SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT FALKIRK

[2024] FAI 21

FAL-B408-22

DETERMINATION

BY

SHERIFF CRAIG HARRIS

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

into the death of

JAY ALEXANDER BOYD

Falkirk, 16 May 2024

DETERMINATION

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 (hereinafter referred to as "the Act"):

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

The late Jay Boyd (born 2 December 1982), then a prisoner within Her Majesty's Prison Glenochil (now His Majesty's Prison Glenochil), King O Muir Road, Tullibody, died at a point between 0752 hours and 1001 hours on 20 June 2020 within cell H2/02 within Harviestoun Hall of that prison.

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

There was no accident. No findings are made.

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

The cause of death was:

1a. Multidrug toxicity.

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

There was no accident. No findings are made.

(5) In terms of section 26(2)(e) of the Act (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):

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

(6) In terms of section 26(2)(f) of the Act (any defects in any system of working which contributed to the death or the accident resulting in the 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 Act (any other facts which are relevant to the circumstances of the death):

Officer MacDonald, the prison officer who carried out a check on Mr Boyd at 0752 hours on 20 June 2020, was then acting in a temporary role as a residential officer but had not been given formal training for that role, including on locking and unlocking procedures for a numbers check of prisoners.

RECOMMENDATIONS

The sheriff, in terms of section 26(1)(b) of the Act, and having regard to the matters mentioned in section 26(4) of the Act, recommends that:

(1) The Scottish Prison Service should review the Standard Operation Procedure: Prisoner Numbers Checks - Completing & Recording (reference number SOP 403) for HMP Glenochil to align the language contained within it to that contained within the Scottish Prison Service's Governors and Managers: Action (GMA 016A/16) notice.

NOTE

Introduction

[1] This determination is made following the fatal accident inquiry held under the Act into the circumstances of the death of Jay Alexander Boyd (born 2 December 1982) (hereinafter referred to as "Mr Boyd") at Her Majesty's Prison Glenochil (now His

Majesty's Prison Glenochil), King O Muir Road, Tullibody (hereinafter referred to as "HMP Glenochil") on 20 June 2020. At the time of his death Mr Boyd was in legal custody. Accordingly this was a mandatory fatal accident inquiry in terms of section 2(4)(a) of the Act.

[2] The death of Mr Boyd was reported to the Crown Office and Procurator Fiscal Service on 22 June 2020.

[3] A first notice of the inquiry was lodged by the Procurator Fiscal dated 21 October 2022 in terms of section 15(3) of the Act. A first order was made on 22 November 2022 fixing a preliminary hearing at Falkirk Sheriff Court on 16 January 2023.

[4] Two parties provided notification of an intention to participate in the inquiry, namely the Scottish Ministers as representing the Scottish Prison Service (hereinafter referred to as "the SPS") and the Prison Officers Association Scotland (hereinafter referred to as "the POAS"). The Procurator Fiscal intimated the inquiry to Mr Boyd's next of kin. Although there was an expression of interest from some family in attending at the inquiry, none indicated a wish to participate.

[5] At the preliminary hearing on 16 January 2023, various further enquiries were identified and a further preliminary hearing took place on 15 March 2023 at which an inquiry was fixed for 5 June 2023 at Falkirk Sheriff Court.

[6] On 2 June 2023, the POAS lodged 3 affidavits, including that of Prison Officer MacDonald. On the evening of 5 June 2023, the day before the inquiry commenced, the SPS lodged 3 affidavits and 19 productions, these documents totalling 90 pages. Whilst both parties apologised for the lateness, the information in these documents gave rise to

what became the significant issues for the inquiry: Officer MacDonald's observations of Mr Boyd; her lack of formal training and, had SPS national guidance been followed, whether that might realistically have resulted in the death being avoided. Further enquiry and additional witnesses were required as a result. Evidence was heard on 5 June 2023 and 6 June 2023. The inquiry was then adjourned to 25 September 2023 when further evidence was heard and submissions made.

[7] As one of the additional witnesses required on 25 September 2023 was a National Health Service (hereinafter referred to as "the NHS") Forth Valley staff nurse, following the evidence on 6 June intimation of the inquiry was given by the Procurator Fiscal Depute to the NHS. The NHS did not wish to participate in the inquiry but had a solicitor present on 25 September in a watching capacity.

[8] At the inquiry, Mr Kerr, Procurator Fiscal Depute, represented the Procurator Fiscal; Mr Bell, solicitor, represented the SPS and Mr Rodgers, solicitor, represented the POAS.

[9] During the course of the inquiry, 4 Joint Minutes of Agreement were submitted and read out. 11 documentary productions were lodged by the Procurator Fiscal, together with CCTV footage of Harviestoun Hall on 19 June 2020 and 20 June 2020. 20 productions in total were lodged by the SPS.

[10] All of the witnesses who gave oral evidence in the case were called from the Procurator Fiscal Depute's list of witnesses. By agreement of parties, the prison officers, with the exception of Officer Miller, were questioned in examination-in-chief by

Mr Rodgers rather than by the Procurator Fiscal Depute. The witnesses who gave oral evidence were:

1. S Bryson, Prison Officer, HMP Glenochil;
2. K Miller, Prison Officer, HMP Glenochil;
3. G Mackie, Prison Officer, HMP Glenochil;
4. F MacDonald, Prison Officer, HMP Glenochil;
5. P Maskell, Forensic Toxicologist;
6. C Thompson, Staff Nurse, HMP Glenochil; and
7. Dr R BouHaidar, Consultant Forensic Pathologist.

Each of the above witnesses, with the exception of Officer Miller, had provided affidavits in advance which they adopted during their evidence.

[11] Affidavits were also provided by, and were agreed as if they were the parole evidence of, the following witnesses (who did not give oral evidence):

8. S Salmans, now Deputy Governor, HMP Cornton Vale (but Head of Operations at HMP Glenochil at the time of Mr Boyd's death);
9. M Milne, now Head of Operations, HMP Glenochil;
10. S Logan, Acting Unit Manager, HMP Glenochil; and
11. F Cruickshanks, SPS Head of Operations and Public Protection.

[12] A statement given to the police on 21 June 2020 by PL (now deceased), a serving prisoner at HMP Glenochil at the time, was agreed as if it was the parole evidence of PL.

[13] On 25 September 2023, following the conclusion of evidence, each party made submissions. The Procurator Fiscal Depute and Mr Bell provided written submissions, which they read out. Mr Rodgers made oral submissions.

Legal framework

[14] The inquiry was held under section 1 of the Act and was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. References to sections or rules in the following paragraphs refer to the Act and the 2017 Rules respectively.

[15] The purpose of a fatal accident inquiry is to establish the circumstances of the death of a person and consider what steps (if any) might be taken to prevent other deaths in similar circumstances (section 1(3)). It is not the purpose of an inquiry to establish civil or criminal liability (section 1(5)).

[16] A fatal accident inquiry is conducted by a sheriff (section 1(2)). The inquiry is conducted in public unless the sheriff orders the proceedings (or any part of them) to be conducted in private (sections 21(1) and (2)). The inquiry is an inquisitorial, not adversarial, process (rule 2.2(1)). At the inquiry the Procurator Fiscal represents the public interest. Certain categories of persons connected to the person who has died, together with any other person who the sheriff is satisfied has an interest in the inquiry, may also participate in the inquiry (section 11). The Procurator Fiscal must, and a participant may, bring forward evidence relating to the circumstances of the death to which the inquiry relates (section 20(1)). The sheriff may require the Procurator Fiscal or

a participant to bring forward evidence about any matter relating to the circumstances of the death (section 20(2)).

[17] As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out certain findings and such recommendations (if any) as the sheriff considers appropriate (section 26(1)). A determination is to be in a prescribed form (rule 6.1).

[18] The findings that must be made in relation to the death to which the inquiry relates are (a) where and when 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 could reasonably have been taken and, 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 and (g) any other facts which are relevant to the circumstances of the death (section 26(2)).

[19] The making of recommendations is discretionary. 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 (section 26(4)). A recommendation 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 (section 26(5)).

Summary

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

Jay Alexander Boyd

1. Mr Boyd was born on 2 December 1982. He died at a point between 0752 hours and 1001 hours on 20 June 2020 within cell H2/02 within Harviestoun Hall of HMP Glenochil. He was 37 years old.

