SHERIFFDOM OF LOTHIAN AND BORDERS AT LIVINGSTON SHERIFF COURT

[2025] FAI 2

LIV-B18-24

DETERMINATION

BY

SHERIFF J FARQUHARSON KC

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

into the death of

JOSEPH ALLAN

LIVINGSTON, 5 December 2024

Findings

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

(1) **In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred):**

Mr Joseph Allan born 7 May 1974, died between 1742 hours on 4 September 2021 and 0802 hours on 5 September 2021 in cell 14, Lomond Bravo Wing, HMP Addiewell, 9 Station Road, West Lothian.

(2) **In terms of section 26(2)(c) of the 2016 Act (the cause or causes of death):**

The cause of death was:

1.a. multi-drug toxicity in a man with coronary artery atherosclerosis.

(3) Makes no findings in terms of section 26(2)(b),(d),(e), (f) and/or (g) of the 2016 Act.

Recommendations

AND FURTHER, the sheriff having considered the information presented at the inquiry, in terms of section 26(1)(b) of the 2016 Act, makes no recommendations.

NOTE

The proceedings and parties

[1] This determination is made following a fatal accident inquiry into the death of Mr Joseph Allan (hereinafter referred to as "Mr Allan").

[2] At the time of his death Mr Allan was in legal custody as he was serving a custodial sentence in HMP Addiewell. Accordingly, this was a mandatory fatal accident inquiry, in terms of section 2(4) of the 2016 Act.

[3] The inquiry was held via a Web Ex link, in Livingston Sheriff Court on 19 November 2024.

[4] The following parties participated in the enquiry:

(i) The Crown (represented by Mr Gregor, Procurator Fiscal Depute:

(ii) The Scottish Prison Service (represented by Mr Richmond, solicitor);

(iii) Lothian Health Board (represented by Mr Holmes, solicitor); and

(iv) Sodexo Justice Services (represented by Ms Clark, solicitor).

No other persons appeared at the inquiry or intimated an interest in the inquiry. Mr Allan's family were not present or represented. They had been provided with a link to view proceedings remotely, but decided not to join on the day.

[5] Fatal accident inquiries are now governed by the 2016 Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 Rules"). The form of a Determination is prescribed by rule 6.1 (ie Form 6.1) of the 2017 Rules which requires the inclusion of certain information within the Determination. In this Determination, I have set out much of this information in the attached Appendix.

[6] I am grateful to all those appearing in the inquiry for their professional contributions, and for the assistance they gave to me during the course of it. All of the evidence in the inquiry was agreed by parties in a joint minute. This included parties undertaking further investigations and agreeing additional matters which I wished to be addressed, in particular whether Mr Allan's blood pressure readings on 2 and 3 September 2021 bore any relevance to his death. As a result of the evidence agreed in the detailed joint minute I did not require to hear oral evidence from any witness.

Procedural history

[7] On 16 January 2024 a notice of an inquiry was given by the procurator fiscal under section 15(1) of the 2016 Act.

[8] A preliminary hearing was assigned at Edinburgh Sheriff Court on 19 March 2024. On that date on Crown motion, there being no opposition, the case was continued

to further preliminary hearings on 23 May 2024 and 20 June 2024 for productions to be received, and on my request for further medical enquiries to be made. A date for the hearing of the fatal accident inquiry on 27 June 2024 was assigned. Unfortunately, due to illness the fatal accident inquiry could not take place on 27 June 2024, and a new date of 19 November 2024 was assigned. The court ordered that a finalised joint minute be lodged, and parties were appointed to provide the court with written submissions at the inquiry.

Information made available to the enquiry

[9] On 19 September 2024, the inquiry was convened.

[10] A joint minute of agreement between the Crown, the Scottish Prison Service, Lothian Health Board and Sodexo Justice Services, was lodged in process. In terms of the joint minute the following documents and other material were admitted in evidence (comprising volumes 1, 2 and 3 of the Crown's productions):

1. Pronunciation of Life Extinct form dated 5 September 2021
2. Intimation of death dated 6 September 2021
3. Final post mortem report
4. Photographs of Mr Allan and his cell on 5 September 2021
5. Forensic Services Drugs Report dated 14 September 2021
6. Prison Medical Records
7. Death in custody folder
8. Death in Prison Learning Audit and Review (DIPLAR)

