgerald and Kanjewe arrived at Mr Bauba's cell. The nurses conducted a check and noted that the deceased's lips, fingers and feet appeared to be blue, cyanosed / hypoxic. Mr Bauba was immediately placed on his back, his head was tilted and his chin lifted. Nurses observed that Mr Bauba's eyes were closed, he was not moving and there were no signs of his chest rising and falling. Nurse Fitzgerald opened his eyes and noted that they were dilated. Mr Bauba's mouth was checked for any sign of obstruction which there was not and it was confirmed by the nurses that he was not breathing. At the same time, Nurse Fitzgerald checked for a pulse and could not detect one.

[74] An oxygen mask was placed on him and at approximately 1348 hours the nurses commenced CPR whilst Mr Bauba was lying on his bed and requested that SPS staff call for a blue light ambulance. At 1350 hours an ambulance was contacted. Mr Bauba was subsequently moved to the floor and nurses continued CPR.

[75] At 1406 hours paramedics Barr and Neil arrived on level 4 at the cell and a further paramedic Baird arrived at 1411 hours. Mr Bauba was moved to the area outside his cell to allow extra room for paramedics to provide advanced life support treatment which included repeated doses of Adrenaline and Naloxone (Narcan). A plastic bag containing 12 partially dissolved Espranor tablets, which were not prescribed to Mr Bauba, 4 pieces of torn paper, 4 unknown yellow tablets and 10 brown unknown tablets in a wrap were found by Paramedic Barr in Mr Bauba's pocket when his trousers were cut off. After approximately 50 minutes, at 1436 hours, a faint heartbeat was established and a plan was formulated to transport Mr Bauba to hospital. At

approximately 1510 hours, Mr Bauba was conveyed by ambulance to the University Hospital Wishaw as a pre alert cardiac arrest, escorted by Prison Officers. No handcuffs were applied to Mr Bauba.

[76] The ambulance arrived at the University Hospital Wishaw Emergency Department at 1550 hours. On arrival Mr Bauba's heart was beating but he was not breathing spontaneously. He had been ventilated by the paramedics prior to arrival at the hospital. Life-saving treatment continued within the Emergency Department however the deceased remained unresponsive throughout. The Intensive Care team reviewed Mr Bauba whilst in the Emergency Department and he was then transferred to the Intensive Treatment Unit (ITU). Mr Bauba was admitted to the Critical Care Unit at 1730 hours. He was intubated and ventilated and given post cardiac arrest care. Mr Bauba was examined by hospital staff routinely overnight and the following morning. Dr Lang, Consultant in Intensive Care Medicine requested a CT Scan of Mr Bauba's brain. The result of the CT scan of the brain was compatible with severe hypoxic brain injury and there was no bedside evidence of brainstem function off sedation. Between approximately 1908 hours and 1926 hours on 24 July 2021, Dr Lang and Dr Kerr carried out two tests for the diagnosis of death using neurological criteria, which confirmed that death had occurred following the irreversible cessation of brain stem function. Dr Iain Lang completed a Do Not Attempt Cardiopulmonary Resuscitation form in relation to Mr Bauba as CPR would have been unlikely to be successful due to brainstem death. Mr Bauba's life was pronounced extinct at 1908 hours on 24 July 2021. His mother and father were with him.

The Cause of Death of Mr Bauba

[77] A post-mortem examination was conducted on 11 August 2021 by forensic pathologist Dr Gemma Kemp on 11 August 2021 at the Queen Elizabeth University Hospital, Glasgow. The cause of death was 1a: Global ischaemic brain Injury due to 1b: Cardiac arrest due to 1c: Buprenorphine, etizolam and pregabalin intoxication.

[78] The toxicology report confirmed the presence of Etizolam and its metabolite Alpha- hydroxyetizolam, Amitriptyline, Buprenorphine and its metabolite Norbuprenorphine, Lignocaine, Pregabalin, and Alcohol within Mr Bauba's blood and urine samples. Mr Bauba was prescribed Amitriptyline 15mg nightly and was administered lignocaine whilst a patient at Wishaw General Hospital.

[79] An examination of Mr Bauba's brain confirmed global ischaemic brain injury.

[80] The conclusion of the Post Mortem examination was:

> "Post mortem examination findings indicate that Marius Bauba died as the result of global ischaemic brain injury due to cardiac arrest which in turn had been caused by buprenorphine, etizolam and pregabalin intoxication.
>
> External examination noted needle puncture marks on the right side of the neck, back of both hands and on the front left wrist. No significant injuries were noted. Internal examination found no significant natural disease that could have caused or contributed to the death. Specialist neuropathological examination of brain slices found global ischaemic brain injury.
>
> Toxicological analyses of blood taken in hospital during life and post mortem blood found low levels of pregabalin, which is an analgesic/anticonvulsant medication that is increasingly being encountered as a drug of abuse. Lignocaine is an antiarrhythmic medication administered in hospital which was found in the post mortem blood sample only.

> A therapeutic level of amitriptyline (antidepressant) was found in the post mortem blood. There were low levels of alcohol in the post mortem blood and urine. Buprenorphine is an opioid analgesic used to treat heroin dependency, but which is also subject to abuse; it was found in the post mortem blood and urine with its metabolite norbuprenorphine. Etizolam, a substituted benzodiazepine which is not licensed for medicinal use in the United Kingdom, was found in the post mortem blood at a high level with its active metabolite alpha- hydroxyetizolam.
>
> Opioids, benzodiazepines and gabapentinoids when taken in excess and/or in combination can cause respiratory depression, coma and death. In this case the combined drug intoxication has caused cardiac arrest leading to a period of ischaemic brain injury which ultimately caused the death."

Investigation into the Death of Mr Bauba by Police and Scottish Prison Service

[81] Police Scotland were notified of the death of Mr Bauba. DC Gorman conducted enquiries including confirming Mr Bauba's prescribed medication with HM Prison Shotts health care staff, reviewing CCTV, interrogating his mobile phones and prison calls, instructing forensic analysis of the drugs found on Mr Bauba's body and within his cell and taking witness statements. DC Gorman was advised by prison staff that associates of Mr Bauba were unwilling to provide any information about his death.

[82] The unidentified tablets and pieces of paper seized from Mr Bauba's cell and from his person by paramedic Barr were analysed and identified as ADB Butinaca (class B), MDMB-4en-PINCA (class B), Buprenorphine (class C), and Amitriptyline, a class c drug which is not controlled.

[83] Police Scotland analysed Mr Bauba's prison issue mobile phone and sim card. The analysis reported that there were 569 SMS messages between 14 May 2020 and 22 July 2021. There were multiple messages sent to the phone up until 22 July 2021

indicating that Mr Bauba was supplying drugs to other prisoners. These messages indicated requests from prisoners for specific drugs and other illicit substances with mentions of "hooch", and "et". There was a sim card found in the deceased's cell which was analysed. The only message on this sim card was "Can u chebk mail for 200plsx". There was no date or time stamp on this message.