Mr Boyd's incarceration

2. On 5 December 2014 at Dundee Sheriff Court Mr Boyd was sentenced to 27 months imprisonment for making criminal threats and contravening section 38(1) of the Criminal Justice and Licensing (Scotland) Act 2010. On 5 January 2015 at Forfar Sheriff Court Mr Boyd was sentenced to 110 days imprisonment for further offences contrary to section 38(1) of the Criminal Justice and Licensing (Scotland) Act 2010, to be served concurrent to his other sentences. On 10 March 2015 at the High Court of Justiciary at Glasgow Mr Boyd was sentenced to 50 months imprisonment for offences under the Misuse of Drugs Act 1971, section 4(3)(b). On 1 August 2017 at Perth Sheriff Court Mr Boyd was sentenced to 6 months imprisonment for

a contravention of section 41ZA(3) of the Prisons (Scotland) Act 1989, to be served consecutively to his other sentences. In total Mr Boyd was serving a sentence of 6 years and 11 months with a sentence expiry date of 8 August 2021.

3. Mr Boyd became eligible for parole on 22 February 2018. On 18 April 2019 he was released on licence. He was readmitted to prison on 21 June 2019 when he was remanded in custody for an allegation of abduction and assault to injury and a contravention of section 127(1)(a) of the Communications Act 20003. He was recalled to prison under section 17 of the Prisoners and Criminal Proceedings (Scotland) Act 1993 on 26 June 2019 to complete his original sentence up to 8 August 2021.

4. Mr Boyd had served his sentences between 2014 and 2018 in HMP Perth and in Open Estate, with his final month prior to liberation being served in HMP Barlinnie. On readmission to prison in June 2019 he went to HMP Addiewell. He was transferred to HMP Glenochil on 3 January 2020.

5. Mr Boyd was serving the remainder of his sentence and was also on remand for his outstanding case at HMP Glenochil and was in legal custody at the time of his death.

6. Mr Boyd was located within a double occupancy cell H2/02 within Harviestoun Hall at HMP Glenochil. At the time of his death he was the sole occupant of this cell.

Mr Boyd's health within prison

7. During his sentence prior to April 2019, Mr Boyd engaged with medical professionals relating to drug addiction. During the period of that original sentence, Mr Boyd was subject to 25 drug tests between 27 May 2015 and 22 October 2018. The tests were all negative. On 10 January 2019 Mr Boyd was noted as presenting under the influence or as having ingested or secreted a substance. He was examined by healthcare staff and placed on hourly observations. He was removed from the Management of an Offender at Risk due to a Substance (MORS) policy on 11 January 2019.

8. On 16 May 2019, whilst at liberty, Mr Boyd reported to his GP that he was previously on suboxone but was no longer taking that. He was prescribed 300mg pregabalin on 21 March 2019 whilst still within prison and reported to his GP in May that he was still taking that for nerve pain and anxiety.

9. On admission to HMP Addiewell in June 2019, Mr Boyd was prescribed a benzodiazepine detox after reporting use of 30-50 street valium daily and 3 bottles of Buckfast daily. He was prescribed pregabalin 300mg twice daily at this time. Following consultation with an advanced nurse practitioner at HMP Addiewell regarding pain management, there was no clear evidence of neuropathic pain therefore pregabalin was discontinued and tramadol 200mg XL was prescribed as a safer alternative. Mr Boyd was reviewed 6 days later where he stated he was "OK. Just down." He was advised to self-refer to mental health. During his time in HMP

Addiewell Mr Boyd was seen on 7 occasions by primary care staff nurses, on 3 occasions by advanced nurse practitioners, once by a mental health staff nurse and on 5 occasions by addictions. He reported pain, anxiety and illicit substance misuse during consultations. He was advised to submit mental health referrals on 3 occasions. Oral fluid tests were positive for tramadol and otherwise negative.

10. As at 3 January 2020 when Mr Boyd was admitted to HMP Glenochil he was on a prescription of 300 milligrams of tramadol daily. On 10 February 2020 Mr Boyd agreed with a doctor to reduce and stop tramadol over the next 2 months and he was prescribed meloxicam 7.5 milligrams daily. On 22 April 2020 Mr Boyd reported that meloxicam was making him feel sick. Meloxicam was discontinued and he was prescribed celecoxib 100mg 1-2 daily, which was later increased to 200mg daily on 5 June 2020.

11. During his time in HMP Glenochil Mr Boyd was seen by primary care team staff nurses at the time of his transfer and was the subject of 5 referrals. These were actioned and related to prescriptions and pain gel for his hip. They did not require a physical attendance with a GP or nurse. Mr Boyd made 2 referrals to the GP, one was at the start of the COVID-19 pandemic and was not deemed urgent so he was asked to re-refer. The other was for back pain. This was referred to the advanced nurse practitioner who actioned a change in medications following GP advice and made a referral to the pain clinic. The outcome of the referral was the aforementioned

discontinuation of tramadol and prescription of meloxicam. A referral was also completed for mental health assessment required for anxiety and review of previous treatments.

12. The mental health team met with Mr Boyd on 4 occasions at HMP Glenochil. On the first 3 consultations there was no further input required. The fourth assessment was on 3 and 4 June 2020 when it was documented that Mr Boyd's mood was low, he was tearful, had poor concentration and was irritable. He was experiencing broken sleep and pain. He reported reduced appetite and weight loss. He was described as experiencing "acute bereavement" following news regarding his grandfather's health. He was assessed as being at no apparent risk of suicide or self-harm.

13. Mr Boyd was discussed at the clinical team meeting on 9 June 2020. The outcome was that mirtazapine 15mgs was prescribed, subject to a 4 week review, and a GP appointment was to be arranged for a review of medication and the completion of a physio referral. A weekly supply of mirtazapine was given to Mr Boyd on 18 June 2020. Following his death, the correct amount of mirtazapine tablets were found in his cell.

Mr Boyd's substance misuse within HMP Glenochil

14. From his admission to Glenochil until his death, Mr Boyd was not someone who came across the prison staff's attention on a one to one basis very often. He was a pantry pass man, working with prison staff issuing food

and cleaning up, which was a trusted position. He had good relationships with prison staff, with whom he would converse freely. He appeared to have good relationships amongst his peer group. In general, Mr Boyd did not give managers or residential prison staff cause for concern in terms of behaviours and day to day dealings.

15. On 15 May 2020 Mr Boyd was noted as presenting under the influence or as having ingested or secreted a substance. He was placed on 15 minute observations, changing to hourly observations the following morning, and observations on him were removed from the Management of an Offender at Risk due to a Substance (MORS) policy at 5.00pm on 16 May 2020. Mr Boyd was accepting of the monitoring and gave no issues during the 24 hours he was under observation. This was the only occasion Mr Boyd was placed on MORS during his time in Glenochil, although he had presented to staff as under the influence of a substance on a few occasions that week and had not appeared to be his usual self. He met with an addictions worker on 18 May 2020. He was offered support at that meeting but declined. On 4 June 2020 he was seen by a mental health triage nurse when he reported no previous issues with alcohol or drugs.

16. Mr Boyd was placed on Governor's report in relation to his presentation on 15 May 2020 and found guilty. He was sacked from his pass man job on 18 May 2020 due to being placed on MORS. He was reinstated to his pass

man job on 27 May 2020 due to the isolated nature of the incident and his character.

17. HMP Glenochil had no specific intelligence prior to Mr Boyd's death to suggest that he was a prolific drug user within the prison. Mr Boyd was known by Prison Officer Mackie, who worked on Harviestoun Hall, to dabble in drugs. He had seen him under the influence of unknown substances on 2-3 occasions but did not consider it to be a regular occurrence or pattern for Mr Boyd.

18. A review of Mr Boyd's telephone calls made to family and friends undertaken after his death showed that he was heavily involved in the drug culture within HMP Glenochil. The calls revealed that he regularly used a concoction of substances and was involved in the introduction and selling of illicit substances. On 13 June 2020 he asked a member of his family to arrange money to pay for cannabis. His explanation for using drugs during these calls was to moderate his behaviour and reduce his aggression.

19. Following his death, a "tick list" was found within Mr Boyd's cell. This was a list of names and money owed. Some of the entries refer to foodstuffs but that could have been a way of covering up the dealing of drugs to other prisoners.

20. Despite his role as a pass man and the impression he gave to prison staff, Mr Boyd was a prolific drug user within HMP Glenochil and was involved in the distribution of illicit substances within the prison.

21. At the time of Mr Boyd's death there were, and there continue to be, a number of detection systems in operation at HMP Glenochil to prevent the introduction of illicit substances into the prison.

