SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT DUNDEE

[2025] FAI 38

DUN-B701-24

DETERMINATION

BY

SUMMARY SHERIFF NEIL KINNEAR

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

into the death of

CHRISTOPHER NICOLL

DUNDEE, 26 August 2025

Determination

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

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

On 26 November 2021, Christopher William Nicoll, born 3 March 1980, died within Cell A13, Murray House, His Majesty's Prison Castle Huntly, Castle Huntly, The Drive, Longforgan, Dundee, DD2 5HL. His life was formally pronounced extinct at 2024 hours by Scottish Ambulance Service Paramedics.

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

Mr Nicoll's death did not result from an accident.

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

The acute and chronic adverse effects of buprenorphine (not prescribed), etizolam (not prescribed) and pregabalin (prescribed). Individual levels of the three drugs were below the expected fatal level, but the effect of taking the drugs together had an additive or cocktail effect resulting in a fatal combination.

1.4 In terms of section 26(2)(d) of the Act (the cause of any accident resulting in the death):

Mr Nicoll's death did not result from an accident.

1.5 In terms of section 26(2)(e) of the Act (the taking of precautions):

There were, on the available evidence, no precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death being avoided.

1.6 In terms of section 26(2)(f) of the Act (defects in any system of working):

There were, on the available evidence, no defects in any system of working which contributed to the death.

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

There were, on the available evidence, no other facts relevant to the circumstances of death.

Recommendations

2 In terms of section 26(1)(b) of the Act, there are, on the available evidence, no recommendations to be made.

NOTE

Representation:

Procurator Fiscal: Maleque, Procurator Fiscal Depute.

Scottish Ministers for Scottish Prison Service ("the SPS"), Turner, Solicitor, Anderson Strathern LLP.

Tayside Health Board: Sargent, Solicitor, NHS Scotland Central Legal Office.

Prison Officers Association: Wishart, Solicitor, Thompsons Solicitors.

[1] This is an inquiry into the death of Mr Christopher Nicoll. Mr Nicoll died within Cell A13, Murray House, His Majesty's Prison Castle Huntly, Castle Huntly, The Drive, Longforgan, Dundee, DD2 5HL on 26 November 2021. At the time of his death Mr Nicoll was a serving prisoner at HMP Castle Huntly. This is, accordingly, a mandatory inquiry in terms of section 2(4)(a) of the Act.

[2] The Procurator Fiscal issued a notice of inquiry on 29 October 2024 and preliminary hearings were held on 23 December 2024, 15 and 29 January 2025, 11 March 2025, 4 and 24 April 2025, and 3 June 2025.

[3] At the preliminary hearing on 23 December 2024 the representatives for the Crown, the Scottish Prison Service, Tayside Health Board, and the Prison Officers Association were all agreed that the evidence could be by way of joint minute. Productions and affidavits of witnesses were agreed in the joint minute subsequently lodged in process.

[4] The inquiry was conducted virtually with participants appearing by video conference on 13 August 2025. All evidence was agreed by way of a joint minute of agreement lodged on 12 August 2025. The next of kin of Mr Nicoll having being intimated upon elected not to observe the inquiry.

[5] I have found that Mr Nicoll died of acute and chronic adverse effects of buprenorphine (not prescribed), etizolam (not prescribed) and pregabalin (prescribed). Although the individual levels of the three drugs were below the expected fatal level for each, the effect of taking the drugs together had an additive or cocktail effect resulting in a fatal combination. It is not possible to determine when Mr Nicoll consumed the etizolam based on volumes of drugs found within his blood samples due to varying metabolic rates of different individuals combined with the consumption of other drugs and an individual's medical conditions. On the evidence, there are no systemic defects arising or precautions that might have been taken to avoid the death. I also provide a narrative of the facts which I found established.

