SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT PERTH

[2026] FAI 21

PER-B265-23

DETERMINATION

BY

SHERIFF JENNIFER S BAIN KC

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

into the death of

REESE FAIRGRIEVE

PERTH 01 May 2026

The sheriff, having considered 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 ("the 2016 Act") as follows:

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

Reese Fairgrieve, born 29 November 1996, died in Cell 36, Bravo Hall, Floor 4, HM Prison Perth, 3 Edinburgh Road, Perth between approximately 0400 and 1100 hours on 13 September 2020. The precise time of his death is not known. His life was pronounced extinct at 1134 hours.

2. In terms of section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred):

Mr Fairgrieve's death was not the result of any accident.

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

The death was caused by the combined adverse effects of Etizolam, 4F-MDMB-BINACA, 5F-MDMB-PICA and Tramadol.

4. In terms of section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in death):

Mr Fairgrieve's death was not the result of any accident.

5. In terms of section 26(2)(e) of the 2016 Act (any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided):

There were no precautions which could reasonably have been taken that might realistically have resulted in the death being avoided.

6. In terms of section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or the accident resulting in death):

There were no defects in any system of working which contributed to the death.

7. In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death):

i. The Scottish Prison Service ("SPS") operates a system whereby prison officers make regular checks of prisoners within their cells at specified times each day. Prison officers are required to undertake these checks in accordance with the requirements of the Scottish Prison Service ("SPS") locking / unlocking and residential numbers checks policy.

ii. At 0719 hours on 13 September 2020, Officer Michael Carlin failed to carry out a cell check at Mr Fairgrieve's cell which complied with SPS policy in that he failed to ensure that Mr Fairgrieve was safe and well. In particular, he entered the cell alone, failed to see Mr Fairgrieve's face and failed to obtain a response from him sufficient to be able to ascertain his welfare. This was contrary to SPS policy.

iii. Officer David Gibson was jointly responsible for the cell check. He failed to carry out any check in relation to Mr Fairgrieve's cell. This was contrary to SPS policy.

iv. Neither officer was aware of the SPS locking / unlocking numbers check policy.

v. Neither officer had received sufficient training.

RECOMMENDATIONS

8. In terms of section 26(1)(b) of the 2016 Act (recommendations (if any) 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, (d) the taking of any other steps,

which might realistically prevent other deaths in similar circumstances), the following recommendations are made:

i. SPS should revise their national and refresher training in relation to locking / unlocking and numbers checks procedures to ensure that it accords with the realities of conducting such checks. To be effective, this training should be developed with sufficient input from operational staff, specifically governors, frontline managers and residential officers, and should reflect what is required of officers and what they are likely to encounter in the various cell types within the prison estate. Such national training should only be implemented once it has been approved at a prison governors meeting chaired by the Operations Director of SPS.

ii. SPS training, policy and guidance materials in relation to locking / unlocking and residential numbers checks should be amended so that they are unambiguous and consistent with each other in relation to what is required of officers during these checks. Greater emphasis should be placed on the welfare aspect of the cell checks and the heightened risk of prisoner death in the event of non-compliance.

iii. Prison Officers should be required to keep a contemporaneous documentary record of each cell check. The flatboard which is currently available and updated for each check, and which informs as to which prisoner is in which cell, should be revised to include a thumbnail image of each prisoner along with space to record which officers conducted the check, that the presence and identity of each prisoner within each cell has been confirmed and that a verbal response sufficient to ascertain the welfare of each prisoner has been received.

iv. Further provision should be made for compulsory ongoing refresher training at regular intervals to ensure that officers remain fully cognisant of the policies in place and the necessity of strictly adhering to the cell check procedures to ensure prisoner safety.

v. All such training should be centrally recorded and only such officers as have received the appropriate training and are aware of the SPS policies in relation to cell checks should be appointed to the role of residential officer.

vi. Where CCTV is available it should be reviewed at specified intervals by governors or other senior officials to ensure the cell checks are being implemented in the manner prescribed. This is necessary to mitigate against the occurrence of further deaths in custody. In the event of non-compliance, the offending officers should be debriefed, sanctions imposed if necessary and corrective training required.