Events of 19 June and 20 June 2020

22. On 19 June 2020 at 1643 hours prison officer Bryson entered Mr Boyd's cell to carry out a search for hooch, which is alcohol illicitly fermented by prisoners. This was part of a random, unannounced search of the cells in Harviestoun Hall. There was no specific intelligence underlying the search. Mr Boyd was sitting in his cell watching television when Officer Bryson entered. Mr Boyd was asked if he had any hooch and said he did not. Officer Bryson searched the cell for 1 minute and then exited. No hooch was found. The search was only in relation to hooch, rather than a more thorough cell search that would be undertaken for drugs, and was only focussed on limited areas where a 2 litre or 5 litre bottle may be kept. Mr Boyd himself was not searched. Officer Bryson did not see any drugs or drug paraphernalia during his search. Mr Boyd appeared well and calm and co-operated throughout the search. His demeanour did not cause Officer Bryson any concern.

23. Mr Boyd was locked alone in his cell on the evening of 19 June 2020 into the morning of 20 June 2020.

24. At some point between approximately 0552 hours and 1001 hours on 20 June 2020, whilst within his cell, Mr Boyd consumed heroin by burning it on a piece of tinfoil and inhaling the fumes.

25. At some point in time before, during or after this consumption, Mr Boyd also consumed etizolam, mirtazapine and cannabis.

26. At 0751 hours on 20 June 2020, Prison Officers Mackie and MacDonald began their number checks of the cells in Harviestoun Hall. Officer Mackie checked the cells on one side of the hall and Officer MacDonald checked the other side.

27. The national guidance in force within SPS for locking and unlocking procedures, both at the time of Mr Boyd's death and at the time of the inquiry, is set out in a document entitled Governors and Managers: Action (GMA 016A/16) which is dated 28 March 2016. That provides that, to ensure compliance with the standard set out in the SPS Prisons Resource Library Standard 1.3.3.3, appropriate steps should be taken by staff conducting number checks "to see the face of, and get a verbal response from all prisoners during all lock up and unlocking periods". It states "This is a measure to reduce the risk of suicide and also identify someone with a deteriorating health condition". The SPS Prisons Resource Library Standard 1.3.3.3 states

> "When conducting checks staff ensure that they physically account for each prisoner. Appropriate steps must be taken to confirm the presence and identity of each prisoner by seeing the face of and getting a verbal response from each prisoner in their cells/dormitories."

28. The procedures within HMP Glenochil for locking and unlocking procedures, both at the time of Mr Boyd's death and at the time of the inquiry, are set out in a document entitled Standard Operation Procedure: Prisoner Numbers Checks - Completing & Recording (reference number SOP 403). That states

> "When participating within Prisoner Numbers Checks, Officers should ensure that they physically account for each prisoner. Appropriate steps must be taken to confirm the presence and identity of each individual in custody and receive a response from them. This is the case for all Numbers Checks."

Under reference to the morning check upon taking up duty, the document states "Residential Officers systematically check each prisoner in cell, ensuring that they receive a response."

29. Officer Mackie was a residential officer of 11 years' experience at the time, namely an officer who worked in the residential areas of the prison to ensure prisoners were safe and secure. He aware of the requirement to obtain a verbal response from each prisoner when doing the numbers check. It had been part of his on the job training when he started as a residential officer.

30. Officer MacDonald was a programmes officer of 7 years' experience at the time, namely an officer who looked at programme interventions for

prisoners. As a result of the COVID 19 pandemic, that was not a priority role. Instead, she was temporarily tasked as a residential officer due to other prison officers being required to shield. She worked on Harviestoun Hall and another hall. She had undertaken the residential officer role previously over festive periods. She had not been given any formal training on the procedure for a numbers check but rather it had been on the job training, following colleagues. She was not aware of the requirement to see the face of, and to obtain a verbal response from, each prisoner when doing the numbers check. She had assumed the response could be either verbal or physical based on her observations of how other officers operated.

31. At 07:52:08 hours Officer MacDonald unlocked Mr Boyd's cell. She put her head into the cell, having heard no response from Mr Boyd to the unlocking of the door. Mr Boyd was lying on the bottom bunk of the bunk beds in the cell, which were situated in line with the cell door and running straight away from it. Mr Boyd had placed a towel at the end of the bunk bed visible from the cell door, thereby obscuring sight of himself from the cell door, which was a commonplace practice amongst prisoners. As she could not see Mr Boyd, Officer MacDonald stepped into the cell and moved to the left. She was able to see Mr Boyd's left arm in a resting position on his chest but could not see his face. She said his name to get a response from him. Mr Boyd moved his left arm down his body and back up to a resting position in acknowledgement. Officer MacDonald took that as a visual

response from Mr Boyd and so left the cell at 07:52:16 hours and locked the cell door.

32. Mr Boyd's cell door remained locked. There was no further interaction with his cell until 08:53:37 hours when Officer MacDonald unlocked the cell to put a carton of milk that had been left outside just into Mr Boyd's cell, which was the usual procedure for the morning milk. Officer MacDonald put her head into the cell and asked Mr Boyd if he wanted to go for exercise. She did not get a response and said "I'll take that as a no then". She considered the lack of response to be normal for a Saturday morning and thought this meant Mr Boyd would rather sit with his friends. She did not enter the cell and could not see Mr Boyd as he was still obscured by the towel. She closed and locked the cell door.

33. Mr Boyd was a pass man and so had his cell opened earlier than non-pass man prisoners. Officer MacDonald unlocked Mr Boyd's cell at 09:05:09 hours and left the cell door slightly ajar. She did not enter his cell.

34. Around 0915-0920 hours Officer MacDonald was walking another prisoner to the exercise yard and noted that Mr Boyd was still not out of his cell. She thought this unusual and thought she would check on him when she returned. On the way back from the exercise yard, she was asked by PL, another pass man who had become friendly with Mr Boyd, what time Mr Boyd's virtual visit was that day. Mr Boyd had a virtual visit arranged that afternoon with family. Another prisoner sitting with PL told him

when Mr Boyd's visit was. PL shouted to Officer MacDonald "It's OK, he's got an e-mail" as she was checking the time of the visit at the officers' desk. Officer MacDonald then thought Mr Boyd must be relaxing in his cell before his visit and took no further action.

35. PL was mostly sitting in the communal area outside Mr Boyd's cell after the cells had been unlocked that morning. He fully closed Mr Boyd's cell door at 09:26:10 hours to prevent Mr Boyd being disturbed by the noise of conversations in the communal area but did not enter the cell.

36. PL opened Mr Boyd's cell door at 09:31:13 hours and put his head into the cell whilst still standing outside. He did not enter the cell. He saw Mr Boyd's body on the bunk bed and assumed he was still sleeping. He closed the cell door over at 09:31:17 hours.

37. No person entered Mr Boyd's cell thereafter until 10:01:57 hours that day.

38. At a point between 07:52:16 hours and 10:01:57 hours on 20 June 2020 Mr Boyd died in his cell.

39. At 10:01:57 hours PL entered Mr Boyd's cell with the intention of waking him up. He shouted his name and tapped Mr Boyd on the shoulder but he was cold to touch. At 10:02:07 PL emerged from the cell and told Officer Mackie he needed to look at Mr Boyd.

40. Officer Mackie immediately went over and entered the cell. Mr Boyd's body was lying on its back on the bottom bunk on top of the bedcovers. Officer Mackie shouted at Mr Boyd but there was no response. He rubbed

his fist onto the sternum in an attempt to stir Mr Boyd. There was no reaction. The skin was cold to touch and not normal body temperature. The body was rigid. Officer Mackie was unable to compress the chest.

41. Officer Mackie alerted prison staff by calling a code sign over his radio. He checked for a pulse and for breathing but there was neither. Officer Mackie formed the opinion Mr Boyd was deceased and so did not attempt resuscitation.

42. Other officers, including Officer MacDonald, came to the cell in response to the call. Staff nurses Thompson and Wright also attended, entering the cell at 10:04:45 hours. A clinical assessment was carried out by the nurses. The body was pale. There was no carotid pulse in the neck. They checked the eyes and looked for breathing and chest movements. A stethoscope was used but there were no heart or lung sounds coming from the body. Rigor mortis was present in the left arm, it was stiff and locked. The body was very cold to touch and the mouth was prised open. The fingers of the body were stiff and appeared discoloured. They rolled the body over to check the back for marks. The body was stiff on being rolled. Blood had started to pool in the back. There were obvious lividity marks along the side of the body. Both nurses concluded Mr Boyd was deceased and pronounced life extinct at 1010 hours. The prison doctor was then contacted and informed of the circumstances. He was content with how things had been dealt with and so did not attend the prison.

43. Mr Boyd's cell was locked and remained secure until shortly after 1300 hours on 20 June 2020 when police officers carried out a search of the cell. The aforementioned tick list was found within a pile of papers on a shelf. A piece of burnt tin foil was found on the top bunk. A bag of white powder was found on a clothing shelf. The bag and powder were never sent for forensic analysis.