[84] At the conclusion of her investigation, DC Gorman was unable to identify any suspects who had provided the drugs to Mr Bauba.

Issues for the Inquiry

[85] The deaths of Mr Thompson, Mr Garscadden and Mr Bauba within HM Prison, Shotts occurred within a period of approximately 14 weeks, were all drug related and therefore raised legitimate concerns. The specific issues explored during the inquiry were as follows:

1. How illegal drugs enter the prison estate generally.
2. How illegal drugs and prescription medication circulate within the prison population.
3. The SPS's policies and procedures to prevent them doing so and to manage the situation where they nevertheless do so (including the MORS policy).
4. Whether / to what extent those policies and procedures were followed.
5. The code red / code blue process.
6. The use of naloxone within HMP Shotts.
7. Nursing shifts.

8. Mr Bauba's removal from Rule 95.
9. Why did the prison officers place Mr Bauba facing the wall?
10. How were staff able to monitor Mr Bauba for deterioration in that position?
11. How did the prison officers decide that placing Mr Bauba towards the wall was the best position for him to allow his airway to be opened with his chin tilted?
12. Are prison officers and those working in the prison required to be first aid trained?
13. What training did the prison officers receive?
14. Was their training up to date?
15. Did the prison officers follow their training with Mr Bauba?
16. Why did the prison officers not take the SPS crash pack to Mr Bauba's cell?
17. Did the prison officers carry out a full head to toe examination of Mr Bauba?
18. Why did some of the officers check Mr Bauba for a pulse when it is not part of their training?
19. How did Nurse Wood monitor Mr Bauba without changing his position?
20. Why did Nurse Wood not change Mr Bauba's position?
21. Was Nurse Wood trained in first aid and was his training in date?
22. Were Nurse Wood's initial actions in line with the training he received?
23. Why are the accounts of the two nurses who attended after Mr Wood so different to his account?

24. What guidance is given to nursing staff about providing CPR on a mattress and was the guidance followed when treating Mr Bauba?

25. Was a defibrillator available and summoned for Mr Bauba? Were staff trained in the use of the defibrillator? Was it used or not, and why?

26. Why did the nurses not administer naloxone to Mr Bauba?

Drugs within HM Prison, Shotts (Issues 1, 2, 3 and 4)

[86] The short timescales between the deaths of Mr Thompson, Mr Garscadden and Mr Bauba are concerning and raise issues over how controlled drugs and other illicit substances are able to enter and circulate within the Scottish Prison Estate. The inquiry heard evidence from Mitchell Baillie in the form of Affidavit and parole evidence. At the time, Mr Baillie was the Acting Head of Operations at HM Prison, Shotts. He is a very experienced officer with 30 years experience in a variety of operational and management roles with the Scottish Prison service. At the time he gave evidence he was responsible for the security of the prison.

[87] It was apparent from his evidence that the presence of controlled drugs within the prison estate is something which is recognised and taken very seriously by the SPS within an ever-changing environment. It was also apparent from his evidence that there is an awareness of the most common methods of entry for these substances and there are measures in place to tackle them which can be described as follows;

- Thrown over the walls or fences of prisons into areas of the establishment for collection and distribution by prisoners within.

- There are regular staff internal and external patrols, staff trained to be constantly observant; CCTV cameras inside and outside the establishment and prisoner searches.

- The use of drones to carry packages over the prison walls.
  - Prisoners open their windows and use something to hook onto the wire attached to the drone to pull the package towards their cell window. I understand from the evidence heard at the inquiry that this is not an issue at HM Prison, Shotts as the windows of the cells do not open, but instead are fitted with ventilation slots. HM Prison, Shotts also has Geofencing which is a technology designed to disable drones.
- Mail soaked in liquid drugs or containing secreted illicit substances.
  - In the presence of the prisoner, staff open the mail, allow the prisoner to see it and then it is photocopied and the prisoner is given a photocopy. The original is kept until their release if requested or shredded. This policy was introduced in December 2021 which is after the deaths of Mr Thompson, Mr Garscadden and Mr Bauba.
- Parcels posted to the prison from suppliers or family members of inmates.
  - A rapiscan itemiser machine is used to scan any item when there is a suspicion that the item contains illicit substances. This machine is a drug detection scanner and is updated regularly to test for a range of new substances.
- Deliveries of prison supplies by third parties.

- All vehicles are searched and drivers are subject to a disclosure check and if there are any suspicions, subject to a rub down search and they are always supervised. Staff remain with vehicles for the entire period and CCTV cameras are used to monitor.

- Prison visits.
  - Visitors must walk through a scanner, their outer garments and personal belongings are put through a scanner and they must store items that are not permitted into the prison in lockers. Officers can ask a visitor to consent to a search. Prisoners all receive a rub down search when they leave the visiting room and certain prisoners will be targeted for body search if staff have observed something suspicious during the visit.
- Prison movement.
  - There is a process of rub down searches. There are also metal detectors and wands used when prisoners are leaving a hall. The national tactical search unit attend regularly and use drug detection dogs.
- Staff corruption.
  - Intelligence is used to identify corruption within SPS staff, partner agencies and contractors. Scottish Prison Service have an Anti-Corruption Policy which is used to raise awareness amongst staff, identify corruption and support those potentially at risk of corruption. Disclosure background checks are conducted on staff, including SPS

employees, partners and contractors and staff are subject to random searches.

- Abuse of prisoner medication.
    - There are regular checks by NHS staff to ensure prisoners have the appropriate amount of medication which can be issued on a weekly basis and stored in a safe in a prisoner's cell. Prisoners who are on supervised medications such as methadone, are subject to tight and restricted movement on taking those medications. NHS staff supervise the taking of medication.

[88] SPS liaise closely with the Police Service of Scotland. In his Affidavit Mr Baillie confirmed that HM Prison Shotts has a very active intelligence team who frequently request the attendance of the national tactical search team with drug detection dogs. There was also evidence that SPS policies are adapted in light of intelligence. Mr Baillie confirmed that intelligence informed them that brightly coloured shredded mail was being intercepted by prisoners trying to find mail contaminated with illicit substances. As a result coloured shredded paper is disposed of separately to avoid this tactic being used.

[89] Elizabeth McNee, Head of Legal Services provided evidence that a new x-ray scanner was to be introduced into HM Prison, Shotts. These scanners are similar to those installed at airport security, will be used on prisoners and will give medical grade images to identify substances.

[90] Mr Baillie was candid in his evidence that the only way to prevent illicit substances entering the prison estate was to create a sterile environment and to take security to a level which would involve visits being non-contact, more resource required to introduce more searches and even then the issue of corruption would have to be eliminated. Whilst he did not think that it would be possible currently to completely stop illicit substances entering the prison system there are appropriate policies and procedures that have been put in place to combat the significant challenge the SPS face. The SPS also have policies in place to support and keep individuals safe who are found to be under the influence of illicit substances. Dr Sayers, in his Affidavit confirmed that the aim of Management of an Offender at Risk due to any Substance Policy (MORS) is to identify and observe patients at risk of overdose due to the use of illicit or prescribed substances. As stated above both Mr Thompson and Mr Bauba were placed on MORS. At the time of his Affidavit, Dr Sayers confirmed that this policy was under review.