NOTE

Introduction

[1] This fatal accident inquiry ("FAI") concerned the death of Reese Fairgrieve. At the time of his death he was remanded in HMP Perth in relation to an allegation of serious assault. It was clear from the evidence given to the inquiry by his sisters that Reese Fairgrieve was much loved by his family and that they continue to be profoundly affected by his tragic and untimely death.

The legal framework

[2] Mr Fairgrieve died while in lawful custody at HM Prison Perth and therefore the inquiry into his death was mandatory in terms of section 2(4)(a) of the 2016 Act. The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017, SSI 2017/103 ("the 2017 Rules"). It was an inquisitorial, as opposed to an adversarial, process in which the procurator fiscal represented the public interest.

[3] The purpose of the Inquiry was, in terms of section 1(3) of the 2016 Act, to establish the circumstances of the death of Mr Fairgrieve and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It was not the purpose of the inquiry to establish civil or criminal liability.

[4] Section 26 of the 2016 Act sets out what must be determined by the inquiry as follows:

> "26 The Sheriff's determination
>
> (1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out –
> (a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and
> (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.
>
> (2) The circumstances referred to in subsection (1)(a) are –
> (a) when and where the death occurred,
> (b) when and where any accident resulting in the death occurred,
> (c) the cause or causes of the death,
> (d) the cause or causes of any accident resulting in the death,
> (e) any precautions which –
> (i) could reasonably have been taken, and
> (ii) had they been taken, might realistically have resulted in the death or any accident resulting in the death, being avoided,

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

(3) For the purpose of subsection (2)(e) and (f), it does not matter whether it was foreseeable before the death or accident that the death or accident might occur –
(a) if the precautions were not taken, or
(b) as the case may be, as a result of the defects.

(4) The matters referred to in subsection (1)(b) are –
(a) the taking of reasonable precautions,
(b) the making of improvements to any system of working,
(c) the introduction of a system of working,
(d) the taking of any other steps,
which might realistically prevent other deaths in similar circumstances.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to –
(a) a participant in the inquiry,
(b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature."

Procedure

[5] Preliminary hearings under rule 3.8 of the 2017 Rules were held on 19 December 2023 and 9 February 2024, at which time an evidential hearing was fixed to commence on 3 June 2025. In preparation for this, further preliminary hearings were held on 28 March, and 13 May 2025.

[6] Parties entered into three joint minutes which substantially reduced the need for parole evidence.

- Joint minute number one agreed matters relating to Mr Fairgrieve's personal details, his time in custody, the cause and circumstances of his death, the medical and police response to it and the postmortem examination and toxicology analysis. Parties also agreed that all Crown and SPS productions and labels were what they bore to be and should be admitted into evidence.
- Joint minute number two agreed that the controlled drug register at HMP Perth during September 2020 is no longer held by Tayside Health Board ("THB") and that THB productions 1, 2 and 3 were what they bore to be and should be admitted into evidence. It also agreed that the statement of David Hope, Senior Nurse at HMP Perth should be admitted into evidence.
- Joint minute number three, agreed that SPS productions 13 – 19 were what they bore to be and should be admitted into evidence.

[7] The evidential hearing took place on 3 and 4 June and 30 July[1] and I heard evidence from:

1. Natasha Fairgrieve, sister of Mr Fairgrieve
2. John Naylor, cellmate of Mr Fairgrieve
3. Prison Officer Michael Carlin

[1] To accommodate the availability of Dr Helen Brownlow

4. Prison Officer David Gibson
5. Charlie Tunstall, former prisoner HMP Perth
6. Dr Eleanor Miller, Toxicologist
7. SPS Operations Director and former Governor of HMP Perth, Andrew Hodge
8. SPS National Public Protection Manager and former Head of Operations at HMP Perth, Richard Coupe
9. Amylee Fairgrieve, sister of Mr Fairgrieve

[8] Affidavits from the following witnesses were also available for the inquiry:

1. Amylee Fairgrieve
2. Andrew Hodge
3. Richard Coupe
4. Frank Slokan

[9] Inventories of productions were lodged by the Crown, THB and SPS. In total the documentary productions were 54 in number.