44. Following Mr Boyd's death, targeted searches took place within Harviestoun Hall on two prisoners. A wrap containing 25.7g of white powder was recovered from one cell but this did not contain any controlled substances. A very small quantity of what was believed to be controlled drugs was recovered from another cell, consisting of a crushed tablet and spice, and this was dealt with internally by prison staff.

The cause of Mr Boyd's death

45. On 24 June 2020 a post mortem examination of Mr Boyd's body was conducted at the City of Edinburgh Mortuary by Dr BouHaidar, Consultant Forensic Pathologist. Samples were also taken for toxicology.

46. The cause of Mr Boyd's death was initially recorded as unascertained pending laboratory studies.

47. Toxicology showed numerous drugs in Mr Boyd's blood and urine. There was evidence of the use of heroin, etizolam, mirtazapine and 4F-MDMB-BINACA metabolite (a synthetic cannabinoid receptor agonist).

48. 4F-MDMB-BINACA metabolite has been reported to cause irregular heartbeat which could have had a role in the death. Heroin, etizolam and mirtazapine are recognised to share similar effects on the central nervous system causing depression of its functions leading to respiratory compromise, coma and ultimately death. The effects of these drugs in combination and in the absence of, or with low tolerance, would be all the more significant in increasing the risk of death.

49. The cause of Mr Boyd's death was multidrug toxicity.

Action taken by the SPS since Mr Boyd's death

50. Following Mr Boyd's death, a Death in Prison, Learning Audit and Review (DIPLAR) was completed. A DIPLAR is the joint Scottish Prison Service and NHS process for reviewing deaths that occur whilst an individual is in custody within a Scottish prison. The DIPLAR raised 5 action points, all of which have been completed. These were:

    (i) To re-issue SPS guidance contained in a document entitled Governors and Managers: Action (GMA 001A/20) regarding the procedure to follow following a suicide or attempt suicide using a ligature. This was circulated to prison staff within Harviestoun Hall on 22 September 2020. It was circulated to SPS staff on 17 December 2020.

(ii) To re-circulate the aforementioned document entitled Governors and Managers: Action (GMA 016A/16) regarding gaining a verbal response from a prisoner during unlock. This was circulated to prison staff within Harviestoun Hall on 22 September 2020. It was circulated to SPS staff on 19 December 2020.

(iii) To review teams referring patients between services to minimise patients having to self-refer. An internal referral process was put in place by the NHS from September 2020.

(iv) To check that Mr Boyd's medication was due to be reviewed in 4 weeks. The NHS reviewed the medication. Mr Boyd would have been reviewed in 4 weeks but was only 10 days into his prescription at the time of his death.

(v) To review the decision surrounding a prisoner self-medicating and the protocol, particularly when a prisoner is transferred. A Risk Assessment for medications in possession of the prisoner is completed at point of transfer. If a prescription is initiated after this point, then the NHS team will decide whether it is appropriate for the prisoner to be in possession of the medication or whether it requires supervised administration.

51. On 31 March 2023 the SPS brought into force a new policy, with immediate effect, contained within a document entitled Governors and Managers: Action (GMA 014A/23) which was circulated to Governors and Managers

within the SPS. That sets out that, as a minimum standard across all SPS prisons, operations officers who are acting up to a residential officer role must complete a recorded induction process prior to commencing duty. The induction process is a mixture of coaching, e-learning, job shadowing, mentoring and awareness of policies contained in documents such as Standard Operating Procedures and Governors and Managers: Action notices. The training includes training on number checks and locking and unlocking procedures. A record of the officer's training must be completed and their competence signed off by a residential manager before the officer takes up any residential duties.

[21] All parties submitted I should make formal findings only. The Procurator Fiscal Depute submitted that I should make one recommendation, namely that the SPS locking/unlocking procedure guidance should be amended to provide that, at least for the morning numbers check, the locking/unlocking procedure should be corroborated, with both prison officers having to see the face of, and obtain a verbal response from, each prisoner. Both Mr Bell and Mr Rodgers submitted I should make no recommendations.

Discussion and conclusions

Discussion

[22] The majority of the evidence was either agreed in Joint Minutes of Agreement or was uncontested in oral evidence or affidavits. That evidence is reflected in the findings

in fact and it is unnecessary to repeat it again. The discussion hereafter focusses on areas of note or contention in the evidence.

[23] There were no issues with the credibility of any witness and no party suggested otherwise. I accepted every witness as credible.

[24] The only witness in respect of whom parties raised a question of reliability was Officer MacDonald. I address that below. I found all of the witnesses to be reliable on the salient points of their evidence, subject to any comments to the contrary made below.

How Mr Boyd obtained the drugs he consumed

[25] The SPS records lodged in the inquiry, and agreed by Joint Minute of Agreement, revealed that a review, undertaken after the death, of Mr Boyd's telephone calls made to family and friends showed he was heavily involved in the drug culture within HMP Glenochil. The calls revealed that he regularly used a concoction of substances and was involved in the introduction and selling of illicit substances. Following his death, a "tick list" was found within Mr Boyd's cell containing a list of names and money owed. Some of the entries refer to foodstuffs but that could have been a way of covering up the dealing of drugs to other prisoners. Taking all matters together, it is apparent that, despite his role as a pass man and the impression he gave to prison staff, Mr Boyd was a prolific drug user within HMP Glenochil and was involved in the distribution of illicit substances within the prison.

[26] It is unknown when or how Mr Boyd obtained the various drugs he consumed and which led to his death. There was no evidence to identify that or trace how those

drugs entered the prison. Evidence was agreed in a Joint Minute of Agreement that, following Mr Boyd's death, targeted searches were carried out with Harviestoun Hall. These did not reveal any drugs that could be linked to those which Mr Boyd had consumed.

[27] Affidavit evidence was given from Ms Salmans, Head of Operations at HMP Glenochil at the time of Mr Boyd's death and from Mr Milne, Head of Operations at HMP Glenochil at the time of the inquiry. Their evidence related to the measures that were in place to prevent drugs from entering HMP Glenochil at the time of Mr Boyd's death and now. 14 Standard Operating Procedure documents relative to such measures at HMP Glenochil were also lodged in evidence.

[28] The unfortunate, and well known, reality is that drugs do enter into prisons in Scotland. When and how the drugs were obtained by Mr Boyd was not the focus of the Fatal Accident Inquiry and there was no evidence on which to make any relevant findings in that regard.

[29] Based on the uncontested affidavit evidence of Ms Salmans and Mr Milne I have restricted my findings to conclude that, both at the time of Mr Boyd's death and at the time of the inquiry, there were a number of detection systems in operation at HMP Glenochil to prevent the introduction of illicit substances into the prison. I have not set out the detail of those detection systems or the techniques employed. To do so would serve little purpose in the context of this inquiry where the time and method of introduction of the drugs into the prison system was unknown and unable to be ascertained. Furthermore, it may provide sensitive information on those detection

methods - and therefore how to circumvent them - to those who seek to introduce illicit substances into the prison system.

The time of Mr Boyd's death

[30] The main focus of the inquiry was around the time of Mr Boyd's death. This was inextricably linked to the reliability of the evidence of Officer MacDonald that she saw Mr Boyd's arm move in response to her saying his name when she checked his cell at 0752 hours on 20 June 2020.

[31] Officer MacDonald's evidence was that she came on shift around 0730 hours on 20 June 2020. The CCTV footage played to the inquiry from Harviestoun Hall showed Officers Mackie and MacDonald beginning their numbers check at 07:51:50 hours. Officer Mackie checked the cells on one side of the hall and Officer MacDonald checked the other side, including Mr Boyd's cell. The footage showed Officer MacDonald unlocking Mr Boyd's cell at 07:52:08 hours and opening the cell door. It showed her placing her head into the cell initially and thereafter fully entering the cell by 07:52:13 hours. It showed her emerging from the cell at 07:52:16 hours and locking the cell door.

[32] Officer MacDonald's evidence was that she put her head into the cell because she had not received a response from Mr Boyd to the unlocking of the door. She was unable to see him because he was lying on the bottom bunk and had placed a towel at the end of the bunk beds (photographs of the cell showed the bunk beds situated in line with the cell door and running straight away from it, with the towel handing at the end

obscuring vision of the bottom bunk from the cell door. Officer Mackie confirmed this to be a commonplace practice amongst prisoners). As she could not see Mr Boyd, Officer MacDonald stepped into the cell and moved to the left. She was able to see his left arm in a resting position on his chest but could not see his face. She said his name to get a response from him. Mr Boyd moved his left arm down his body and back up to a resting position. She described it in her affidavit as seeing "his left arm move slightly" and in oral evidence as "not a massive movement" but something which was obvious to her. She took that as a visual response from Mr Boyd and was happy with that and so left the cell. She did not see his face. If she had not received a response from him, she would have called Officer Mackie over to stand at the cell door so that she could walk further into the cell to see the whole of Mr Boyd and try to get a response from him. She described that as a safety procedure.