9. A Significant Adverse Event Review (SAER)

10. NHS Improvement Plan

11. The Management of Offenders at Risk of Substances Policy

12. Affidavit of witness John Morrison (Head of Operations)

13. Witness statement - W (Prison Custody Officer)

14. Witness statement - W (Prison Custody Officer)

15. Witness statement - B (Prison Custody Officer)

16. Witness statement - Elaine Riley (sister of Joseph Allan deceased)

17. Witness statement - R (Senior Prison Custody Officer)

18. Witness statement - M (Senior Prison Custody Officer)

19. Witness statement - Gail Topping (Paramedic)

20. Witness statement - Marc Lunn (Detective Constable)

21. Witness statement - L (Prison Custody Officer)

22. Witness statement - L (Prison Custody Officer)

23. Witness statement - L (Prison Custody Officer)

24. Witness statement - Lorraine Mitchell (Senior Charge Nurse)

25. Witness statement - Lorraine Mitchell (Senior Charge Nurse)

26. Witness statement - Lorraine Mitchell (Senior Charge Nurse)

27. Witness statement - Lynsey Ross (Ambulance technician)

28. Witness statement - Steven Little (Sodexo Rehabilitation Unit Manager)

29. Witness statement - Andrew Meikle (Police Sergeant)

30. Witness statement - John Bowerbank (Detective Sergeant)

31. Witness statement - Kenneth Alexander (Detective Constable)

32. Witness statement - Kayleigh Robertson (Police Constable)

33. Precognition - Dr Ralph BouHaidar (Pathologist)

[11] On 19 September 2024 written submissions had been received and each party adopted the same. I clarified an issue about the chronology of intelligence information provided in the joint minute, which confirmed that the information was passed on following Mr Allan's death and not before. No party wished to make any further oral submissions, and I made avizandum.

A summary of all parties' positions

[12] All parties submitted that the court should make formal findings only in terms of section 26(a) and (c) of the 2016 Act in relation to the date and cause of Mr Allan's death. There were no precautions which could reasonably have been taken, that might realistically have avoided Mr Allan's death (section 26(2)(e)). There were no defects in any system of working which contributed to Mr Allan's death (section 26(2)(f)). I was not invited by any party to make findings under section 26(2)(b),(d) and (g) or any recommendations under section 26(4) of the 2016 Act.

The circumstances of the deceased and his death

[13] On 25 June 1998 Mr Allan was convicted of murder and sentenced to life imprisonment with a punishment part of 8 years, backdated to 27 February 1998.

[14] Mr Allan was released from custody on licence on 15 March 2006, but that licence was revoked on 27 May 2010. Thereafter he was released for a second time on licence on 21 July 2014, but that licence was revoked on 16 January 2015. He returned to custody within HMP Addiewell where he remained until the date of his death.

[15] Mr Allan was well regarded and respected amongst inmates and prison officers alike. He secured a roll as wing gym ambassador on Lomond B. He was hard worker and took pride in this role. He had a historic record of illicit drugs use whilst in custody, but there was no information to alert prison staff that he was sourcing and/or using illicit drugs in the weeks prior to his death.

[16] At the time of his death Mr Allan had various medical complaints that were being managed within the prison environment. He was prescribed a number of medications, specifically: Methadone, Pregabalin, Mirtazapine, Omeprazole and Rivaroxaban. A recent hospital admission in September 2021 and high blood pressure readings on 2 and 3 September 2021, did not cause or contribute to his death.

[17] Throughout the course of the day on 4 September 2021 Mr Allan was described as being his usual self. He engaged positively with staff and other prisoners alike, discussing in particular, a change in his son's care arrangements. Mr Allan was supporting a particular prisoner who had suffered a recent family bereavement. On 4 September 2021 that prisoner was suspected to be under the influence of illicit drugs, and Mr Allan took it upon himself to speak to him and offer advice and support. He confirmed the same to prison officers that evening.

[18] Mr Allan attended the unit dispensary for his night time medication without incident, and was described as being chatty and laughing with prison officers at lock up that evening.

[19] Around 1720 hours on 4 September 2021 Mr Allan was in his cell when the door was locked and secured. He was speaking to prison officers during their numbers check, and said good night. He gave no cause for concern and did not present as being under the influence. Had Mr Allan been deemed to be under the influence, he would have been referred to a nurse for assessment as the prisoner he was supporting, had been earlier on that day. Mr Allan did not activate any alarms whilst in his cell.

