SHERIFFDOM OF LOTHIAN AND BORDERS AT LIVINGSTON

[2025] FAI 13

LIV-B262-24

DETERMINATION

BY

SHERIFF PETER G.L. HAMMOND, Advocate

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

into the death of

ANDREW GALLACHER

Livingston 5 February 2025

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

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

The late Andrew Gallacher, born 17 June 1978, died at a time between 9.33 pm on 11 November 2021 and 07.43 am on 12 November 2021 within Cell 46 in Forth C Wing, HM Prison Addiewell, 9 Station Road, Addiewell, West Lothian.

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

The cause of the death of said Andrew Gallacher was: 1(a) Cocaine, Etizolam and Amitriptyline intoxication.

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 being avoided)

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

In terms of section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death)

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

In terms of section 26(2)(g) (any other facts which are relevant to the circumstances of the death)

There are no other facts relevant to the circumstances of the death of said Andrew Gallacher.

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)

There are no recommendations made.

NOTE

The legal framework

[1] This inquiry was held in terms of section 1 of the 2016 Act and was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (hereinafter referred to as "the 2017 Rules"). This was a mandatory inquiry in terms of section 2 of the 2016 Act as Mr Gallacher was a prisoner in legal custody at the time of his death.

[2] The purpose of the inquiry is set out in section 1(3) of the 2016 Act as being to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. It is not intended to establish either criminal or civil liability. The inquiry is an exercise in fact finding - not fault finding. The inquiry is an inquisitorial process. The Procurator Fiscal represents the public interest on behalf of the Crown.

[3] In terms of section 26 of the 2016 Act the inquiry must determine certain matters, namely; where and when the death occurred; the cause or causes of the death; any precautions which could reasonably have been taken and might realistically have avoided the death; any defects in any system of working which contributed to the death, and any other factors relevant to the circumstances of the death. It is open to the Sheriff to make recommendations in relation to matters set out in section 26(1)(b) and section 26(4) of the 2016 Act. As the death was not the result of an accident, it is unnecessary to make any findings in terms of section 26(b) and (d) of the Act.

Introduction

[4] This inquiry was held into the death of Andrew Gallacher. Mr Gallacher died within his sole occupancy cell at HMP Addiewell sometime during the night between 09.33 pm on 11 November 2021,when he was last seen alive and apparently well, and 07.43 am the following morning, when he was discovered collapsed and unresponsive on the floor of his cell. It was apparent that he had died some time prior to his discovery, and he was formally pronounced life extinct shortly thereafter. There were no suspicious circumstances.

[5] Post-mortem examination initially recorded the death as unascertained pending further investigations. Once the results of toxicological examination were received, the cause of death was identified and formally certified as: 1(a) cocaine, etizolam and amitriptyline intoxication. Police investigations were unable to ascertain who had supplied these substances to Mr Gallacher. He had previously had items of mail seized due to them testing positive for illicit substances, but he reported that he had no addiction issues and therefore did not have any engagement with NHS addiction services or mandatory drug testing. Neither had he reported any mental health issues.

[6] Following a preliminary hearing on 30 October 2024, this Inquiry heard evidence and submissions remotely by Webex video link on 5 February 2025. In addition to the Crown, the parties represented at and participating in the Inquiry were the Scottish Ministers on behalf of Scottish Prison Service, Sodexo (as operators of HMP Addiewell) and Joanne Jones, Ashleigh Muldoon and Craig Gallacher (members of Mr Gallacher's family).

[7] The evidence presented at the Inquiry was uncontroversial and undisputed. The evidence consisted in its entirety of a Joint Minute of Agreement, which covered the contents of all of the productions, witness statements and affidavits, and the relevant features of the background, circumstances of death, investigations and review of procedures; all as set out in the joint minute.

Evidence

[8] The agreed evidence presented to the Inquiry in the Joint Minute was:

[9] Mr Gallacher was born on 17 June 1978. He was pronounced life extinct, at 08.00am within his single occupancy cell, 46 Forth, C Wing at HMP Addiewell, 9 Station Road, Addiewell, West Calder, EH55 8QF on 12 November 2021.