[33] Officer MacDonald's evidence was that she unlocked Mr Boyd's cell later that morning to place the milk delivered by the milk pass man into the cell and to ask Mr Boyd if he wanted to go for exercise. The CCTV footage showed no interaction with Mr Boyd's cell from when Officer MacDonald had locked it at 07:52:16 hours until 08:53:37 hours when she unlocked the cell to put a carton of milk inside. She placed the milk inside at 08:53:43 hours and then, whilst still standing outside the cell, placed her head inside the cell at 08:53:47 hours. Officer MacDonald's evidence was that she put her head into the cell and asked Mr Boyd if he wanted to go for exercise. She did not get a response and said "I'll take that as a no then". She considered the lack of response to be normal for a Saturday morning and thought this meant Mr Boyd would rather sit

with his friends. She could not see Mr Boyd as he was still obscured by the towel. She knew she did not need to obtain a response when enquiring if a prisoner wanted to exercise and assumed no response was an indication that the prisoner did not want to go. She closed and locked the cell door. Mr Boyd was a pass man and so had his cell opened earlier than non-pass man prisoners. The CCTV footage showed Officer MacDonald thereafter unlocked Mr Boyd's cell at 09:05:09 hours and left the cell door slightly ajar. She did not enter his cell at this point.

[34] In her affidavit and examination-in-chief, Officer MacDonald misremembered placing the milk and asking Mr Boyd to go for exercise as two separate visits to his cell but, in cross-examination, she clarified this must have been at the same point. That was confirmed by the CCTV footage which showed that the only two times she entered his cell, prior to the discovery of Mr Boyd's body at 1001 hours, were at 0752 hours and 0853 hours.

[35] The only other person to lay eyes on Mr Boyd that morning before 1001 hours was PL. PL was deceased by the time of the inquiry but had given a statement to police on 21 June 2020. CCTV footage showed PL was mostly sitting in the communal area outside Mr Boyd's cell after the cells had been unlocked on the morning of 20 June 2020. It showed he closed over Mr Boyd's cell door at 09:26:10 hours, it having been left slightly ajar by Officer MacDonald at 0905 hours. PL referred in his statement to the conversation he and others were having becoming loud and so he closed the cell door over as he thought Mr Boyd was still sleeping. The CCTV footage showed PL thereafter opening Mr Boyd's cell door at 09:31:13 hours and putting his head into the cell whilst

still standing outside. He did not enter. It showed he fully closed the cell door over at 09:31:17 seconds. PL made no reference to this event in his statement. He only referred to entering Mr Boyd's cell (at 1001 hours) to wake him up so Mr Boyd could have a shower; finding him unresponsive and cold to touch and telling Officer Mackie he needed to come to check on Mr Boyd. Given PL's lack of further enquiry or reaction at 0931 hours; the brief period in which he looked in the cell; the position of the towel on the bunk beds and PL's reference in his statement that he later entered the cell to wake Mr Boyd up, it can be inferred that PL saw Mr Boyd's body lying in the bottom bunk at 0931 hours and assumed he was still sleeping.

[36] Parties agreed in a Joint Minute of Agreement that Mr Boyd died at a point between 4.44pm on 19 June 2020 (when he was seen in his cell by Officer Bryson when it was searched for hooch) and 10.01am on 20 June 2020 (when his body was discovered by PL). That timeframe can, however, be narrowed.

[37] Dr Maskell, a senior forensic toxicologist, explained that 6-Monoacetylmorphine had been found in Mr Boyd's blood and urine. When diamorphine, ie heroin, is consumed it is broken down by enzymes in the human body. The heroin is broken down into 6-Monoacetylmorphine. That, in turn, rapidly metabolises to morphine. As a result of that rapid conversion into morphine, concentrations of 6-Monoacetylmorphine in the blood are typically very low, if detected at all, and will only be detected for a short period after the administration of heroin. However, upon death, the body stops metabolising 6-Monoacetylmorphine into morphine. Therefore the fact that 6-Monoacetylmorphine was found in Mr Boyd's blood was a very good marker that

he had taken heroin and that he had died shortly after taking it (as otherwise it would have all metabolised into morphine and 6-Monoacetylmorphine would not have been detected in Mr Boyd's blood).

[38] In terms of the timescale between Mr Boyd's consumption of heroin and death, Dr Maskell could only say that the time of death would not have been more than 2 hours after Mr Boyd's consumption of heroin. That was based on an approximate 20 minute half-life of 6-Monoacetylmorphine (the time taken for its concentration in the blood to reduce by half) and that, as a general rule, within 5 half-lives the drug would have been eliminated, depending on the individual. The timescale of death would be within 1 to 2 hours but Dr Maskell could not be more specific than that. There was unlikely to be a very wide range in that; if a massive dose of heroin was taken (thus needing many more half-lives to eliminate) that would likely kill a person and never metabolise at all. The actual amount of heroin consumed by Mr Boyd would need to be known to give a more specific time between the consumption and death.

[39] Dr Maskell confirmed that the finding of burnt tin foil would suggest Mr Boyd had put the heroin in foil and burnt it to inhale it. However that did not assist with knowing how much heroin Mr Boyd initially consumed or, when he had consumed it relative to his death. There was no significance, in terms of timescales, to the other drugs found in Mr Boyd's system.

[40] I am satisfied, on the balance of probabilities (which is the standard I must apply), that Mr Boyd died within 2 hours of his ingestion of heroin. That does not, however, assist in determining when Mr Boyd ingested the heroin, particularly in

relation to 0752 hours when he was seen by Officer MacDonald. As Dr Maskell confirmed in evidence, his findings were equally consistent with Mr Boyd having ingested heroin prior to 0752 hours or after 0752 hours, given he was found dead at 1001 hours. His findings did not assist in determining whether Mr Boyd was or was not dead at 0752 hours (and therefore whether Officer MacDonald's observation of Mr Boyd's arm at that time was or was not correct). What Dr Maskell's observations do show is that, if Mr Boyd was alive at 0752 hours, he must have consumed heroin no earlier than 0552 hours that day.

[41] The other expert evidence regarding Mr Boyd's time of death was from Dr BouHaidar, Consultant Forensic Pathologist and Professor of Forensic Pathology at the University of Edinburgh. Dr BouHaidar carried out the post-mortem on Mr Boyd's body on 24 June 2022 and, following toxicology results, determined the cause of death to be multidrug toxicity. His evidence at the inquiry related to both those findings and his opinion on the time of death, under particular reference to the evidence of Officer Mackie and Nurse Thompson regarding the condition of Mr Boyd's body when it was seen by them just after 1000 hours on 20 June 2002.

[42] Officer Mackie's evidence was that, upon entering the cell (which CCTV showed to be at 10:02:19 hours), he found Mr Boyd's body lying on its back on the bottom bunk on top of the bedcovers. He shouted at Mr Boyd but there was no response. Mr Boyd looked sound asleep. Officer Mackie rubbed his fist onto the sternum of the body in an attempt to stir Mr Boyd. There was no reaction. The skin was cold to touch and not normal body temperature. The body was rigid. In his evidence, Officer Mackie likened

it to a wooden worktop within the courtroom. He was unable to compress the chest. He alerted prison staff by calling a code sign over his radio. He checked for a pulse and for breathing but there was neither. He formed the opinion Mr Boyd was deceased and so did not attempt resuscitation. The cell was a normal temperature, neither cold nor warm (Officer MacDonald gave similar evidence).

[43] Officer Mackie said in his evidence that he believed Mr Boyd's right arm was lying on the bed and the left arm was slightly off the bed. However, at this particular point in his evidence, given the language he used, I considered he was working on the basis of deduction rather than actual memory. PL's statement indicated he thought Mr Boyd's arms were at his sides when he entered the cell just before Officer Mackie but he could not be sure. I am unable to conclude on reliable evidence where Mr Boyd's arms were and have not made a finding in fact on this particular point. In any event, Mr Boyd could easily have shifted arm position subsequent to Officer MacDonald seeing him at 0752 hours so this evidence does not cast doubt on her observations at that point.