[10] At the conclusion of the evidential hearing on 30 July 2024, a timetable was agreed for the lodging and exchanging of written submissions and an oral hearing fixed for 4 October 2024.

[11] On that date, I heard submissions seeking that a further in person evidential hearing should take place to hear evidence from Frank Slokan Theme Lead for Criminal

Justice and to hear further evidence from the above noted Andrew Hodge. A further evidential hearing was assigned to 7 March 2025 for that purpose.

[12] Prior to the hearing on 7 March 2025, a further Joint Minute of Agreement (no 4) was lodged agreeing that SPS productions 20 – 22 were what they bore to be and should be admitted into evidence.

[13] At the conclusion of the evidential hearing on 7 March 2025, a timetable was agreed for the lodging and exchanging of written submissions. An oral hearing took place on 30 May 2025. Thereafter I reserved my determination.

[14] In the inquiry, Mr Burton, Procurator Fiscal Depute, represented the Crown, Ms Arnott represented the Scottish Prison Service ("SPS"), Mr Brodie represented Amylee Fairgrieve ("NOK"), Mr Rodgers, represented the Prison Officers Association ("POA") and Ms Smith, Advocate represented Tayside Health Board ("THB").

[15] I am grateful to parties for the care and respect with which they conducted this inquiry and for their comprehensive submissions. I will not narrate those submissions in full but I have taken them into account while writing this determination and I express my thanks to agents and counsel for their considerable assistance.

Facts

[16] Having regard to the information presented to the Inquiry, I found the following facts to be established:

Reese Fairgrieve

[17] Reese Fairgrieve was born on 29 November 1996. He died on 13 September 2020, aged 23 years.

[18] At the time of his death, he was a remand prisoner at HMP Perth occupying cell 36 on floor 4 of Bravo Hall alongside fellow prisoner John Naylor.

[19] Mr Fairgrieve had appeared on petition at Kirkcaldy Sheriff Court in relation to an allegation of serious assault, he made no plea and was committed for further examination and remanded in custody. He appeared again on 31 August 2020, made no plea, was fully committed and remanded in custody.

[20] On admission to HMP Perth on 24 August 2020, Mr Fairgrieve was medically assessed. It was recorded that he misused cocaine, cannabis and diazepam and that he suffered from anxiety. Mr Fairgrieve self-reported that he used illicit diazepam and valium on a daily basis. He was prescribed a benzodiazepine detoxification programme. This began on 25 August 2020 and was completed on 5 September 2020. During this period, each dose of the prescribed medication was given under supervision. At the conclusion of the programme, he was not prescribed any further medication.

[21] During the period of his remand, Mr Fairgrieve was not assessed as being under the influence of substances at any time by SPS or NHS staff and was not managed on the Management of an Offender at Risk due to any Substance ("MORS") policy.

[22] Talk To Me ("TTM") prevention of suicide in prison risk assessments were conducted on 24 August 2020 and 31 August 2020 and Mr Fairgrieve was assessed as

having no thoughts of suicide or harm. Each assessment outcome was recorded as, "no apparent risk".

[23] On 2 September 2020, Mr Fairgrieve self-referred to a doctor within HMP Perth to discuss his diazepam detoxification. An appointment was arranged for 10 September but was cancelled due to an unexpected doctor absence. The appointment was being rearranged to a date within the week of 14 September 2020.

[24] Mr Fairgrieve received weekly visits from his sister Natasha Fairgrieve and they spoke daily by telephone. In the three days prior to his death, they discussed (in person on 10 September and by telephone on 11 and 12 September) the deteriorating health of their grandfather and Mr Fairgrieve's concerns that he would not be able to see his grandfather before he died and would not be able to attend his funeral. Mr Fairgrieve was upset about this, but his mood did not cause Miss Fairgrieve any concern.

[25] Mr Fairgrieve engaged in a similar discussion with his cellmate John Naylor on 12 September. He appeared to be upset at the prospect of missing his grandfather's funeral but he "perked himself up" and John Naylor had no concerns.

[26] Mr Fairgrieve also spoke at length to Officer Michael Carlin on 12 September 2020 about the health of his grandfather and the possibility of a compassionate visit. It was apparent to Officer Carlin that Mr Fairgrieve was upset but this did not cause Officer Carlin any concern and Mr Fairgrieve did not appear to be under the influence of any substance.