[10] At the time of his death, Mr Gallacher was in lawful custody at His Majesty's Prison (HMP) Addiewell serving a sentence of twenty years.

Productions

[11] It was agreed that all copy documents lodged were true and accurate copies of the originals.

[12] Crown Production one comprises the Medical Certificate of Cause of Death (form 11) and the Postmortem Toxicological Analysis request form in relation to Mr Gallacher both dated 28 November 2022.

[13] Crown Production two comprises the Intimation of Death to Procurator Fiscal (Form PF) for Mr Gallacher dated 23 November 2021.

[14] Crown Production three is the final postmortem report authored by Dr Robert Ainsworth BSc(hons) MBChB FRCPath DipFMS, Consultant Pathologist, dated 22 November 2021, compiled following an autopsy examination carried out within Edinburgh City Mortuary of the body of Mr Gallacher.

[15] Crown Production four is the redacted Death in Custody Pack of documentation and records held by the Scottish Prison Service in relation to Mr Gallacher.

[16] Crown production five comprises the redacted Death In Prison Learning, Audit and Review (DIPLAR) report, which was carried out following the death of Mr Gallacher. A DIPLAR is a joint Scottish Prison Service and National Health Service process for reviewing deaths that occur while an individual is in custody within a Scottish Prison.

[17] Crown production six comprises of NHS Lothian documents detailing medications prescribed to Mr Gallacher dated 4 May 2020 covering the period up to 8 November 2021.

[18] Crown Production seven comprises the redacted prison health care records for Mr Gallacher covering his time at HMP Addiewell.

[19] Crown Production eight comprises a collection of 23 photographs, produced by the Scottish Police Authority, showing cell 46 within the Fourth C Wing at HMP Addiewell and Mr Gallacher, deceased, within.

[20] Crown Production nine is the scene examination report, produced by the Scottish Police Authority, for cell 46 within the Fourth C Wing at HMP Addiewell and pertains to photos taken therein on 10 November 2021. The report is dated 8 November 2022.

[21] Crown Production ten is the signed affidavit of Steven Little, Rehabilitation Unit Manager within HMP Addiewell at the time of Mr Gallacher's death, dated 5 April 2023.

[22] Crown Production eleven is the signed affidavit John David Morrison, Head of Operations within HMP Addiewell at the time of Mr Gallacher's death, dated 28 November 2022.

Witness statements

[23] The following witness statements lodged were agreed to be true and accurate copies of the originals, and the statements treated as the equivalent of the parole evidence of the witnesses concerned.

- Jordan Lewty, Prison Custody Officer, c/o Sodexo Justice Services, dated 23 March 2022.
- Mohamed Aly, Prison Custody Officer, c/o Sodexo Justice Services, dated 13 November 2021.
- Connor Craig, Prison Custody Officer, c/o Sodexo Justice Services, dated 23 March 2022.
- Emma Brown, Senior Prison Custody Officer, c/o Sodexo Justice Services, dated 2 April 2022.
- Melissa Bell, Primary Care Staff Nurse, c/o The Police Service of Scotland, dated 12 November 2022.
- Gillian Rowan, Care Support Worker, c/o The Police Service of Scotland, dated 12 November 2021.

- Gary McDougall, Senior Prison Custody Officer, c/o Sodexo Justice Services, dated 23 March 2022.
- William Smith, General Practitioner, c/o The Police Service of Scotland, dated 12 November 2021.
- Gertruida (Vicky) Thomson, Advanced Nurse Practitioner, c/o The Police Service of Scotland, dated 28 September 2023.
- Robert Young, Scene Examiner, c/o the Scottish Police Authority, dated 8 November 2022.
- Jamie Duthie, Detective Constable, c/o The Police Service of Scotland, dated 8 August 2022.
- Lisa Cairney, Detective Sergeant, c/o The Police Service of Scotland, dated 21 September 2022.

Background history

[24] On 25 April 2019 at Glasgow High Court Mr Gallacher was convicted, following trial, of one charge of Conspiracy.