[91] Taking all of this into account I found that there was no evidence before the inquiry that the relevant policies and procedures were not followed by SPS staff.

The Code Red / Code Blue Policy (Issue 5 and 16)

[92] The Code Red / Code Blue Policy was raised as an issue following the Death in Prison Learning Audit & Review (DIPLAR) held in relation to the death of Mr Bauba. Following investigation it transpired that there was no breach of the policy.

[93] In essence the Code Red and Code Blue are the two emergency codes used in Scottish prisons to convey quick and specific information to initiate a timely response.

Code Red is when an individual is bleeding and requires an immediate health care assessment. Code blue is used when an individual is experiencing severe breathing difficulties and may or may not be responsive, irrespective of the cause.

[94] In the DIPLAR for Mr Bauba a learning point/recommendation was recorded as: "Reminder of code blue/notification to staff process".

[95] On 23 July 2021, the relevant radio call which was recorded confirmed that a code blue was called by Officer Smith when he discovered Mr Bauba at the point that he unlocked the cell.

[96] Mr Frank Wilson, the compliance manager and the suicide prevention manager at HM Prison Shotts provided evidence by affidavit. Mr Wilson said that as part of his role as the suicide prevention manager, he organises the DIPLAR process following every death in custody within HMP Shotts, invites all relevant persons and ensures each DIPLAR is completed within the appropriate timescales. At the conclusion of the DIPLAR, Mr Wilson circulates the minutes to all parties involved and the independent chair, who will all sign off the minutes, following which the DIPLAR is officially recorded and stored.

[97] Mr Wilson explained the reason why code blue is mentioned as one of the action points in the DIPLAR of Mr Bauba. He stated that this was a general point and not directly associated to Mr Bauba's death, explaining that there were a number of deaths in the establishment after Mr Bauba died and before the DIPLAR was complete, where some of the staff were not following the policy and were radioing for a nurse without using the appropriate code. Mr Wilson said that he does not believe there were any

issues with the radio code calls after Mr Bauba was discovered. Mr Wilson said that they felt each DIPLAR should be used as an opportunity to reiterate the policy and best practice to staff.

[98] An issue which did arise in relation to the policy in the deaths of Mr Garscadden and Mr Bauba related to crash packs. Paragraph 5.4 of the SPS Code Red / Code blue Policy states that "Following a CODE being relayed by radio an SPS member of staff should immediately uplift a crash pack and take it to the scene of the incident". From the evidence it would appear that no SPS crash pack was taken to Mr Garscadden's cell or Mr Bauba's cell when the respective code blues were called.

[99] The pathological and toxicological evidence confirms that the absence of the crash pack when officers initially attended the cells of Mr Garscadden and Mr Bauba was not relevant to the circumstances of their deaths. There was, however, a lack of understanding of the process and the responsibility on the officers involved in these cases. I understand that this issue is being addressed by SPS in their review on all policies in relation to emergency procedures referred to in paragraph 110 below.

The Use of Naloxone (Issue 6 and 26)

[100] Naloxone is a medication administered to reverse the effects of an opioid overdose. The inquiry considered the use of naloxone within HM Prison, Shotts and whether it should have been administered to Mr Bauba.

[101] The Scottish Prison Service have policies in place in relation to the use of naloxone. On 31 July 2018 Scottish Prison Service issued a Governors and Managers

Action (GMA) 046A/18, the subject of which was naloxone administration in emergency situations during night shift. Governors / Directors were to liaise with the NHS Prison Health Board Leads and develop a safe operating procedure for the supply of naloxone, to put in place a system to ensure that naloxone kits are stored safely and securely within residential areas accessible to prison staff during the night shift.

[102] On 9 June 2023 the SPS issued GMA 022A/23 the subject of which was training for operational staff in overdose prevention, intervention and administration of intranasal naloxone (nyxoid). The GMA advised all operational prison staff that they could access training in overdose prevention, intervention and the administration of intranasal naloxone on a voluntary basis, to provide a rapid response to a suspected opiate overdose incident within establishments. Staff will have a supply of naloxone for use in emergency situations. The Scottish Prison Officers Association are supportive of the roll out of the training.

[103] The SPS Code Red / Code Blue Revised Guidance dated October 2016 regulates what is contained in a crash pack. It is contained in Table 1. It does not include naloxone

[104] NHS Staff of Lanarkshire Health Board within HMP Shotts will follow their Standard Operating Procedure for the administration of naloxone in HMP Shotts to ensure that patients are provided with the appropriate emergency intervention in cases of suspected opiate / opioid overdose.

[105] In relation to Mr Bauba, Officer Smith in his evidence stated that he had assumed Mr Bauba was under the influence of a substance. From his evidence this assumption

was based on the prevalence of drug deaths within HM Prison, Shotts at that time. Whilst he did not communicate this assumption to the nurses, it was not based on observations or evidence of drug consumption in general or opiate consumption in particular by Mr Bauba. Both nurse Kanjewe and Fitzgerald did not see anything in his cell to indicate drug consumption by Mr Bauba. Nurse Fitzgerald is trained in administering naloxone and at that time would have been very experienced in identifying opiate and opioid overdoses and was experienced in administering naloxone She stated that the typical signs of an opioid overdose are small pupils, low stats and respiratory failure. It was her clinical judgment that Mr Bauba did not present with any signs of opioid overdose and the immediate priority was to get his heart started again. As naloxone is only administered if there is evidence of drug consumption this was not considered by the nurses and they prioritised the preservation of Mr Bauba's life and the commencement of CPR.

[106] Nurses Wood, Fitzgerald and Kanjewe confirmed that they had received annual basic life support training and had followed their training in their interaction with Mr Bauba. Mr Joe Douglas, Senior Advanced Nurse Practitioner reviewed Mr Bauba's prison medical records and his evidence was agreed by the parties. His evidence was that as Mr Bauba was in established cardiopulmonary arrest it was appropriate to prioritise Cardio Pulmonary Resuscitation rather than administer naloxone.

[107] Dr Kemp, the Consultant Forensic Pathologist was asked whether the administration of naloxone may have changed Mr Bauba's condition and his subsequent death. Her view was that Mr Bauba was found to have the opioid drug

buprenorphine in his blood at the post mortem, but also had a high level of the benzodiazepine drug etizolam and a low level of the gabapentinoid drug pregabalin. Dr Kemp explained that naloxone would not have had an effect on the benzodiazepine or gabapentinoid intoxication. Additional toxicology results confirmed the same drugs identified in his hospital admission as his post mortem blood.