[27] At 1654 hours on 12 September 2020, Mr Fairgrieve left his cell with an unidentified prisoner. His movements were captured on CCTV. Insofar as it can be

ascertained from the footage, he did not appear to be under the influence of any substance.

[28] At 1707 hours on 12 September 2020, an unknown female prison officer attended the door of Mr Fairgrieve's cell and checked the door was locked. The cell door remained locked until the following morning.

[29] During the evening of 12 September John Naylor did not see Mr Fairgrieve consuming any drugs. Mr Naylor retired to his bed between 2100 and 2200 hours to watch television. His bed was the upper bunk above Mr Fairgrieve. Mr Naylor was aware that Mr Fairgrieve was using a mobile telephone.

[30] Mr Fairgrieve communicated with his sister Natasha Fairgrieve by mobile telephone from around 2200 hours on 12 September until between 0400 and 0500 hours on 13 September. Miss Fairgrieve had no concerns about his emotional wellbeing during that period.

[31] Mr Fairgrieve told his sister that he had taken pregabalin, amitriptyline and buprenorphine in the day and a half preceding the call and that he had consumed ten street Valium tablets over the space of the preceding 2 days. He said that he had swapped Valium for pregabalin. Miss Fairgrieve was not aware of him consuming any drugs during the telephone call and she had no concerns about his physical wellbeing.

Cell checks

[32] The Scottish Prison Service ("SPS") operates a system whereby prison officers make regular checks of prisoners within their cells at specified times each day. Prison

officers are required to undertake these checks in accordance with the requirements of the Scottish Prison Service locking / unlocking and residential numbers checks policy.

[33] In September 2020, the details of the policy were set out in Crown production 4, Standard Operating Procedure ("SOP") for HMP Perth in relation to the Residential Numbers Checks dated April 2020 and SPS production 7, Governors and Managers Action ("GMA") 016A/16 dated 28 March 2016. These documents specified that the checks were to be undertaken by two officers. The door to each cell was to be opened by the first officer who was to see the face of and obtain a response from each occupant. The second officer was to follow immediately behind and also see the face of and gain a response from each occupant before securing the door and moving on to the next cell. In the event of there being no response, officers would check for signs of life and, if necessary, raise the alarm.

[34] The stated purpose of the checks was to "confirm the presence and identity" of the cell occupants and to "prevent escapes and other security breaches, maintain order and control and ensure that the prisoners feel safe from violence and harm", to "ensure that all prisoners are accounted for and are safe and secure" and to "reduce the risk of suicide and to identify any person with a deteriorating health condition".

[35] The last such check of Mr Fairgrieve's cell prior to the discovery of his death was the responsibility of Officers Michael Carlin and David Gibson.

[36] At 0719 hours on 13 September 2020, Officer Carlin unlocked the door of cell 36 and entered. Contrary to SPS policy, he was not followed by Officer Gibson who moved

on to check the neighbouring cell, a practice known as "leapfrogging". There was no practical reason for this other than to reduce the time taken for conducting the checks.

[37] Officer Carlin did not remember seeing the face of Mr Fairgrieve and failed to obtain a response from him sufficient to confirm that he was safe and well.[2] Officer Gibson did not enter the cell and did nothing to ascertain Mr Fairgrieve's presence within or welfare.

[38] The actions of Officers Carlin and Gibson were contrary to SPS policy. Neither officer was aware of the existence of the policy documents and neither had received any formal training in relation to the locking / unlocking and residential numbers checks procedure[3].

[39] At that time, the practice of "leapfrogging" or carrying out the cell check as a single officer was commonplace. The priority of the said officers was to do a head count of the prisoners, and neither was able to confirm that the correct prisoners were within the correct cell. Cells were often dark and curtains or sheets were used by prisoners to obstruct the view of their beds. Officers did not necessarily see the face of the prisoner and would accept a movement, even from a prisoner under a duvet, as sufficient response.