[25] On 13 May 2019 at Glasgow High Court Mr Gallacher was sentenced to 20 years imprisonment, backdated to 20 February 2018 accounting for the period spent on remand.

[26] Following sentence at Glasgow High Court, Mr Gallacher was sent to a long-term prisoner wing within HMP Addiewell.

[27] During his annual Integrated Case Management Case Conference (ICM), held on 11 November 2020, Mr Gallacher reported that he had no addictions issues and therefore had no contact with the NHS addiction service and was not subject to mandatory drug testing. Mr Gallacher also stated that he had no contact with mental health and no history of self-harm or suicidal thoughts. As such he was not subject to the "Talk to Me" policy and had never been managed in the suicide prevention strategy whilst in custody. (Crown Production five at page six)

[28] Mr Gallacher had been scheduled to attend his annual ICM on 16 November 2021 (4 days after his death).

[29] Throughout his time in custody Mr Gallacher had no contact with or referrals made to addiction services or mental health services. (Crown Production five at page six)

[30] During his time at HMP Addiewell Mr Gallacher had six items of mail seized, prior to being delivered to him, due to them testing positive for illicit substances (Crown Production five page five). The dates of the seizures and substances detected were:

- 15/10/2018 Cannabis
- 22/01/2020 Subutex
- 26/02/2020 Spice (Psychoactive Substance)
- 04/03/2020 Cocaine & Spice
- 14/05/2020 Amphetamines and MPS (Psychoactive Substance)
- 03/11/2021 Spice (Psychoactive Substance)

Medical background

[31] Mr Gallacher had a past medical history of chronic back pain and heartburn. He had been being treated for sciatica since 2018 and received weekly doses of co-codamol.

[32] Mr Gallacher was last reviewed by nursing staff on 12 August 2021 after being assaulted by another prisoner. Nursing staff treated lacerations to his head, neck, back and ear by cleaning them and applying glue and steri-strips. There was no further treatment required. (Crown production seven page one)

[33] At the time of his death Mr Gallacher was prescribed the following medication (page one to four of Advanced Nurse Practitioner Gertruida (Vicky) Thomson's statement) :

- Lansoprazole (30mg twice a day)- He was taking a NSAID (Non-steroidal anti-inflammatory drug) for back pain. The Lansoprazole was for possible stomach irritation due to the NSAID, to guard against risk factors for a gastric ulcer.
- Mucogel (10ml three times a day as needed)- antacid prescribed for acid reflux
- Lodine SR (600mg once a day)- NSAID for musculoskeletal back pain.
- Balmosa cream (as needed)- topical cream for aches and pains.
- Co-codamol (30/500mg two tablets for times a day)- opioid with paracetamol. Indicated for moderate to severe pain. Prescribed for his back pain.
- Lactulose (15ml twice a day)- a laxative prescribed for opioids-induced constipation.

Circumstances of death

[34] At around 1800 hours on 11 November 2021 Prison Custody Officer Jordan Lewty was conducting welfare checks on prisoners on Forth C Wing whilst he assisted with locking cells for the night. He briefly spoke to Mr Gallacher and recalls him lying on his bed within cell 46 alone, watching television and Mr Gallacher stating he was fine before being locked his cell. No concerns were noted. (page one of Prison Custody Officer Jordan Lewty's statement)

[35] At around 2133 hours, same date, Prison Custody Officer Mohammed Aly responded to a cell call from Mr Gallacher, initially speaking with him via intercom before attending at his cell door. He then had a short conversation with Mr Gallacher through the observation hatch on the cell door, which Mr Gallacher had opened from his side, before Mr Gallacher thanked him and said, "see you the morra Mo". No concerns were noted. (page one of Prison Custody Officer Mohammed Aly's statement)

[36] At around 0700 hours on 12 November 2021 Prison Custody Officers Jordan Lewty and Connor Craig commenced daily duties on Forth C Wing. Those duties included a welfare check on each prisoner located within the wing as they unlocked the cells. (page one of their respective statements)