[108] Dr Iain Lang, Consultant in Intensive Care medicine, who treated Mr Bauba whilst a patient in University Hospital Wishaw provided the opinion that Mr Bauba had suffered a cardiac arrest at HM Prison Shotts, most likely as a result of toxicity. Mr Bauba was confirmed brain stem dead in the hospital ICU secondary to hypoxic brain injury. He stated that the administration of naloxone in this case would not have influenced the outcome. If the nurses who had attended to Mr Bauba in his cell had administered naloxone when he was first found it would not have changed the outcome in his view.

[109] In the absence of any evidence of drug consumption it seemed to me that the actions of the nurses were reasonable and appropriate. In addition the expert evidence provided to the inquiry was that it would not have changed the outcome for Mr Bauba.

[110] Suzanne Calder, Head of Health at SPS Headquarters provided evidence by affidavit and confirmed that SPS have started to review all policies in relation to emergency procedures, including the Code Red / Code Blue policy in addition to the policies in the use of defibrillators, Do Not Attempt CPR and naloxone use. Ms Calder said the Scottish Prison Service intends to bring all these policies under one key policy. Whilst reviewing the Code Red / Code Blue policy it will be recorded that the Scottish

Prison Service crash pack will include naloxone and specifically record where the crash packs will be stored.

[111] From this I understand that the revised policy will include instruction that naloxone will be kept in the Scottish Prison Service crash pack and state where the crash pack will be stored in the prison.

Nursing Shifts (Issue 7)

[112] The issue in relation to nursing shifts arose in the deaths of Mr Thompson and Mr Garscadden. Both were found unresponsive when prison officers were opening cells in the morning which according to Mr Baillie was a numbers and welfare check of all prisoners. This commences prior to 0800 hours when nurse's start work. This means that there is a possibility that there is no medical support on site if a prisoner is found unresponsive.

[113] The deaths occurred when restrictions due to the Covid-19 pandemic were applied in HM Prison Shotts. Mr Baillie told the inquiry that prior to the covid pandemic the regime for prisoner unlock hours within HMP Shotts was 0730 hours to 2130 hours, which changed during the covid regime to 0730 hours to 1730 hours. This was the regime in place at when Mr Thompson, Mr Garscadden and Mr Bauba died. Mr Baillie explained that there were several factors for this namely, no NHS staff were available in the evening, social distancing was in place and there was a change of officer's shift patterns.

[114] Trudi Marshall who is the nurse director Health & Social Care North Lanarkshire

provided evidence by Affidavit. She said that nursing staff in HMP Shotts, in common with other Scottish prisons, predominantly provide primary care long term condition management, although they do respond to medical emergencies, along with SPS colleagues. This is to provide basic first aid and that the Scottish Ambulance Service are the first responders to major medical emergencies. Pre covid, nursing cover was provided 0700 hours to 2100 hours on weekdays and 0800 hours to 1800 hours at weekends. During the covid period this changed to 0800 hours to 1800 hours, 7 days per week as prisoners were in their cell all day during the peak covid lockdown (with 1 hour exercise). When restrictions were lifted and prisoners were allowed out of their cells during the day (social distancing compliant), they were still locked in individual cells by 1700 hours. There was no change to the hours that the NHS provided nursing cover to HMP Shotts on the weekends during the covid pandemic.

[115] Ms Marshall said that since November 2023 nursing cover is provided 0800 hours to 2000 hours on weekdays and 0800 hours to 1800 hours at weekends. Nursing staff no longer start at 0700 hours and extend until 2100 hours during the week as there is no access to patients at these times and staff were purely undertaking administrative duties in the health centre. These changes allow the Health Board to maximise the clinical staff available to see patients during the periods when they can access them.

[116] Mr Baillie told the inquiry that the officers started work at 0730 hours and they have 7 minutes to walk to their work location. There are two halls in HMP Shotts, each with four levels. The officer's first task is to do a number check and a welfare check of

all prisoners. Both halls are checked at the same time. Officers would open the door of each cell, obtain a response from the prisoner and lock the cell again. I understand that this generally does not happen before 0750 hours. After the checks are complete, the numbers are reported to the control room. When it is confirmed that all prisoners are in place, a "check correct" code is called, then the staff unlock the "pass men" who are prisoners that work in the prison cleaning or issuing breakfast. Prisoner unlock times have returned to what they were before the covid pandemic, 0730 hours to 2130 hours.

[117] Mr Thompson was discovered by prison officers unresponsive in his cell when they unlocked his cell to carry out a morning check at approximately 0750 hours on Saturday 17 April 2021. At the time that his cell was unlocked, Nurse McPherson was within HMP Shotts and attended at Mr Thompson's cell between 0750 hours and 0755 hours. Mr Garscadden was discovered by prison officers unresponsive in his cell when they unlocked his cell to carry out a morning check at approximately 0740 hours on Sunday 27 June 2021. There was no nurse in the establishment at that time. Prison officers immediately started CPR and an emergency ambulance was requested. Nurse Ms O'Brien was rostered to work from 0800 hours and arrived for work at HMP Shotts at 0747 hours and immediately made her way to Mr Garscadden's cell and assisted with CPR awaiting the arrival of the ambulance.

[118] In the operational debrief following the death of Mr Thompson it was noted that staff were initially advised that there was no nurse on duty at 0745 hours, quickly followed by a call that a nurse was on their way. It was highlighted that nursing staff did not start until 0800 hours on weekends and during the covid regime in place at the

time of the death the prison unlocks at 0730 hours.

[119] Mr Baillie was asked about medical contact when nurses were not working in HMP Shotts. He said that the nurses leave at 2000 hours on weekdays and 1730 hours or 1800 hours on weekends and that there is a process should a prisoner need medical treatment after the nurses leave. HMP Shotts recently implemented the use of the NHS Lanarkshire flow navigation centre, which started as a pilot and has been extended. Prior to this, staff would telephone 999 or NHS24. Now, officers call flow navigation, they give factual information about the patient and flow navigation gives advice to the officers. 999 is still called if there is an emergency.

[120] Mr Baillie was asked about the process for ambulance attendance at HM Prison, Shotts. He was directed to SPS Production Number 47, the HMP Shotts standard operating procedure OPS 204, Call In – Ambulance Service. Mr Baillie explained that on arrival, the ambulance enters the vehicle lock where staff meet the vehicle and check it and the driver. The ambulance crew are met by a manager who gives them access to the patient. The ambulance crew will be escorted by prison staff. If the patient needs to leave the prison for treatment, appropriate security measures are implemented and an officer will escort the patient in the back of the ambulance. The ambulance will be escorted to the vehicle lock and it will leave the prison.

[121] I have concluded that there was no evidence before the inquiry that the timing of nurses attending the cells of Mr Thompson and Mr Garscadden contributed or failed to prevent their deaths.

Mr Bauba's Removal from Rule 95 (Issue 8)

[122] Mr Bauba was removed from a Rule 95 order just 4 days before his death and the inquiry investigated whether there was a link between his removal and his death. The factual position was not in dispute between the parties.