---

[2] Officer Carlin gave evidence that he may have received a grunt by way of response from Mr Fairgrieve and John Naylor. This was not confirmed by John Naylor and was not mentioned by Officer Carlin in the statements he gave to the police on 13 and 14 September 2020. Officer Carlin confirmed in his evidence that his recollection to the police would be more reliable than now.

[3] Each officer made reference to "learning on the job" from other residential officers.

[40] A documentary sheet ("flatboard") providing the up-to-date details of which prisoner was housed within which cell was available prior to each check, but this was not utilised and no contemporaneous record of the check was kept. The officers kept a mental tally of the "head count" and this was then communicated to a central point to confirm its accuracy.

[41] On 13 September 2020 the time taken to check all of the cells on floor 4 was less than one minute.

13 September 2020

[42] At various times prior to the discovery of his death, Officers Carlin and Gibson attended at Mr Fairgrieve's cell. They did not interact with him and understood him to be sleeping.

[43] Prisoners Charlie Tunstall and another prisoner also attended at cell 36. They did not interact with Mr Fairgrieve.

[44] At 0913 hours, Mr Naylor left cell 36. He returned at 1020 hours in the presence of another prisoner. Both entered the locus for approximately 10 seconds before leaving. Mr Naylor was returned to his cell by Officer Carlin at approximately 1023 hours. Both entered the cell and Officer Carlin left around one minute later. Officer Carlin was satisfied that Mr Fairgrieve was present but did not remember seeing him. Officer Carlin then locked the door.

[45] At 1059 Mr Naylor attempted to rouse Mr Fairgrieve and found him to be cold to the touch. He activated the alarm. Officers Gibson and Carlin then entered the locus

and found Mr Fairgrieve lying on the bottom bunk on top of a duvet. They attempted to rouse him, received no response and called "code blue"[4]. Approximately 30 seconds later, both officers left the locus.

[46] At 1101 hours on 13 September 2020 Officers Gibson and Carlin and an unknown female officer returned to the locus and removed the deceased by carrying him on his duvet to the landing floor. Mr Fairgrieve's body was not fully rigid at this time. Officer Carlin and his first line manager immediately commenced CPR on Mr Fairgrieve and an ambulance was called.

[47] Between 1102 hours and 1134 hours nursing and paramedic staff administered medical treatment and advanced life support to Mr Fairgrieve. There was no response from Mr Fairgrieve throughout this time.

[48] At 1134 hours on 13 September 2020, all medical intervention was withdrawn, and Mr Fairgrieve's life was pronounced extinct.

Police involvement

[49] At 1240 hours on 13 September 2020, Detective Constables Lana Warrender and Matthew Henry attended HMP Perth, observed Mr Fairgrieve and noted statements from witnesses.

[50] Detective Constable Iain McIntosh was appointed Crime Scene Manager and along with Scene Examiner Alice Greenhill conducted a search of the deceased. From

[4] A code used when an individual has severe breathing difficulties or is unresponsive.

his left shirt pocket, they recovered a small snap bag with a prescription label in the name of John Naylor. This contained two pieces of 1x1cm paper, and a further small piece of paper folded over and found to contain a trace amount of white rock like substance. The rock like substance was presumptively tested on 3 December 2020 and was found to be a trace amount of crack cocaine.

[51] At approximately 1340 hours, Scene Examiner Alice Greenhill took a series of photographs of Mr Fairgrieve, cell 36 and the item seized.

[52] When cell 36 was searched by the Crime Scene Manager and Scene Examiner on 13 September 2020, no suicide note was present.

[53] At 1645 hours on 13 September 2020, Mr Fairgrieve was removed from the HMP Perth by undertakers who conveyed him to the Police Mortuary in Dundee.

Post-mortem examination and toxicology analysis

[54] On 13 September 2020, the Crown Office and Procurator Fiscal Service received the death report from the Police Service of Scotland and instructed a postmortem examination take place, along with toxicology analysis.

[55] On 18 September 2020 a post-mortem examination of Mr Fairgrieve was carried out by Doctor Helen Brownlow and Doctor David Sadler, both Forensic Pathologists. Their external examination of his body did not reveal any marks or injuries which could be regarded as suspicious or give rise to concerns and there were no recent injuries. Post-mortem lividity was distributed over the rear of the torso, in keeping with the position in which Mr Fairgrieve was found. Internal examination demonstrated the

accumulation of a significant amount of blood and fluid (severe pulmonary congestion and oedema within the lungs). The remainder of the internal organs were normal.