The legal framework

[6] This inquiry was held under section 1 of the Act. The relevant procedural rules are found in the Act of Sederunt (Fatal Accident Inquiries Rules 2017) ("the 2017 rules"). The purpose of the inquiry as defined by section 1(3) is to:

(a) establish the circumstances of the death and:

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

It is not the purpose of the inquiry to establish civil or criminal liability.

[7] Section 26 of the Act requires the sheriff to make a determination which in terms of section 26(2) is to set out the factors relevant to the circumstances of the death, in so far as they have been established to his satisfaction. These are:

(a) when and where the death occurred;

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

(c) the cause or causes of death;

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

(e) any precautions which could reasonably have been taken and if they had been taken might realistically have resulted in the death being avoided;

(f) any defect in any system of working which contributed to the death or to the accident; and

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

[8] In terms of section 26(1)(b) and 26(4) of the Act, the inquiry is to make such recommendations (if any) as the sheriff considers appropriate as to:

(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 steps which might realistically prevent other deaths in similar circumstances.

[9] Responsibility for the provision of health care to prisoners transferred from the Scottish Prison Service to the NHS on the 1 November 2011 in terms of the Health Board Provision of Healthcare in Prisons (Scotland) Directions 2011. Since that date individual regional NHS health boards have been responsible for the delivery of health care services within prison settings in Scotland which fall within their geographical remit.

Summary

Background

[10] That Christopher Nicoll was born on 3 March 1980. At the time of his death, he was 41 years of age and was being held in legal custody at His Majesty's Prison Castle Huntly, Castle Huntly, The Drive, Longforgan, Dundee, DD2 5HL.

[11] That on 26 October 2020, Mr Nicoll was convicted and sentenced at Dundee Sheriff Court for offences contrary to section 5(1A) of the Firearms Act 1968 and section 5(2) of the Misuse of Drugs Act 1971. He was given a sentence of 5 years

imprisonment discounted to 40 months. Prior to serving his sentence at HMP Castle Huntly, Mr Nicoll served at HMP Perth.

[12] That Mr Nicoll's death occurred within his cell, A13, Murray House, HMP Castle Huntly Castle Huntly, The Drive, Longforgan, Dundee, DD2 5HL on 26 November 2021 and his life was pronounced extinct at 2024 hours.

Medical history, care and treatment

[13] That prior to admission to HMP Perth, while in the community, Mr Nicoll was prescribed sertraline 150mg and pregabalin 100mg. He was first prescribed sertraline on 19 August 2015 to help with mood and anxiety. He was first prescribed pregabalin on 18 August 2020, this having been suggested by the Community Mental Health Team to help with anxiety and PTSD.

[14] That on 16 November 2020 Mr Nicoll was reviewed in the Health Centre within HMP Perth. He complained of insomnia and was given advice on sleep pattern. He was prescribed amitriptyline 10mg and commenced treatment on 17 November 2020.

[15] That on 20 July 2021, Mr Nicoll was reviewed in the Health Centre within HMP Castle Huntly. He complained of low back pain radiating down his left leg. Pregabalin was increased to 125mg twice daily.

[16] That on 5 October 2021, Mr Nicoll was reviewed in the Health Centre within HMP Castle Huntly. He had been suffering from an ear problem which had resolved. He complained of pain in his hand and sciatica for which he was awaiting a neurosurgical appointment. He had previously been prescribed pregabalin 125mg twice

a day. He requested an increase in dose to 175mg twice a day. On straight leg testing he had pain at 45 degrees. The dose was increased to 175mg. He had previously been prescribed amitriptyline. Mr Nicoll asked if the dosage of amitriptyline (which he found helpful for sleep and anxiety) could be increased to 20mg. The dose was increased. He requested probanthine for sweating. He was prescribed a dose of 15mg three times daily on an as required basis.

[17] That on 19 October 2021, Mr Nicoll was reviewed at the Health Centre within HMP Castle Huntly. He was diagnosed with an upper respiratory tract infection. His right ear was discharging but not painful. He had a temperature of 36 degrees. The GP noted what looked like thrush in his mouth. He was prescribed Betnesol drops to treat his ear and miconazole for thrush. He requested probanthine weekly which was prescribed.