[123] The legal authority for placing a prisoner on a Rule 95 is the Prisoner and Young Offenders Institutions (Scotland) Rules 2011. The Rule authorises the removal of a prisoner from association with other prisoners, either generally or to prevent participation in a prescribed activity or activities. There are a number of grounds which the Governor can be satisfied that removal is appropriate including protecting the interests of any prisoner. Mr Bauba was placed on a Rule 95 from 26 June 2021 to 20 July 2021 for his own protection after his prison issued telephone was found in the cell of another prisoner. There was intelligence that Mr Bauba had been threatened as prisoners thought he told staff about his telephone. Whilst on the Rule 95 he was accommodated in Allanton Hall, cell 64 and at no time was he moved from this cell. He remained in his own cell. Mr Baillie confirmed that there was a case conference on 28 June 2021. Following the case conference Mr Baillie applied to the Scottish Ministers for an extension of the Rule 95, as it was still believed that there was a valid threat to Mr Bauba's safety. This was granted. Mr Bauba was removed from the Rule 95 on 20 July 2021. It was documented that Mr Bauba did not consider that his safety was at risk.

[124] There was no evidence before the inquiry that the Rule 95 order was connected to drugs or that the removal of Mr Bauba from the Rule 95 order was relevant to the

circumstances of his death.

Mr Bauba Facing the Wall (Issues 9, 10 and 11)

[125] The inquiry looked at a number of issues which flowed from the decision to move Mr Bauba when he was found unresponsive so that he was facing the wall of his cell. The evidential position in relation to the position and the re-positioning of Mr Bauba to face the wall was not in dispute.

[126] Officer Smith unlocked Mr Bauba's cell after lunch and discovered him unresponsive. Mr Bauba was lying on his bed closer to the edge of the bed than the wall, with his head where it should have been and his feet hanging off the side of the bed towards the door. Officer Smith described the bed as narrower than a single bed, about two foot wide and that you could touch the wall standing next to the bed. When Officer Smith put Mr Bauba into the recovery position he rolled him onto his side which resulted in him facing the wall. In his evidence Officer Smith explained that he did this because in his opinion if he had rolled Mr Bauba towards himself, he would have fallen off the bed and possibly injured himself.

[127] Officer Lang, in his evidence said that when he entered the cell, Mr Bauba was on the bed close to the edge and Officer Smith was moving him over so he did not fall off the bed. He assisted to put Mr Bauba into the recovery position.

[128] Officer Smith told the inquiry that he made sure his head was back and the airway open with his upper arm free to feel for a pulse. Mr Bauba's face would have been less than a foot from the wall when he was in the recovery position. Officer Smith

said he was able to monitor Mr Bauba by looking at him. He said he was right above him, standing, and was as able to lean over to monitor him. He said he checked Mr Bauba's pulse and breathing. Officer Smith said when he was in Mr Bauba's cell he did nothing other than observe Mr Bauba, from when he was put into the recovery position until the arrival of the nurses.

[129] In his evidence Officer Lang was also of the view that he was able to monitor Mr Bauba's face by leaning over him. He said that after Mr Bauba was in the recovery position he was checking Mr Bauba's breathing and his airway whilst waiting for the nurses to come.

[130] As a result of his observations, Officer Smith described Mr Bauba as not having much of a pulse, slow, about 30 beats per minute and also described Mr Bauba as "struggling to breathe", describing his breathing as very subtle with no deep breaths. Officer Smith said that at no point did he think that Mr Bauba had stopped breathing or that his heart had stopped beating. If it had stopped beating he told the inquiry that he would have carried out CPR. Mr Smith explained that he did not do CPR as he was satisfied Mr Bauba had a pulse. Officer Lang also advised the inquiry that he would also have carried out CPR if Mr Bauba had stopped breathing.

[131] Nurse Wood was the first medical practitioner to attend Mr Bauba's cell in answer to the code blue call. Although employed as a mental health nurse, he confirmed that all nurses within HM Prison, Shotts are expected to respond if a code red or blue is called. Nurse Wood's involvement was limited. From the cctv evidence he was in the cell of Mr Bauba one minute and one second prior to Nurse Kanjewe

attending the cell who assumed responsibility for Mr Bauba. Nurse Wood said that when he entered the cell Mr Bauba was on his left hand side in the middle of the bed in the recovery position facing the wall. Nurse Wood said he believed he heard a breathing noise similar to a "grunt or a snore" from Mr Bauba as he approached him. Whilst his statement referred to hearing this on two occasions I do not think that this discrepancy is significant given the passage of time.

[132] He said that he tried to rouse Mr Bauba and access a pulse and could see one side of his face and a side on view of his chest. Nurse Wood felt he was unable to obtain a discernible pulse prior to the arrival of Nurse Fitzgerald.

[133] Nurse Wood sated that he tried to rouse Mr Bauba, touching him on his shoulder and speaking to him. Nurse Wood looked around him to see if there was anything that was dangerous to himself and proceeded to feel for a pulse on Mr Bauba's wrist. Nurse Wood said he was unhappy with that as he was unable to get a "discernible full pulse" and it wasn't clear to him if he was feeling in the correct position. Nurse Wood was asked what he means by "discernible full pulse" and confirmed that he could not feel any sign of a pulse on Mr Bauba's wrist. Nurse Wood states he made attempts to feel for a carotid pulse on Mr Bauba's neck and he was unhappy with that because he could not feel a pulse. In his evidence Nurse Wood said he spent up to 50 seconds trying to find a pulse on Mr Bauba by feeling his wrist and his neck. When he was unable to feel a pulse on Mr Bauba's neck he advised that he was going to try to check for a femoral pulse and was about to ask the officers to assist him to move Mr Bauba when the staff nurses entered the room and he handed over to them.

[134] Placing Mr Bauba into a position in which his back was to the wall and he was facing the officers would, as I understand it, have been in line with the SPS Emergency Response Training. The explanation given by the prison officers was that they were concerned that he could have fallen off the bed and injured himself if they rolled him the opposite way to face them. Rolling Mr Bauba over so that he was facing the prison officers would have been in line with training and would accord with common sense as it would have made it easier to monitor him. The key issue is whether the prison officers were able to monitor his vital signs. The only evidence available to the inquiry was from the prison officers who said that they were able to and did in fact continue to monitor Mr Bauba by leaning over him. Nurse Wood's involvement with Mr Bauba last just over one minute. His evidence was that he would have sought assistance to move Mr Bauba but by this stage the nurses had entered the cell and taken over responsibility for Mr Bauba.

[135] There was no evidence presented at the inquiry that the actions of the prison officers or nurse had any impact on Mr Bauba's death or would have resulted in his death being avoided.

First Aid Training (Issues 12, 13, 14, 15, 17, 18, 21 and 22)

[136] The issues in relation to First Aid training primarily arose in relation to the immediate response when Mr Bauba was found unresponsive in his cell. The main issues were whether the relevant officers/medical practitioners were within competence for first aid/emergency response training and whether their training was followed in

their interaction with Mr Bauba. One of those issues related to whether it was appropriate to check for a pulse which was also a feature in relation to Mr Garscadden.