[56] The medical cause of death was certified as:

a. Combined adverse effects of Etizolam, 4F-MDMB-BINACA, 5F-MDMB-PICA and Tramadol.

[57] It was not possible to determine the exact time of death of Mr Fairgrieve.

[58] The post-mortem examination revealed that Mr Fairgrieve's bladder was very full with almost a litre of urine consistent with Mr Fairgrieve having been asleep or unconscious and not having voided his bladder for some time.

[59] Toxicology analysis performed on the bodily fluids of Mr Fairgrieve by Doctors Hazel Torrance and Eleanor Miller, both Forensic Toxicologists detected the presence of:

a. Buprenorphine and its metabolite norbuprenorphine (opiate substitute)

b. Etizolam and metabolite

c. Tramadol

d. Amitriptyline

e. Mirtazapine

f. 4F-MDMB-BINACA and metabolite

g. 5F-MDMB-PICA metabolite

[60] Tramadol is a prescription medication. Etizolam, 4-F MDMB BINACA and 5F MDMB-PICA are synthetic cannabinoid receptor agonists ("SCRAs") which are

commonly known as New Psychoactive Substances ("NPS") which are not prescribed and would have to be sourced illicitly within the prison.

[61] Etizolam is much more potent than diazepam. It is frequently found in street Valium as opposed to prescription Valium, which is diazepam. There was no diazepam noted as being in Mr Fairgrieve's system.

[62] The toxicological analysis did not reveal when Mr Fairgrieve took the drugs or what amount was taken.

[63] The combination of opioids, SCRAs and benzodiazepines would result in sedation and drowsiness.

Drugs in HMP Perth

[64] SPS and THB have introduced a comprehensive range of measures to prevent, disrupt and detect the circulation of prescription and illicit drugs within the prison estate. These include regular scans and searches and restrictions on the items received by prisoners and strict controls on the distribution of prescription medication. Regular intelligence briefings are held and new measures and technologies are regularly introduced.

Subsequent training

[65] Following the death of Mr Fairgrieve, investigations carried out by SPS identified that the locking / unlocking, residential numbers checks procedures were not being strictly adhered to by staff at HMP Perth.

[66] Despite their non-compliance with SPS policy on 13 September 2020, neither Officer Carlin nor Officer Gibson were debriefed.[5]

[67] Governor Hodge instituted a review whereby every member of staff received refresher training from October 2020 and had to sign to confirm it had been completed.[6]

[68] In response to the death in custody of Gary Ross and the determination of Sheriff MacRitchie of 4 July 2023, a new training package[7] was introduced. It was developed by Frank Slokan, SPS Theme Lead for Criminal Justice. Frank Slokan has no operational experience within SPS. He had not visited any SPS prison, he had not seen the policy guidance in relation to locking /unlocking and numbers checks from HMP Perth or any other prison within the estate and he had not read Sheriff MacRitchie's determination in advance of developing the training package. Mr Slokan's understanding was that only one officer was required to carry out the cell check and his training package shows views of a single officer carrying out the check through the hatch which (on the evidence of Andrew Hodge) would not be possible in several of the establishments in the prison estate. Carrying out the cell checks in accordance with this training would not safeguard the welfare of prisoners.

[69] The national training introduced by Mr Slokan supersedes all training and policies at local level and it is almost identical to the training that is given to all new

---

[5] It was of particular concern that neither officer was debriefed in relation to their non-compliance and both remained unaware of the SPS policy in relation to how these procedures should be carried out.

[6] Despite their compliance being documented, neither Officer Carlin nor Officer Gibson had any recollection of this training.

[7] SPS 15

recruits. It is inconsistent with local policies and thus has the potential to create confusion for officers in relation to how the lock / unlock procedures should be carried out.