[18] That at the time of his death, Mr Nicoll was prescribed sertraline 150mg once a day; Cetirizine (antihistamine) 10mg once a day; pregabalin 175mg twice a day; amitriptyline 20mg once a day and probanthine 15mg three times a day.

Transfer to open conditions

[19] That in order to be eligible for consideration to progress to open conditions a prisoner should have no positive drug tests and a minimum of one negative compulsory drug test in the last 3 months.

[20] That on 19 April 2021, 6 May 2021 and 1 June 2021, Mr Nicoll was subject to three drugs test as part of his risk assessment considering his transfer to open conditions. All tests gave negative results.

[21] That on 22 July 2021, HMP Perth Risk Management Team assessed Mr Nicoll to be of low risk and were satisfied that it would be in the public interest that he spent a period of time in open conditions where he would be better prepared for release. Mr Nicoll was given full community access.

[22] That on 23 November 2021 and on 20 July 2021, Mr Nicoll undertook voluntary drugs test. Both tests gave negative results.

Circumstances of death

[23] That on 25 November 2021, Mr Nicoll was afforded unescorted day release and spent the day with his family.

[24] That on 25 November 2021 upon his return to HMP Castle Huntly, Murray House, Mr Nicoll was not subject to a full body search in terms of the Standard Operating Procedure called "Searching of Prisoners and those with Significantly Impaired Mobility", dated 19 September 2022 and with reference OPS 022. He was not subject to a full body search as prisons officers had no intelligence that he would attempt to introduce drugs into the establishment. No risk assessment was carried out as the deceased's home visit was assessed as a straightforward visit to see his family. There was intelligence dated October 2021 to suggest that Mr Nicoll was under the influence of drugs most evenings. Mr Nicoll would have been subject to a rub down search on

25 November 2021 in terms of the Standard Operating Procedure upon his return to HMP Castle Huntly, however records of search have not been retained and as a result this cannot be verified. The Standard Operating Procedure states that every prisoner returning to the establishment after being in the community must receive a rub down search. In accordance with the Standard Operating Procedure, 1 in 10 prisoners returning to the establishment will be given a body search. The body searching of a prisoner can also be intelligence led. A prisoner returning to the establishment will always be searched, whether it be a rub down search and/or a body search. There is no evidence which suggests that the Standard Operating Procedure was not followed.

[25] That on 26 November 2021 prison officer RH began work at about 1130 hours. He saw, Mr Nicoll within his cell, A13 within Murray House at around 1715 hours. He was alone within his cell and when asked if he was ok, he replied "Yes".

[26] That on 26 November 2021 prison officers BS and WA began their morning shifts at about 1130 hours. At 1955 hours officers RH, BS and WA, were conducting their evening checks. Officer RH entered Mr Nicoll's cell and found Mr Nicoll, alone in his cell, lying face down with a dark coloured liquid on the floor where he lay. Officer RH instantly called officers WA and BS into the cell. Mr Nicoll was unresponsive, and a code blue was called at around 1955 hours. The gate officer was instructed to call an emergency ambulance.

[27] That on 26 November 2021, at approximately 2005 hours, prison officers began cardio pulmonary resuscitation utilising a defibrillator. A total of three shocks were applied.

[28] That on 26 November 2021, at 2010 hours ambulance staff arrived at Mr Nicoll's cell and took over the application of CPR. Further attempts to resuscitate Mr Nicoll were unsuccessful and paramedic staff pronounced extinction of life at 2024 hours.