[37] At around 0743 hours, same date, Prison Custody Officer Jordan Lewty, accompanied by Prison Custody Officer Connor Craig, opened Mr Gallacher's cell door and discovered him to be lying on the floor next to his bed unresponsive. A "Code Blue" alert to signify there was a prisoner who was not breathing was issued. (page one of their respective statements)

[38] At around 0744 hours, same date, Senior Prison Custody Officer Emma Brown, responded to the "Code Blue" and attended at Mr Gallacher's cell. She found Mr Gallacher to be lying face down, unresponsive with a small amount of blood coming from his nose and mouth. She attempted to obtain a verbal response from Mr Gallacher by calling his name, which was not successful. She then checked if Mr Gallacher had a pulse on his neck and states he did not. (page one of Senior Prison Custody Officer Emma Brown's statement)

[39] At around 0745 hours, same date, Primary Care Staff Nurse Melissa Bell and Care Support Worker Gillian Rowan also arrived at Mr Gallacher's cell responding to the "Code Blue" alert. They examined Mr Gallacher and noted no radial or carotid pulse. There were no chest sounds and rigor mortis appeared to have set in. Both agreed that Cardiopulmonary Resuscitation (CPR) was not appropriate as Mr Gallacher appeared to have been deceased for some time. (page one and two of Primary Care Staff Nurse Melissa Bell's statement and page one of Care Support Worker Gillian Rowan's statement)

[40] At around 0759 hours, same date, Dr William Smith, GP, attended at cell 46 Forth C Wing, finding Mr Gallacher to be cold, stiff, unresponsive, pulseless, with no breath sounds and fixed dilated pupils. He pronounced his life extinct at 0800 hours. (page one of Dr Smith's statement)

[41] At around 0801 hours, same date, Senior Prison Custody Officer Gary McDougall secured the door of cell 46 Forth C Wing with Mr Gallacher remaining within. (page one of Senior Prison Custody Officer Gary McDougall's statement)

[42] At around 0950, same date, Detective Constable Jamie Duthie and Detective Sergent Lisa Cairney attended at HMP Addiewell and admitted to cell 46 Forth C Wing where they observed Mr Gallacher in situ. They observed no apparent injuries or any weapons around him and concluded his cell was in order with no signs of a disturbance. The cell was thereafter secured. (page one and two of Detective Sergeant Lisa Cairney's statement)

[43] At around 1136 hours, same date, Detective Sergent Lisa Cairney and Scene Examiner Robert Young attended at cell 46 to take photographs of the cell (Crown production eight) and conduct a search there. (page two of Detective Sergeant Lisa Cairney's statement)

[44] Detective Sergent Lisa Cairney seized a number of blister packs of medication including Amitriptyline, Naproxen, Furosemide, Lodine, Meloxicam, Mirtazapine and Solpadol.

[45] Mr Gallacher was not prescribed Amitriptyline, Furosemide, Mirtazapine or Solpadol at the time of his death. (page one to four of Advanced Nurse Practitioner Gertruida (page one of Advanced Nurse Practitioner Gertrude (Vicky) Thomson's statement and Crown Production six)

Postmortem

[46] A postmortem examination was carried out at the City Mortuary, Edinburgh by consultant forensic pathologist Dr Robert Ainsworth on 22 November 2021 on the body

of Mr Gallacher, with his cause of death initially being recorded as: 1a Unascertained (Pending Further investigations)

[47] Dr Robert Ainsworth thereafter produced Crown Production three, Final Post Mortem Report, following toxicological analysis of samples taken at the post mortem, which amended Mr Gallacher's cause of death to: 1a: cocaine, etizolam and amitriptyline intoxication.

Post death investigations

[48] On 26 January 2022, following toxicology results being received, an instruction was sent to Detective Sergent Lisa Cairney by the Custody Death Unit at the Crown Office and Procurator Fiscals Service to investigate who supplied the deceased with Cocaine, Etizolam and amitriptyline.

[49] On 16 April 2022 Detective Sergent Lisa Cairney confirmed to the Custody Death Unit that, she had been unable to ascertain who supplied Mr Gallacher with the drugs that lead to his death and the investigation was at an end.