[137] The duties imposed on the SPS under the Health and Safety at Work etc Act 1974 and the First Aid at Work Regulations were a matter of agreement between the parties. It was also agreed that SPS provide training to staff in First Aid in the form of Emergency Response Training. This training was revised in 2019. The training was revised to align to the nationally recognised and regulated Emergency First Aid at Work Training. This training is described as compulsory to role training. This means it is compulsory on appointment and thereafter refreshers are classified as compulsory or critical. Critical training is "where risk to the individual and/or organisation is significant enough to warrant further training and /or evidence of competency, or where it is necessary to inform staff of immediately changing strategy, policy or practice". Compulsory training is "where the organisation deems an individual as unable to continue with specific duties of a role without the training".

[138] Emergency response training is now compulsory core to role training and all staff have to attend training with a refresher course every three years. Although there was some amendment to the timescales for refresher training as a result of the Covid-9 Pandemic it was not significant to the issues in this inquiry.

[139] At the time of Mr Bauba's death officers Smith, Whyte and Brown were out with competency for Emergency Response Training. Emergency Response Training was last completed by these officers on 2 May 2018, 3 November 2017 and 4 September 2013 respectively. Officers Lang and McCracken were within competency.

[140] The inquiry heard evidence in relation to the system in place to ensure core to role training is completed. My Learning Online is a program where each SPS staff member can access their own training records. There is an onus on individual officers to ensure that compulsory training courses and refresher training is completed and up to date. Evidence was heard that 12 weeks before the staff member reaches their renewal date they will receive an automated email, which will also be sent to their first line manager and an electronic system of reminders. From submissions on behalf of SPS I also understand that establishment reports are now run designed to identify those SPS staff who fall out of competency and this is reported to the local senior management team to enable remedial action to be taken.

[141] It is clearly crucial that the system in place for training and refresher training is robustly followed by individual officers and managed by local managers. Whilst I acknowledge that there is in place a system which has been subsequently improved it was disappointing that there was no evidence led before the inquiry to adequately explain why the relevant officers did not make arrangements to complete the relevant training.

[142] As stated earlier Nurse Wood was the first medical practitioner to attend Mr Bauba's cell. Nurse Wood completed the NHS Lanarkshire Adult Basic Life Support training on an annual basis. Prior to Mr Bauba's death he completed this training on 25 April 2018, 20 May 2019, 9 September 2020 and 1 July 2021 and was, therefore fully trained in first aid at the relevant time. In his evidence Mr Wood said he was satisfied that he had followed this training. It seemed to me that he did his best in a very short

period of time to ascertain whether Mr Bauba had signs of life. After approximately 1 minute he handed over to the registered general nurses.

[143] The importance of being in competence for first aid/emergency response training is highlighted when assessing whether the current training was followed.

[144] Officer Smith had completed a number of courses with the last being the Pre 2019 Emergency Response training which was last completed on 2 May 2018. The Emergency Response Training (Pre 2019) that Officer Smith completed says that the responsibility of the emergency responder is to assess the situation, protect the casualties, identify the injury or illness affecting a casualty, give the casualty appropriate treatment and get assistance / call for help – code blue or code red.

[145] Officer Smith considered that he followed the training as he assessed the situation, and his assessment was that Mr Bauba was unresponsive. Officer Smith said that he did not protect the casualty although it is clear from the evidence that he moved Mr Bauba and put him in the recovery position, albeit in a position facing the wall not in line with the relevant training and proceeded to monitor him. Officer Smith said that he assumed Mr Bauba's illness was as a result of being under the influence of an illicit substance, because it was happening often, at the time. Officer Smith did not give Mr Bauba any treatment prior to calling the code blue as he considered there was no treatment to be given.

[146] The Emergency Response Training (Pre 2019) says that a code blue is when an individual is experiencing severe breathing difficulties and may or may not be unresponsive. Officer Smith's understanding of severe breathing difficulties is anything

from laboured breathing to no breathing, explaining that laboured breathing is someone who is struggling to breathe. Officer Smith said that he would describe Mr Bauba as having severe breathing difficulties.

[147] The Emergency Response Training (Pre 2019) states the staff member must conduct a primary survey which includes checking for danger, try to get a response from the casualty, check the casualty's airway, breathing and CPR / Circulation. Officer Smith said he checked for danger, that he initially spoke to Mr Bauba, using his first name "Marius" when he unlocked the cell, and when he got no response he went inside. Mr Smith said he tried to wake Mr Bauba by shaking his shoulder and he said he continued to speak to him. Officer Smith said he checked Mr Bauba's airway to make sure there was no obstruction, and he maintained Mr Bauba's airway. He put Mr Bauba's head back to keep his airway open, unobstructed.

[148] Officer Smith said he would have followed his routine practice and satisfied himself that Mr Bauba had a pulse by checking his wrist and that he was breathing by watching that his chest was rising and falling, no matter how slight. Officer Smith stated that he always checked for a pulse on the wrist as it was more successful than the neck. The Emergency Response (Pre 2019), teaches officers to look, listen and feel for breathing. Officer Smith said he looked for signs of breathing. Whilst he did not refer in his evidence that he listened for breathing or felt for breath he was of the view that Mr Bauba was still breathing from his visual observations. Mr Smith checked for a pulse on Mr Bauba, although the training does not instruct officers to do so. Officer Smith stated that he checked for a pulse despite it not being in the training materials as he had

been first aid trained since he was 16 years old which is how he knows to check for a pulse and the importance of checking for a pulse

[149] Officer Smith confirmed that Mr Bauba was unresponsive and identified the appropriate response was to call a code blue, requesting assistance from the nursing staff. Officer Smith determined that Mr Bauba needed to be placed in the recovery position as previously described. The training Mr Smith received in Emergency Response (pre 2019) in relation to the recovery position was to kneel beside the casualty. He did not do that as Mr Bauba was on his bed and he had to lean over him to monitor him. The next step was to place the arm nearest you into the "how" position. The training instructs that the responder was to bring the arm farthest away across the chest of the casualty and hold the palm of the hand against the nearest cheek, grasp the farthest away leg just above the knee and pull it up keeping the foot on the ground and then pull on the leg to roll the casualty gently towards the responder. Mr Smith disagreed when it was put to him that he did not follow the training, saying that although he did not know what the "how" position was that the scenario in the training is in relation to someone who is on the floor with space, which was not the scenario with Mr Bauba. Mr Smith said that there was a danger of causing further harm if he went with the documentation to roll Mr Bauba towards him and would potentially make him fall onto the floor causing further harm.

[150] Officer Lang believes that when he was in the cell, he too made attempts to wake Mr Bauba, by calling his name and holding on to him to get a response as that is what he would have done. Officer Lang said that he too made sure Mr Bauba's mouth was open

and he was breathing. His evidence was that his normal practice would be to check that Mr Bauba was breathing by watching to see if his chest was moving and feel for it.