[29] That on 30 November 2021 a post-mortem examination was carried out by Dr David William Sadler. The examination revealed no acute natural disease or trauma which could have contributed to Mr Nicoll's death. Cause of death was attributed to the acute and chronic adverse effects of buprenorphine (not prescribed), etizolam (not prescribed) and pregabalin (prescribed). It is stated that individual levels of drug were below the expected fatal level, but the effect of taking the drugs together had an additive or cocktail effect resulting in a fatal combination. It is not possible to determine when Mr Nicoll consumed the etizolam based on volumes of drugs found within his blood samples. This is due to varying metabolic rates of different individuals combined with the consumption of other drugs and an individual's medical conditions.

[30] That on 8 February 2022, a Death in Prison Learning, Audit and Review ("DIPLAR") was undertaken in relation to Mr Nicoll's death. The DIPLAR noted that there was good response time and practice in relation to Mr Nicoll's death. They considered the purchasing of additional defibrillator machines for the establishment and making naloxone (a drug which can reverse the effects of opioid overdose) freely available in prisoner accommodation.

Police investigation

[31] That on the 27 November 2021, Detective Constable David Feeney and Detective Constable Irvine, Police Constable Smith and Police Constable Bosman, from Police Service of Scotland attended at HMP Castle Huntly. As the deceased died in custody, the scene was preserved by SPS staff for Police Scotland attendance and investigation. The police seized several items from Mr Nicoll's cell. A tablet was recovered from the deceased's trouser pocket. Further items removed from the deceased's cell included handwritten letters, a black mobile phone, colouring books and a quantity of prescribed medications.

Conclusion

[32] On the evidence I have no difficulty in making the formal findings in terms of section 26(2)(a) to (c) with no findings in relation to section 26(2)(d) to (g) as submitted by all parties. These findings are set out above.

[33] Mr Nicoll received the appropriate care and treatment in an open custodial setting. I do not consider that his death could have reasonably been anticipated, nor that the procedures operated at HMP Castle Huntly were deficient in the context of open conditions where he would be better prepared for release and where he was given full community access after appropriate risk assessments had been carried out.

[34] The source of illicit substances which played a part in the Mr Nicoll's death cannot be properly determined. Mr Nicoll may have brought illicit substances into HMP Castle Huntly or obtained illicit substances within HMP Castle Huntly. The

function and purpose of HMP Castle Huntly is as an open prison facility aimed at housing low risk prisoners who are preparing for reintegration into society. Part of that reintegration involves placing a degree of trust in prisoners that they will be compliant with rules set by prison staff and that they would adhere to policies set out by the Scottish Prison Service in order to benefit from the advantages afforded to prisoners at HMP Castle Huntly. There is acceptance that HMP Castle Huntly is not a "normal" prison. There are no walls and the establishment is described as "porous". Prisoners have trust placed in them where they have properly demonstrated that they have earned specific privileges and that they can demonstrate they are ready for reintegration into the community. Making them subject to rigorous searches goes against these principles and would have the potential of continual institutionalisation of prisoners where the purpose of HMP Castle Huntly is to afford prisoners a sense of independence as they prepare for reintegration into the community. I consider that HMP Castle Huntly took a balanced approach in assessing the level of search Mr Nicoll would be subject to. There was clear evidence in the form of negative drugs test that took place 3 days prior to his death. This is balanced alongside the purpose of his visit being family related and that his day visit was relatively short. There was no other intelligence to suggest Mr Nicoll would bring drugs into the prison community.

[35] All of that being so, I have not identified any issues that would merit a finding in terms of section 26(1)(b) and section 26(4) of the Act. I am satisfied that appropriate procedures were in place and were adhered to in respect of Mr Nicoll who received an appropriate level of care. There are no reasonable further precautions which might have

prevented Mr Nicoll's death, and no defects in any system of working which materially contributed to his death.

[36] I am grateful to the parties for their preparation for this inquiry, including the detailed submissions provided by all parties in this case, as a result of which all the evidence was agreed without the necessity of any witness having to give oral evidence.

[37] In conclusion along with all other parties to the inquiry I offer my personal sympathies and condolences to the family, friends and next of kin of Mr Nicoll for their loss.