DIPLAR review

[50] A Death in Prison Learning Audit Review (DIPLAR) was carried out in relation to Mr Gallacher's death on 10 May 2022. As part of the DIPLAR, three action points were identified:

- To develop a referral process to addiction services based on intelligence

- The case management team to be briefed on consulting with intelligence department prior to case conferences
- Safer custody meeting to start discussing which residents are receiving mail which contains illicit substances, and referrals to be made to both addictions and recovery team through that department as indicated.

[51] Steven Little, who was the Rehabilitation Unit Manager within HMP Addiewell at the time of Mr Gallacher's death, addresses each action point within his affidavit (Crown production ten):

[52] Fraser Munro and Fiona Delaney were responsible for the first action point. It was agreed that the Intelligence Management Unit would email the NHS (via their multiple email addresses) when they got an intelligence log that a resident was suspected of using or distributing illicit substances. A protocol has now been established in the circumstances when intelligence is received to state a resident may be using illicit substances within the prison. The intelligence is graded and logged by the Intelligence Management Unit. They then disseminate the intelligence by emailing the manager responsible at the resident's location and the NHS department which includes the addictions team. This process had always been in place but there has been an emphasis on the Intelligence Management Unit sharing this with the NHS since Andrew Gallacher's death.

[53] In relation to the second point, it was agreed that all Case Managers, as part of their preparation process, should consult with the Intelligence department prior to any annual Integrated Case Management (ICM) Case Conferences to identify any relevant

information or issues that might need to be addressed at the case conference. This may include, but is not limited to, their involvement in drug use, introduction or distribution. This should be done by both referring to Prison Records System (PR2) and discussing with the Intelligence Management Unit (IMU) either verbally or via email. The communication between the case managers and the intelligence department will also be included in the ICM minutes. Steven Little was responsible for this action point. He actioned this with Kevin Ogg, SPCO, who is responsible for overseeing the case conferences. Kevin Ogg thereafter briefed the team.

[54] The third point was that the Safer Custody meeting should start discussing which residents are receiving mail which contains illicit substances and referrals to be made to both Addictions and the Recovery team through that department.
Alan Haggerty was responsible for this action point. During the weekly Safer Custody Meetings, residents deemed to be at risk of violence were discussed. This was extended to include discussion of any resident who has received any mail which tested positive for drugs on more than one occasion.

Submissions and conclusion

[55] The parties sought only formal findings as to the time, place and cause of death, as required by the 2016 Act. These are reflected in my determination above.

[56] None of the parties suggested that there were any reasonable precautions which might have realistically prevented the death. Nor was it suggested that any defects in any system of working contributed to the death. In the rule 3.7 Note lodged on behalf of

the family, the speculative question was posed whether there existed any drug which could have reversed the combined effects of cocaine, etizolam and amitriptyline intoxication; similar to Naloxone in cases of opiate overdose. In the event, no evidence was led on the matter and Mr Ross did not pursue it in his submissions

[57] Having considered the terms of the joint minute, the witness statements, affidavits and productions, together with the parties' written submissions, I am in agreement that only formal findings are appropriate here. It is not known where Mr Gallacher got these substances from. Although there had been items of mail addressed to him in the past which had been seized because they tested positive for illicit substances, Mr Gallacher had reported that he did not have addiction or mental health issues.

[58] Any death in custody is a tragedy. There is a well-publicised problem with availability of illicit substances within the prison estate. The prison authorities are alert to this and monitor the situation as best as they can to prevent such substances getting into the custodial setting. When incidents such as the drug related death of an inmate occur, they are taken seriously, and followed up to identify learning points.

[59] Following Mr Gallacher's death, the DIPLAR review identified action points which have been taken forward by management. These relate to broadening out discussions to evaluate and share intelligence with other agencies operating within the prison and make decisions about referral to Addictions and Recovery teams when mail is found to be contaminated in this way. That seems to me to be a reasonable and appropriate response by the prison authorities.

[60] I have no further observations or recommendations to make.

[61] In closing this Determination, may I join the representatives of the parties at this Inquiry in expressing my condolences to the family of Mr Gallacher for their loss