[44] CCTV footage showed staff nurses Thompson and Wright entering the cell at 10:04:45 and 10:04:48 hours. Their observations and actions were agreed in a Joint Minute of Agreement and were expanded upon in Nurse Thompson's evidence. Mr Boyd's body was lying on its back on the bottom bunk. She could not remember where his arms were or whether they were in the same position was shown in in the photographs of the body shown to the inquiry (taken shortly after 1.00pm that day by police). A clinical assessment was carried out by the nurses. The body was pale. There was no carotid pulse in the neck. They checked the eyes and looked for breathing and

chest movements. A stethoscope was used but there were no heart or lung sounds coming from the body. Rigor mortis was present in the left arm, it was stiff and locked. The body was very cold to touch and the mouth was prised open. The fingers of the body were stiff and appeared discoloured. They rolled the body over to check the back for marks. The body was stiff on being rolled. Blood had started to pool in the back. It was less evident than was shown in the photographs of the body. There were obvious lividity marks along the side of the body. Both nurses concluded Mr Boyd was deceased and pronounced life extinct at 1010 hours. The prison doctor was then contacted and informed of the circumstances. He was content with how things had been dealt with and so did not attend the prison.

[45] Nurse Thompson had previous experience of working in hospital wards and had dealt with a number of deceased patients. She would do the last offices after a family had been with a deceased for an hour or so after death. Bodies might have started to go slightly cold in that time. When she saw Mr Boyd's body, it was beyond that stage. He seemed to her to be "far more gone".

[46] Dr BouHaidar explained that the temperate of a body and whether rigor mortis had set in are not exact sciences to ascertain time of death. Neither were very accurate to determine a time of death. Even in the best laboratory conditions, within a period of 24 hours the margin of error with rigor mortis was still plus or minus 2 hours. There were also exceptions to the general guide for considering time of death using rigor mortis. As a pathologist, he would generally favour a conclusion based on additional

information such as the last sighting of a person alive; CCTV footage; food left in a fridge; etc.

[47] In terms of temperature, the external temperature of the body was not relied on by forensic pathologists. Instead a thermometer would be used to obtain an internal temperature or various parts of the body would be checked to see whether there was any warmth left anywhere. The room temperature would be taken. A formula could be used to give an indication of time of death but that was not very accurate.

[48] Rigor mortis arises because, when a person dies, everything in the body relaxes. However chemical reactions in the body continue. Muscles then contract but, when the chemicals in the body deplete, the muscles relax again. It starts on small muscles, moves to big muscles and then goes away in reverse order, big muscles first then smaller muscles. The evidence of Officer Mackie and Nurse Thompson was consistent with rigor mortis being present. In particular, the body moving as one block when it was rolled indicated that, as the larger muscles would flex if rigor mortis was not present.

[49] Insofar as Officer MacDonald's evidence of seeing Mr Boyd's arm move down his body and back up, Dr BouHaidar advised that when rigor mortis sets in, sometimes muscles can contract and it can appear as if the arm is moving. It may look like an arm flex. Normally rigor mortis could move an arm in one direction, not both. He was not aware of a situation where an arm had gone down and back up through rigor mortis. The muscles on the back are larger in the arm so it would normally move towards the body through rigor mortis. The general rule was that the arm would move inwards towards the body and in one way only. He was not prepared, however, to entirely

discount rigor mortis as an explanation for Officer MacDonald's observation as there were always exceptions to the rule. In answer to a question from Mr Rodgers, Dr BouHaidar hypothesised a scenario in which Mr Boyd had been holding onto his clothing, his fingers released which moved the arm down and then rigor mortis pushed the arm back up the body. Dr BouHaidar described this scenario as "possible" but one he had never seen.

[50] Dr BouHaidar highlighted that he had not seen the body at the time of death; had therefore not undertaken measurements and was reliant on the subjective evidence of others who were not trained in forensic pathology. He indicated that a cold, stiff body at room temperature in a laboratory setting may indicate, as a guide rather than scientific calculation, a timescale of death 8-36 hours previous. However he was at pains to point out that there were many exceptions to that. He referred to needing to take it "with a pinch of salt". There were so many factors to a setting in which a body was located and so many exceptions where bodies had been warmer or colder or had rigor mortis. Even if it had been him at the scene, he would still be dubious.

[51] Dr BouHaidar also commented on the blood pooling and lividity marks seen by the nurses. Pooling on the back was a gravity led mechanism. When the blood stops moving in the body at death, it is pulled towards a part of the body through gravity. The stages involved were pooling of blood but it is not fixed and still moves with the body; pooling with some blood fixed and then finally when the blood is completely set in one or more parts of the body. It was an even poorer method than rigor mortis to estimate time of death.

[52] With all the caveats present, Dr BouHaidar was unable to comment on the likelihood of Mr Boyd being alive at 0752 hours. He could not discount Mr Boyd being alive at that time. He could not give a more specific time of death than that in the Joint Minute of Agreement. The furthest he was prepared to go was that the observations of the witnesses could be more consistent with a time of death in the region of 8 hours or more before 1002 hours but it could not medically be ruled out that Mr Boyd was alive at 0752 hours.

[53] Dr BouHaidar's evidence also confirmed that the mechanism of death and the manner in which Mr Boyd was found did not assist with the time of death.

[54] The tolerance to drugs between individuals is very variable. Reactions of people to the drugs involved in this case was very unpredictable. Dr BouHaidar had seen drug deaths from lower, similar and higher levels than were found in Mr Boyd's system. Some people died from this level of drugs; some people did not. Sometimes people could mix high levels of drugs and be fine. It was how a person reacted to the combination of many different drugs which was significant. There was also the issue of a person's tolerance to drugs to consider. However, a person's body could simply decide to take no more and death ensue, even if that person had consumed the same mixture and level of drugs previously and been fine.

[55] Dr BouHaidar was unable to be exact on the effect the drugs consumed had on Mr Boyd's heart. At post-mortem there was nothing of interest in the heart but that did not mean there was not something there which could not be seen. There could be multiple effects on different organs. It was possible that the addition of heroin, on top

of the other drugs earlier consumed, could have caused Mr Boyd's death. Equally, Mr Boyd could have taken heroin and then introduced other drugs on top of that and that had caused his death. The complexity required the use of multidrug toxicity as the cause of death.

[56] Dr BouHaidar explained that, with drug deaths, people could fall asleep and die; people could go into a coma and at some point their heart could stop functioning and for some people their heart could just stop at any point, although he was not aware of someone taking heroin and dying immediately. Some people could develop an allergic reaction and die suddenly. There was no way to tell if Mr Boyd had died immediately on the consumption of whichever drug was the final one consumed or whether he fell into a coma and died or whether he died in his sleep. Mr Boyd's body being found resting on the bottom bunk did not assist in any real way. The most that could be said was that, if he had suffered a fit, there might have been some evidence of that at the scene. A person sleeping in their bed and dying peacefully was seen very often in drug deaths.

[57] The Procurator Fiscal Depute submitted that all that could be said was that Mr Boyd died at a point between 4.44pm on 19 June 2020 and 10.01am on 20 June 2020 (ie what was stated in the Joint Minute of Agreement). When pressed for a position regarding Officer MacDonald's observation at 0752 hours of Mr Boyd's arm moving, the Procurator Fiscal Depute merely submitted it was a matter for me whether to accept or reject her evidence: it was possible she was mistaken; it was possible she was not.

[58] Mr Bell for the SPS went further in his submissions. He invited me to conclude that Mr Boyd had died prior to 0752 hours. He placed significant reliance on the 8-36 hour timescale referred to by Dr BouHaidar. If Officer MacDonald had seen Mr Boyd's arm move then it was rigor mortis.

[59] Mr Rodgers for the POAS submitted that the time of death could only be said to be at a point between 4.44pm on 19 June 2020 and 10.01am on 20 June 2020. Beyond that was speculation. Dr BouHaidar's evidence, and the observations of Mr Boyd's body, tended to suggest death 8-36 hours beforehand but his extreme caution in his evidence had to be considered. Officer MacDonald may have been mistaken about seeing the arm move, which could be because of the trauma she herself experienced. If she was correct, rigor mortis as an explanation would be highly coincidental but could not definitively be ruled out.

[60] Whilst Officer MacDonald misremembered some things, which were shown either by the CCTV footage or the photographs to be incorrect, I accept her evidence that she saw Mr Boyd's arm move and that this was in response to her saying his name. Accordingly, I am satisfied that Mr Boyd was still alive at 0752 hours. I come to this conclusion for the following reasons:

- Officer MacDonald was entirely credible in her evidence. No party suggested otherwise. She was clearly doing her best throughout her evidence to assist the inquiry. There was no suggestion at all that she was making up an account.