Analysis and conclusions

Time, place and cause of death

[70] The facts in support of my findings under sections 26(2)(a) – (d) of the 2016 Act in relation to the time, place and cause of Mr Fairgrieve's death were largely uncontroversial. There was no dispute that his death occurred in cell 36, Bravo hall, Floor 4 at HMP Perth PH2 8AT. The cause of his death was agreed in terms of the post-mortem findings as the combined adverse effects of Etizolam, 4F-MDMB-BINACA, 5F-MDMB-PICA and Tramadol and parole evidence was heard from Dr Helen Brownlow and Dr Eleanor Miller in support of this.

[71] As to timing, there was unchallenged evidence that Mr Fairgrieve spoke to his sister Natasha Fairgrieve by telephone until between 0400 and 0500 hours on 13 September 2026 and that by the time his cellmate John Naylor tried to rouse him at around 1100 hours, he was unresponsive and cold to the touch. Attempts were then made to resuscitate him but he remained unresponsive and his life was pronounced extinct at 1134 hours.

[72] Beyond those times, it is not possible to tell precisely when Mr Fairgrieve's death occurred. Dr Brownlow explained that the descriptions of him feeling cold are subjective and not a reliable indicator of when death occurred. Similarly other potential

indicators such as the evidence of rigor mortis and lividity were also unreliable. Dr Brownlow did comment that if, as stated by officer Carlin, Mr Fairgrieve's body was not completely rigid when they moved him from his cell around 1100 hours, it was possible that he was alive in the early hours of the morning. Further, Dr Brownlow's evidence that his bladder was full, indicative of him not having voided his bladder and having been unconscious for some time. That was consistent with Mr Fairgrieve being alive at around 0400 / 0500 hours and falling unconscious to the point of death at some point thereafter.

[73] Officer Carlin gave evidence to the inquiry that he may have had a grunt of a response from Mr Fairgrieve when he conducted the cell check at 0719 hours. He appeared far from confident about this and given that this evidence was inconsistent with the two statements he gave to the police on 13 and 14 September 2020, when he accepted his memory would have been fresher and when no such response was mentioned, I was not satisfied that this evidence could be relied upon.

Precautions which could reasonably have been taken

[74] As regards section 26(2)(e) of the 2016 Act (any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided), the court must decide whether there is a precaution which arises from and is supported by the evidence that could reasonably have been taken and if taken might realistically have resulted in the death being avoided. It is not necessary for the court to be satisfied that the

precaution would necessarily have had this result, or even that it would probably have done so. What is required is a realistic possibility that the death might have been avoided, an actual rather than a fanciful possibility, a real rather than a remote chance [8].

[75] It is accepted by all parties that the cell check was not carried out in accordance with SPS policy. This was a precaution which arises from and is supported by the evidence that could reasonably have been taken. It is submitted on behalf of Amylee Fairgrieve, that had a compliant numbers check been carried out Mr Fairgrieve's death *may* have been avoided, it is however accepted that it is not possible in the circumstances of this case to be satisfied that if that precaution had been taken it might realistically have resulted in Mr Fairgrieve's tragic death being avoided. To make such a finding would be to resort to speculation given the lack of evidence in relation to when or in what quantity the various drugs were taken and in the absence of a precise time of death and of any medical evidence to suggest that Mr Fairgrieve's death would realistically have been avoided had this precaution been taken. Accordingly, I agree with parties that no finding should be made.

Defects in a system of working

[76] The question that arises from section 26(2)(f) as to whether "any defects in a system of working… contributed to the death…" requires me to consider whether there

[8] Sheriff Kearney used the oft quoted expression "lively possibility" as signifying something less than a probability in the context of section 6(1)(c) of the 1976 Act: *Determination into the death of James McAlpine 17 January 1986, Glasgow Sheriff Court*, referred to in Carmichael, *Sudden Deaths and Fatal Accident Inquiries*, 3rd edition, paragraph 8-99

were any systemic defects which were at least a significant or material cause but not so remote from the death to have played no real part in it.

[77] It is clear from the unchallenged evidence surrounding the residential numbers checks that on 13 September 2020, SPS policy was not complied with and moreover that there was a lack of understanding and training in relation to how the numbers checks should be carried out and what the purpose of the check was. This was clearly a defect in the system of working. That being said, for the reasons specified above, there is no evidence to support a finding that it was a significant or material cause in relation to Mr Fairgrieve's death and I agree with parties that I should make no such finding.