[151] Officer Lang said the natural way was to put Mr Bauba toward the wall, if he was put the other way he would fall off the bed. Mr Lang knew that in terms of the relevant training you should pull the casualty towards you but there are circumstances where that would not be done, such as if it put the casualty in danger, or if there was a wall and he could not get on that side.

[152] Officer Smith said he was aware that distressed rapid breathing and pale, gray / blue skin affecting nails, lips and eyelids was a sign that someone wasn't getting enough oxygen and that he monitored that whilst waiting for the nurse, when he leaned over Mr Bauba and was watching him in the recovery position.

[153] Officer Lang could not remember if he could see Mr Bauba's face, but said he would have looked to check his breathing, looking at his chest and face. Mr Lang said that during the time he was in the cell he would have been checking that Mr Bauba was breathing, trying to get a response and checking his pulse, either on his neck or on his wrist. Officer Lang said he would have leaned over Mr Bauba to check on him.

[154] Officer Lang, who attended at Mr Bauba's cell approximately two minutes after Officer Smith, had completed Emergency Response training on 28 April 2021, which was three months before Mr Bauba was found unresponsive in his cell. This version was updated from the version that existed before 2019. The Emergency Response training that Officer Lang completed instructs that upon arrival at a scene an emergency responder must carry out a scene survey. Officer Lang could not recall if he did a scene

survey of Mr Bauba's cell, but said it is what he would have done.

[155] The Emergency Responder is instructed to carry out a secondary survey. This is not included in the training pre 2019 which Officer Smith completed. Part of the secondary survey includes a head to toe assessment of Mr Bauba. Officer Lang could not recall given the time since his involvement if he felt Mr Bauba's skull for cuts bumps bruises or signs of blood and he could not recall if he checked Mr Bauba's face to see if his lips were changing colour. Officer Lang said it was a long time ago and he could not remember, but said he was observing Mr Bauba for signs of injury, to see if he was breathing and to get a response.

[156] Although it was not identified as a specific issue I have also noted that a similar issue arises in relation to officers checking a pulse on an unresponsive person in relation to Mr Garscadden. When Mr Garscadden was discovered unresponsive in his cell on the morning of 27 June 2021 Officer Baillie was one of the officers who responded and attended his cell. Officer Baillie said in his statement dated 27 June 2021 that Mr Garscadden's face had no colour and his lips were blue, his eyes were still and unresponsive. He checked Mr Garscadden for a pulse and could not feel one and Mr Garscadden did not appear to be breathing. Mr Garscadden was moved from his bed to the floor of his cell and CPR commenced.

[157] The pre and post 2019 Emergency Response training does not instruct officers to check for a pulse. The instruction is to commence CPR if the casualty is not breathing. The explanation to check for a pulse in relation to Mr Bauba was provided by Officer Smith who explained that he had been first aid trained since he was 16 years old

which is how he knows to check for a pulse and the importance of checking for a pulse and that he would start CPR when a casualty's heart is no longer beating. Nurse Fitzgerald in her evidence explained that they also checked to see if Mr Bauba had a pulse as they had to make sure Mr Bauba did not have a pulse before they started chest compressions as chest compressions could damage the patient if they have a pulse. When the nurses had completed their checks and confirmed that Mr Bauba had no pulse and was not breathing, they immediately commenced CPR. It was a matter of agreement between all parties that this was one minute after the nurses entered Mr Bauba's cell. There was no evidence that the checking of a pulse had any impact on the death of Mr Bauba or would have resulted in his death being avoided. The position is the same for Mr Garscadden.

[158] Despite some of the officers being out of competence in terms of their First Aid at Work and Emergency Response Training and aspects of the training not being followed there was no evidence before the inquiry that the death of Mr Bauba would have been avoided. The position is the same for Mr Garscadden. For these reasons I make no recommendations in terms of Section 26(2) (e) and (f) of the 2016 Act. The importance of being within competence, the robust management of officers core to role training and the following of the training does, however, merit reference as a fact relevant to the circumstances of the death in relation to Mr Bauba in terms of Section 26(2) (g) of the 2016 Act.

Differences in Nurse's Evidence (Issue 23)

[159] This issue arose in relation to Mr Bauba. In terms of the hand over, Nurse Wood in his statement dated 27 July 2021 stated that he advised Nurse Kanjewe and Nurse Fitzgerald of his initial assessment. In his evidence he said that to the best of his recollection he told nurse Kanjewe that he couldn't get a pulse. Nurse Fitzgerald said in evidence that when she entered the cell someone said that Mr Bauba was making grunting noises and she thought it was Nurse Wood who told her that. In her statement dated 26 July 2021, Nurse Kanjewe said that Nurse Wood told them that Mr Bauba was in the recovery position because he was making grunting noises. In her evidence Nurse Kanjewe said that when they entered the cell they asked what had happened and they were told that they didn't know what had happened, Mr Bauba had been found unresponsive.

[160] Nurse Wood stated that he touched Mr Bauba and he was not cold but could not say if he was a normal temperature. He did not think he was dislcoured and he did not observe cyanosis of the lips or ears. Shortly afterwards, when Mr Bauba was rolled onto his back Nurse Kanjewe considered that his lips, toes and fingers were blue.

[161] It seemed to me that Nurse Wood did his best to ascertain whether Mr Bauba had signs of life. Whilst there were discrepancies between his evidence and the evidence of nurses Kanjewe and Fitzgerald in relation to cyanosis and temperature of Mr Bauba I did not think that in the circumstances these were significant when analysed in the short time frame that Nurse Wood interacted with Mr Bauba compared with the interaction in different positions by nurses Kanjewe and Fitzgerald over a longer period

of time in what was a traumatic event. In addition, there was no evidence that any discrepancies in the accounts of the nurses had any impact on the death of Mr Bauba or would have resulted in his death being avoided.

CPR Performed on Mattress (Issue 24)

[162] There were concerns raised that CPR was commenced on Mr Bauba whilst he was lying on his bed and whether there was any guidance in relation to this and if so whether this guidance was followed. CPR was commenced on Mr Bauba whilst he was lying on his bed. There was conflicting evidence from a number of witnesses in relation to who suggested that Mr Bauba should be moved to the floor to continue CPR, however it is not in dispute that he was moved to the floor and CPR continued.

[163] Nurse Fitzgerald, in her evidence advised that the reason CPR was started while Mr Bauba was on his bed was to ensure that it was started as soon as possible and that she would have done the same if she was in a hospital. Nurse Kanjewe also did not have any concerns about performing CPR on the bed because in her view CPR is as effective on a bed as on the floor. She explained that in a hospital they leave patients on the bed to perform CPR.