- Her evidence of what she did on her first visit to the cell, given before she was shown the CCTV footage, aligned with that footage. The footage showed her placing her head into the cell initially and thereafter fully entering the cell, staying within for about 3 seconds. That confirmed her evidence that she put her head into the cell because she had not received a response from Mr Boyd to the unlocking of the door and then, as she could not see him, she stepped into the cell and moved to the left. This evidence showed that Officer MacDonald was looking for a response and took action to obtain it, by fully entering the cell. Having taken that proactive step, I consider it highly unlikely that Officer MacDonald would then have abandoned her efforts without obtaining any response. I also accept her evidence that, if she had received no response, she would have called Officer Mackie over. Her actions of thereafter leaving the cell, and carrying on her normal duties that morning including later asking Mr Boyd if he wanted to go for exercise, supports that she saw a response at 0752 hours which she considered to be satisfactory.
- Officer MacDonald's evidence was that, after seeing Mr Boyd deceased in his cell, she fainted at the staff desk and was taken home. This was supported by the prison documentation. Her evidence was that she was completely shocked because she had had a response from him 2 hours earlier. Officer MacDonald's later reaction was consistent with her having thought Mr Boyd was alive shortly beforehand.

- Officer MacDonald was consistent in her recollection of seeing Mr Boyd's arm move. It was not an account only provided in preparation for, or at, this inquiry. The statement of Officer MacDonald's line manager (contained within the prison documentation) dated 20 and 21 June 2020 recorded

  > "Officer (F) MacDonald was the Officer who checked Mr Boyd at morning numbers check and advises that a response was given by Mr Boyd at this time. On Sunday 21st June, I spoke further with Officer (F) MacDonald…regarding the incident the previous day. I discussed with Officer MacDonald the point regarding her being the Officer who checked on Mr Boyd during morning numbers checks. Officer MacDonald states that to the best of her knowledge she received a response from Mr Boyd in that he moved his arm, she did not however get a verbal response from him."

  The DIPLAR review on 13 August 2020 recorded

  > "Mr Boyd was last seen at number check in the morning where an officer was certain she received an acknowledgment by the prisoner raising his arm. No verbal response was received".

  Officer MacDonald's position from the very outset has always been that she saw Mr Boyd's arm move.

[61] Dr BouHaidar's evidence has to be considered as a whole. His oral evidence was given once he had the benefit of knowing the salient points from the earlier witnesses. Whilst he mentioned a time of death of 8-36 hours prior to discovery, it was not his evidence that this was the most likely scenario. He was at pains to highlight the many caveats, qualifications and inaccuracies that plagued any calculation of time of death. He would not say that the observations of the witnesses were more consistent with a time of death in the region of 8 hours or more; only that they "could be more

consistent". He could not discount Mr Boyd having been alive at 0752 hours. Notably, Dr BouHaidar stated that the more reliable method of working out the time of death was to look to evidence of when people had last seen a person alive and independent sources such as CCTV evidence. For the reasons already stated, those factors in Mr Boyd's case support Mr Boyd being alive at 0752 hours.

[62] I do not accept that what Officer MacDonald saw was rigor mortis. It would have been the most remarkable of coincidences that, at the very moment she was looking at Mr Boyd's body and saying his name, that Mr Boyd's fingers relaxed on whatever they were gripping in order to release his arm downwards and then rigor mortis immediately took effect to move his arm upwards and that all of these movements looked like an acknowledgment to Officer MacDonald. Dr BouHaidar had never come across such an event. The far more probable scenario is that Mr Boyd was acknowledging Officer MacDonald.

Had Officer MacDonald been formally trained and SPS guidance followed, might that realistically have resulted in the death being avoided?

[63] Officer MacDonald was temporarily acting in a residential officer role as a result of the consequences of the COVID pandemic, with other officers requiring to shield and her normal role not being considered essential at the time, although she had previously undertaken the residential officer role over festive periods. Officer MacDonald had not been formally trained in the residential officer role. She had instead learned on the job, following the lead of colleagues. She was not aware of the requirement in line with the

national guidance to see the face of, and obtain a verbal response from, each prisoner when doing the numbers check. She had assumed the response could be either verbal or physical based on her observations of how other officers operated.

[64] This therefore raises the question: had Officer MacDonald been formally trained and followed the national guidance - precautions which could reasonably have been taken - might that realistically have resulted in Mr Boyd's death being avoided?

[65] Nurse Thompson's evidence was that, if she had been called to intervene at 0752 hours and had Mr Boyd still been alive at the time, measures would have been taken to try to assist him by nursing staff. However, that would depend on knowing that he had taken drugs; when he had taken the drugs and what condition he was in. The intervention would depend on his presentation:

- If he was able to walk and talk, but clearly under the influence of drugs, and observations were fine, he would have been put on a care plan and observed by prison staff every 15, 30 or 60 minutes.
- If he was unresponsive but breathing and it was suspected he had taken drugs, oxygen and Naloxone would have been administered and an ambulance called. Naloxone is a drug given to counteract opioids but only works on opioids so, in this case, heroin. As far as she was aware there were no drugs which could be administered to counteract the other substances Mr Boyd had taken (Dr Maskell was unable to offer an opinion on that). Naloxone has 5 doses which come in a vial. She would not have felt comfortable giving more than that. It has a short half-life so a patient

can become unresponsive again after 20 minutes or so, even if they have had 5 doses. In that event, a nurse would stay with the patient until the ambulance arrived and would give oxygen, monitor blood pressure and give CPR if they went into cardiac arrest. A lot would depend on how long it took for the ambulance to arrive.

- If he was not breathing, a pulse would be checked for, Naloxone administered and the airway kept clear. Any vomit would be suctioned out and CPR would be started if there was no pulse. An ambulance would be called.

[66] Nurse Thompson's evidence was that it was not possible to say what intervention may have been given at 0752 to Mr Boyd or whether it would have saved him without knowing what condition he was in. She was unable to say whether any intervention at that time would have saved his life as his survivability would have wholly depended on his condition at that time.

[67] Dr BouHaidar was unable to comment on how Mr Boyd would have reacted if he had been provided with treatment at 0752 hours or thereby (assuming he had consumed the drugs by that point).

[68] The Procurator Fiscal Depute submitted that both Officer MacDonald and Officer Mackie's evidence showed that the national guidance was not always being followed at HMP Glenochil at the time of Mr Boyd's death. However the Procurator Fiscal Depute did not submit that, had it been, then the death might realistically have been avoided. That seems to have been a consequence of the Procurator Fiscal Depute's approach to

the time of death which left open the possibility that Mr Boyd was dead before Officer MacDonald arrived in the cell at 0752 hours. Instead, the Procurator Fiscal Depute submitted that a recommendation should be made that the SPS national guidance should be amended so that, at least for the morning numbers check, the locking/unlocking procedure should be corroborated with 2 prison officers required to see the face of, and obtain a verbal response from, each prisoner in their cell. It was submitted that this would mitigate the risk of individual error and increase the chance that, if a prisoner was in need of medical assistance, this would be obtained for them and thereby might prevent other deaths in similar circumstances. It was not, however, suggested that, had a corroborated check been done on Mr Boyd at 0752 hours, his death would have been avoided.

[69] Mr Bell on behalf of the SPS submitted, as already noted, that Mr Boyd was already dead before Officer MacDonald entered his cell. Accordingly, even if she had been fully trained and had attempted to obtain a verbal response and seen Mr Boyd's face, nothing could have been done to save him. To require corroboration of the morning numbers check would be unnecessary, disproportionate and unreasonable. There was an absence of evidence as to the benefits of that. On the contrary, such a requirement would place pressure on staffing and services that could otherwise be offered. If the national guidance was followed and a prisoner's face was seen and a verbal response received by an officer there would be no dubiety whether a prisoner was alive and how they were presenting. Corroboration would not achieve anything different and would not have created a different outcome in the present case. It was

accepted that Officer MacDonald had received no formal training in respect of locking and unlocking procedures but it was highlighted that had now been addressed through the introduction of Governors and Managers: Action (GMA 014A/23) which required training and sign off by a manager prior to a prison officer assisting in a residential officer role.

[70] Mr Rodgers on behalf of the POAS submitted that, if Mr Boyd had been alive at 0752 hours, there were 2 potential scenarios. Either Mr Boyd had already consumed the drugs which would prove to be fatal to him or he had not yet done so. It was not known which scenario existed. In the latter scenario, Officer MacDonald following the national guidance would have made no difference at all. In the former scenario, it was speculation as to what would have happened had Officer MacDonald followed the national guidance. There was no evidence of what would have happened. It was not known what state Mr Boyd would have been in at that time. It was unknown whether he may have been able to respond verbally or how he would have physically presented, including whether he would have shown signs of being intoxicated or in distress. Dr BouHaidar's evidence showed the drugs could have different effects on different people. The evidential gap was too wide to be bridged for the purposes of determining that Officer MacDonald following the national guidance might realistically have resulted in the death being avoided.