[78] I was invited by the Crown and the Next of Kin to make a finding under section 26(2)(g) regarding any other facts that are relevant to the circumstances of the death. In assessing whether a finding should be made, I do not require to be satisfied that the facts in question are causally connected to the death; the question for determination is whether those facts are relevant to the circumstances of the death. In this case, I consider it relevant to the circumstances of Mr Fairgrieve's death that the numbers check deviated from the SPS locking / unlocking and residential numbers checks policy in that it was carried out by a single officer, who failed to make sufficient visual check or receive a response sufficient to ascertain that Mr Fairgrieve was safe and well. It was clear from their evidence that neither officer on duty that morning had, at that time, received formal training in relation to this important procedure and neither understood what was required of them. Moreover, there was evidence that the failures of that morning were commonplace.

Recommendations

[79] The final issue that it is necessary to address is whether any recommendations should be made. Reading the terms of section 26(1)(b) and 26(4) together it would be open to me to make a recommendation as regards to the taking of any reasonable precautions, the making of improvements to any system of working, the introduction of a system of working or the taking of any other steps which might realistically prevent other deaths in similar circumstances and I was invited by the Crown and on behalf of Amylee Fairgrieve to do so.

[80] The inquiry focussed primarily on the following two issues

1. The ability of Mr Fairgrieve to access drugs while in HMP Perth, and
2. The locking / unlocking and residential numbers checks procedure.

[81] It was not established by the evidence from where Mr Fairgrieve had sourced drugs while in HMP Perth. Nor was it established with any certainty when he had ingested any or all of the drugs or when he had died. It is of course concerning that Mr Fairgrieve had access to a fatal dose of drugs while held in lawful custody, but it was clear from the evidence that SPS and THB had introduced a comprehensive range of measures to prevent, disrupt and detect the circulation of prescription and illicit drugs within the prison estate and that this range of measures is under regular and effective review. I am not asked to make any recommendations in this regard and against the background of that evidence, I am satisfied that it is not necessary for me to do so.

[82] The recommendations I am invited to make relate to the locking / unlocking and residential numbers checks procedure. The recommendations are invited in light of the evidence of the working practices of Officers Carlin and Gibson which they described as commonplace and which they had learned from other officers. These working practices are contrary to SPS policy.

[83] Their priority was to count the number of prisoners without any confirmation that the correct people were housed in the correct cells and without any emphasis being placed on the need for a facial view and verbal response to confirm that each prisoner was safe and well. It was particularly concerning that Officers Carlin and Gibson had no knowledge of the SPS policy documents relating to the conduct of these checks and failed to recollect that they had completed refresher training introduced following Mr Fairgrieve's death.

[84] In light of suggestion in the evidence that officers were concerned only with a "head count" and in light of the failure of the officers to recollect or comply with SPS training or policy, even after a refresher training session, I am satisfied that a recommendation should be made for a contemporaneous record of the cell check to be maintained. This would serve not only as a prompt to officers of the need to carry out all aspects of the check but would require the officers to confirm in writing the identity and welfare of each prisoner.

[85] I am also invited to make various recommendations in relation to the national training and consistency between SPS policy and that training. It was submitted for the Scottish Ministers on behalf SPS that the new national training developed by

Frank Slokan and the anticipated revision of that training obviated the need for any such recommendations. I do not agree. The national training package was developed without sufficient operational input and according to the evidence of Mr Hodge is not fit for purpose. It fails to train in relation to the realities of an operational prison, and it fails to take into account the various cell types a residential officer may encounter and it is contrary to national and HMP Perth policy.

[86] I have also recommended that where CCTV of the check is available, it should be reviewed. I appreciate the concerns in relation to this being considered as surveillance, but I am satisfied that it is no more than is regularly done during the DIPLAR process and that it is necessary to avoid any further deaths resulting from the systemic failure to implement the locking / unlocking and numbers checks policy.

[87] It remains for me to extend sincere condolences on behalf of all parties and the court to the family of the deceased for the loss of Mr Fairgrieve in these most tragic and unfortunate circumstances. I also extend my thanks to them for their patience in awaiting this decision which for a variety of reasons has taken many months longer than was anticipated.