[20] At 0802 hours on 5 September 2021 when his cell door was opened by prison officers, Mr Allan was found lying on the floor. He was not breathing, was unresponsive and cold to touch with signs of post mortem staining. A "Code Blue" was activated to alert a medical response. Healthcare workers confirmed that Mr Allan had died. He was lying on the floor on his left hand side with his arms tucked underneath his body and a pillow under his head. Bodily fluids from his mouth and nose had stained the pillow. His body was stiff. Cardiopulmonary resuscitation (CPR) was not performed, as it was clear that Mr Allan had been deceased for some time. An ambulance was requested, and paramedics pronounced life extinct at 1002 hours.

[21] Police attended at Mr Allan's cell at about 1011 hours on 5 September 2021.

[22] Mr Allan's dinner from the night before was sitting untouched on his worktop within the cell.

[23] White powder was seen on the floor of Mr Allan's cell and an empty Pregabalin capsule found nearby. Analysis of the white powder confirmed it was Pregabalin, a prescribed medication. No other controlled drugs were found within Mr Allan's cell.

[24] A post mortem examination of Mr Allan's body was conducted on 10 September 2021. A toxicological examination thereafter, showed the presence of his prescribed medications: Methadone, Mirtazapine, and Amitriptyline. Also present within Mr Allan's system was Etizolam (a benzodiazepine), a non-prescribed class C controlled drug under the Misuse of Drugs Act 1971.

[25] The mixture of drugs (in particular the addition of a non-prescribed medication) in Mr Allan's system, increased his risk of respiratory depression, coma and death. Mr Allan had badly blocked arteries leading to the heart, but there was no evidence post mortem of scarring or heart attack. The effect of the drugs in Mr Allan's system was more important in terms of causing his death.

[26] Intelligence received by prison staff after Mr Allan's death, confirmed that he had taken Etizolam on the evening of 4 September 2021.

Conclusions

[27] Based on the information presented it has been established that the death of Mr Allan resulted from an ingestion of drugs, combined with a pre-existing coronary artery atherosclerosis. These likely acted in combination leading to progressive respiratory depression coma, and ultimately death.

[28] There was no evidence before me that the medical care or the prison care afforded to Mr Allan was in any way substandard. To the contrary, Mr Allan was provided with a high level of care and treatment during his time in prison. No criticism can be made of the health professionals and/or other prison staff involved in his care and treatment.

[29] I am satisfied on the evidence before me that, as submitted by those representing the various parties in the inquiry, there is no need to make any findings other than the formal findings in relation to place and cause of death.

[30] It is regrettable that controlled drugs found their way into the prison estate, and are responsible for the untimely death of Mr Allan.

[31] All of the parties at the inquiry expressed condolences to Mr Allan's family on their own behalf and on behalf of those whom they represented, and to these I add my own condolences.

APPENDIX

The legal framework

[A1] The purpose of a fatal accident inquiry is set out in section 1(3) of the 2016 Act. It is to (a) establish the circumstances of the death or deaths; and (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It is not the purpose of a fatal accident inquiry to establish civil or criminal liability (see section 1(4)). A fatal accident inquiry is inquisitorial, not adversarial (see rule 2.2.(1) of the 2017 Rules).

[A2] Section 1(2) provides that an inquiry is to be conducted by a sheriff. An inquiry can be conducted by a sheriff principal, a sheriff or a summary sheriff exercising the powers of a sheriff. The procedure at an inquiry is to be as ordered by the sheriff (see, in particular, rule 3.8.(1) and rule 5.1).

[A3] As soon as possible after the conclusion of the evidence and submissions in an inquiry, the presiding sheriff must make a determination setting out certain findings and such recommendations (if any) as the sheriff considers appropriate. A determination under section 26 is to be in Form 6.1 (see rule 6.1).

[A4] The findings the sheriff is required to make are set out in section 26(2), namely, (a) when and where the deaths occurred; (b) when and where any accident resulting in the deaths occurred; (c) the cause or causes of the deaths; (d) the cause or causes of any accident resulting in the deaths; (e) any precautions which (i) could reasonably have been taken; and (ii) had they been taken, might realistically have resulted in the

deaths, or any accident resulting in the deaths, being avoided; (f) any defects in any system of working which contributed to the deaths or any accident resulting in the deaths; and (g) any other facts which are relevant to the circumstances of the deaths.

[A5] The making of recommendations is discretionary. The recommendations which the sheriff is entitled to make are set out in section 26(4). The recommendations must be directed towards (a) the taking of reasonable precautions; (b) the making of improvements to any system of working; (c) the introduction of a system of working; and (d) the taking of any other steps which might realistically prevent other deaths in similar circumstances. Recommendations may (but need not) be addressed to (i) a participant in the inquiry; or (ii) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.