[164] It was apparent from the evidence of a number of witnesses that Mr Bauba's bed and cell was small and so the decision was made to transfer Mr Bauba to the floor to continue CPR. Nurse Fitzgerald thought it was appropriate as she considered that there would not be much space for paramedics and in any event he may have had to be

moved from the cell to the section with screens required. Nurse Kanjewe felt there was insufficient space with Mr Bauba on his bed to give effective chest compressions.

[165] Dr Iain Lang, Consultant in Anaesthesia and Intensive Care medicine at University Hospital Wishaw was asked to review the statements of the attending nurses and Mr Bauba's medical records and provide his opinion on the first aid provided by the nurses to Mr Bauba, including the commencement of CPR on his bed. His evidence was agreed by all parties. Dr Lang's opinion was agreed by all parties that Mr Bauba was in established cardio-pulmonary arrest when Nurse Fitzgerald arrived at his cell and "appears to have followed life support algorithms appropriately". Dr Lang is of the opinion that "the position of Mr Bauba on the bed versus on the floor during resuscitation lacks relevance". His view is that resuscitation on a bed is equally effective when compared to the floor. Dr Lang could not identify anything that the nursing staff did or did not do that would have influenced the outcome for Mr Bauba.

[166] Mr Joe Douglas, Senior Advanced Nurse Practitioner reviewed Mr Bauba's records. His opinion was also a matter of agreement between the parties. Mr Douglas noted that Ms Fitzgerald arrived at Mr Bauba's cell "very quickly" and established that he was not breathing and did not have a peripheral pulse and basic life support protocols were initiated. Mr Douglas said commencing CPR on a bed is standard practice in a hospital setting. He noted that it was documented that Mr Bauba was moved to the floor to facilitate better access to the patient due to the limited space in the cell and to facilitate more effective CPR, which he said was a very sensible decision. Mr Douglas said that from the documented clinical notes it appears to him that basic life

support protocols were initiated swiftly and executed correctly.

[167] I was satisfied that the actions of the nurses to prioritise CPR and to adjust Mr Bauba's position form the bed to the floor as the incident progressed was appropriate.

Use of Defibrillator (Issue 25)

[168] The inquiry was invited to look at whether a defibrillator was available and summoned for Mr Bauba, whether staff were trained in the use of a defibrillator, whether it was used or not. Evidence was heard that a defibrillator was brought to Mr Bauba's cell by nurses Fitzgerald and Kanjewe when they responded to the code blue. Nurse Fitzgerald said in her statement dated 27 July 2021 that SPS staff cut Mr Bauba's shirt in order for the defibrillator pads to be attached. Nurse Fitzgerald said that SPS staff attached the defibrillator pads to Mr Bauba as she and Nurse Kanjewe continued with CPR. The defibrillator advised no shocks and CPR continued. As Nurse Fitzgerald and Nurse Kanjewe became exhausted, the officers offered to take over with chest compressions monitored by the nurses.

[169] The Emergency Response Pre 2019, Emergency Response from 2019 and the First Aid at Work training all include a module on using a defibrillator.

[170] I concluded that the use of a defibrillator was not relevant to the circumstances of the death of Mr Bauba nor would it have prevented their deaths.

Any Other Facts Relevant to the Circumstances of the Deaths

[171] The Crown have made a number of submissions arising out of matters which were identified during the course of the inquiry that may be considered relevant to the deaths of Mr Garscadden and Mr Bauba.

[172] The Crown submitted that the SPS process to ensure that officers are competent in their training is not adequate. An associated submission related specifically to the positioning of Mr Bauba into the recovery position. All of the officers had received training but some of the officers had not completed refresher training within the relevant time period contained with SPS policy. In my view the change in guidance from the pre 2019 and post 2019 training compounds the issue of failing to follow the correct procedures when dealing with Mr Bauba. It is essential that officers take responsibility to ensure that training is up to date and managers robustly monitor to ensure compliance. In the case of Mr Bauba there was no evidence that a failing to follow the relevant training and in particular the positioning of Mr Bauba when placed in to the recovery position, checking for a pulse and commencement of CPR would have avoided his death. It is fair to say, however, that at the time of Mr Bauba's death it was clear that the process to ensure that training by SPS Officers was complete was not effective. Although there is a responsibility on individual officers, a robust system to monitor and ensure compliance for core to role training has to be managed diligently by local managers. I have noted the revised process and consider that this should provide an appropriate framework for SPS to ensure compliance if managed diligently. For the reasons outlined above, I have concluded that the issue in relation to training does merit

comment in terms of Section 26(2)(g) of the 2016 Act.

[173] In relation to evidence that the SPS crash packs were not taken for officers to use when Mr Garscadden and Mr Bauba were found in their cells, the crown submission is that all staff should be aware of the contents of the crash pack, the location of the crash pack and a crash pack should have been taken immediately after a code (blue/red) was called. The crown further submit that the policy which makes it mandatory to uplift a crash pack and take it to the scene of the incident is not happening within HM Prison Shotts. The same submission was made on behalf the family of Mr Garscadden.

[174] There was no dispute that crash packs were not brought to the cells of Mr Garscadden and Mr Bauba. From the evidence I accept that the officers were not alert to the precise terms of the SPS policy. However, the evidence was confined to these two cases with some vague general comments and was not explored in depth in relation to general practice. It seems to me, therefore, that this is conclusion is speculative. All the evidence pointed to was a failure to adhere to the policy in the cases of Mr Garscadden and Mr Bauba. This is not to diminish the failure to adhere to the policy. It is clear that the policy should have been followed. From the evidence led at the inquiry this failing did not have an impact on the death of Mr Garscadden or Mr Bauba. I have also noted the review on all policies by SPS in relation to emergency procedures which includes the storage of crash packs. I am content that this review should resolve the issue in relation to crash packs and it seems to me it will also be covered in relation to the training issue referred to above and the associated comments I

have made in terms of Section 26(2)(g) of the 2016 Act. For these reasons I make no recommendation in this regard.

[175] The crown further submitted that the SPS Emergency Response and First Aid training is not adequate as it does not include instructions for officers on the importance of checking a pulse. This submissions rests on limited evidence provided to the inquiry from Officer Smith and Nurse Fitzgerald. The genesis of the guidance, the guidelines it is based on, the science behind them and expert evidence to support this submissions was not part of the inquiry. For these reasons I make no recommendation in this regard.

Conclusions

[176] The deaths of Mr Thompson, Mr Garscadden and Mr Bauba occurred within a short period of time. Despite this, there was no evidence that the deaths were linked other than the involvement of illicit substances and the fact all three were inmates at HM Prison, Shotts.

[177] Following careful consideration of all of the evidence before the inquiry and for the reasons set out, I have made the findings as detailed at the commencement of this determination.

[178] I wish to express my sincere condolences to the families of Mr Thompson, Mr Garscadden and Mr Bauba. It was apparent that Mrs Bauba, who attended all Hearings found the evidence of her son's death understandably difficult. I want to express my gratitude for the submissions made on her behalf and in particular the understanding and empathy she has with the witnesses who attended her son during

the incident.