[71] Given that I have concluded that Mr Boyd was still alive at 0752 hours, either of the 2 scenarios outlined in Mr Rodgers' submissions must have existed: Mr Boyd had either taken whichever drugs proved to be the fatal tipping point by then or he had not

yet done so. I am unable to establish which scenario it was. Dr Maskell's findings were equally consistent with Mr Boyd having ingested heroin prior to 0752 hours or after 0752 hours, given he was found dead at 1001 hours. The consumption of the other drugs could not be timed. Dr BouHaidar's evidence did not favour one scenario over the other.

[72] If the fatal drugs had not yet been consumed by 0752 hours, it is most likely that Officer MacDonald would have been able to obtain a verbal response from Mr Boyd and not have seen anything untoward. She would have carried on her morning in the same way as she did, having no reason to do otherwise. The outcome would have been the same.

[73] If the fatal drugs had been consumed by 0752 hours, what would Officer MacDonald have seen or heard if she had viewed Mr Boyd's face and invited a verbal response from him? There is indeed a danger of speculation but some inferences can be made. Mr Boyd knew the morning number check procedure and would have known Officer MacDonald was there to check on him. He heard Officer MacDonald in his cell saying his name. He moved his left arm down his body and back up to a resting position in acknowledgement. It can be inferred that, if he was in distress at that point, he would have signalled that to Officer MacDonald, either verbally or, if unable to do so, by motioning the arm he was able to move. Accordingly, it can be inferred that he was not in distress at that time. In that circumstance, would he have been unable to give a verbal response or would he have otherwise physically appeared in such a state to have given Officer MacDonald a concern? This is where the realm of speculation is entered.

It might be thought that, if he was sufficiently able to move his arm in acknowledgement, he would have also been able to make some noise to do likewise if required to do so. It is unknown how Mr Boyd would have looked, particularly given that he was not in a state of distress. He may have appeared exactly as one might imagine a prisoner waking up to look. Dr BouHaidar's evidence did not give a basis for concluding that Mr Boyd would have obviously looked under the influence of drugs in the few moments Officer MacDonald would have spent looking at him and getting a verbal acknowledgement. I cannot conclude that, had Officer MacDonald sought a verbal response and seen the face of Mr Boyd, she would have known something was wrong and raised the alarm. I cannot therefore conclude that the outcome would have been different.

[74] Even if Officer MacDonald had seen something wrong and raised the alarm, it is unknown, based on Nurse Thompson's evidence, whether medical intervention would have been able to save Mr Boyd at that point. There are multiple unknown factors involved in that including when Mr Boyd had taken the drugs; how quickly he would have deteriorated and whether Naxolone would have been sufficient to save his life, given the other drugs that had been consumed.

[75] The SPS submissions set out some authorities on the interpretation given to the words "any precautions which could reasonably have been taken, and, had they been taken, might realistically have resulted in the death… being avoided" found in section 26(2)(e) of the Act. Speculation must be avoided: Macphail, *Sheriff Court Practice* (3rd edition) at paragraph 28.17. The phrase "might have been avoided" was a wide one

which means less than "would on the balance of probabilities have been avoided" and directs one's mind in the direction of "lively possibilities": Sheriff Kearney in Inquiry into the death of James McAlpine, Glasgow, 17 January 1986 and Carmichael, *Sudden Deaths and Fatal Accident Inquiries*, 3rd edition at paragraph 5.75. The term "might" incorporates a notion of something qualitatively more than a remote possibility: a possibility with some substance or potential rather than a fanciful or notional possibility: Sheriff Ruxton in Inquiry into the death of Kathryn Beattie, Glasgow, 4 July 2014. Reference was also made to paragraph 179 of the Scottish Government's Policy Memorandum to the Act at Bill stage which stated that the inclusion of the "realistically" in the Act was intended to imply an actual, rather than fanciful, possibility that the recommendation might have prevented the death. Mr Bell submitted that all of this meant that, before a finding could be made under section 26(2)(e), I required to be satisfied that the precaution might (in the sense of a lively possibility) have prevented the death. Mr Rodgers adopted the language of "lively possibility" in his submissions also.

[76] It would have been reasonable for Officer MacDonald to have been formally trained and, if she had been, in accordance with that training to have sought a verbal response and seen the face of Mr Boyd. However, following the authorities and given the conclusions on the evidence I have reached, I cannot make a finding that, had those precautions been taken, they might realistically have resulted in the death of Mr Boyd being avoided. Such a finding would involve substantial speculation.

Finding under section 26(2)(g) and recommendation

[77] I was invited to make one recommendation by the Procurator Fiscal Depute that the SPS national guidance on locking and unlocking be amended to require corroboration, at least for the morning check. I was invited to make that recommendation "under section 26(2)(g)". That appears to conflate findings and recommendations, which are separate matters under section 26(1) of the Act.

[78] Section 26(2)(g) refers to findings as to any other facts which are relevant to the circumstances of the death. As the SPS submissions highlighted, there is no requirement for there to be a causal connection between the "fact" and the death. The SPS submitted that the fact still required to be related to the death; simply because evidence was heard at an inquiry did not mean it was related to the death.

[79] The issues this inquiry revealed were the lack of formal training for those acting in a temporary residential officer role and, as a result, the national SPS guidance that the face of a prisoner be seen and a verbal response received from them during a numbers check not being followed. Neither has contributed to Mr Boyd's death nor, had those precautions been taken, might they realistically have avoided Mr Boyd's death. Notwithstanding that, it is concerning that this issue has arisen once again in a Fatal Accident Inquiry. The Governors and Managers: Action (GMA 016A/16) dated 28 March 2016 states as background

> "A review of Fatal Accident Inquiry (FAI) determinations identified four cases where no verbal response was obtained either before lock up or during unlock following a patrol period, morning unlock or evening lock up. The Sheriffs determined that the lack of a verbal response did not directly

> contribute to the death of the individual however they did make comment on SPS reviewing their locking and unlocking procedures."

The issues that have arisen in this inquiry are therefore not new and, notwithstanding the national guidance, have come to the fore once again.

[80] I am satisfied a finding should be made under section 26(2)(g) that Officer MacDonald, the prison officer who carried out a check on Mr Boyd at 0752 hours on 20 June 2020, was then acting in a temporary role as a residential officer but had not been given formal training for that role, including on locking and unlocking procedures for a numbers check of prisoners. This is a fact which is relevant to the circumstances of the death, albeit there is no causal link between it and the death.

[81] The inquiry revealed a need for those acting temporarily in a residential prison officer role to be formally trained, including in relation to locking and unlocking procedures when conducting a numbers check. The SPS have already recognised this and taken steps to address it. Evidence was put before the inquiry that on 31 March 2023 the SPS brought into force a new policy contained within a document entitled Governors and Managers: Action (GMA 014A/23) which was circulated to Governors and Managers within the SPS. That sets out that, as a minimum standard across all SPS prisons, operations officers who are acting up to a residential officer role must complete a recorded induction process prior to commencing duty. The induction process is a mixture of coaching, e-learning, job shadowing, mentoring and awareness of policies contained in documents such as Standard Operating Procedures and Governors and Managers: Action notices. The training includes training on number checks and locking

and unlocking procedures. A record of the officer's training must be completed and their competence signed off by a residential manager before the officer takes up any residential duties.

[82] It is to be hoped that this step taken by the SPS will ensure that all those acting in a residential officer role are fully trained and fully aware of the requirements in the national guidance set out in Governors and Managers: Action (GMA 016A/16) regarding seeing the face of, and getting a verbal response from, all prisoner during lock up and unlocking periods. Given the steps already taken by the SPS, no recommendation requires to be made.

[83] Although it was not mentioned by any party, the documentation lodged during the inquiry revealed a disconnect between the aforementioned national guidance and the Standard Operating Procedure within HMP Glenochil.

[84] Governors and Managers: Action (GMA 016A/16) states

> "To ensure compliance with the PRL Standard 1.3.3.3, appropriate steps should be taken to see the face of, and get a verbal response from all prisoners during all lock up and unlocking periods. This includes patrol periods at lunchtime and in the evening. This is a measure to reduce the risk of suicide and also identify someone with a deteriorating health condition."

The SPS Prisons Resource Library Standard 1.3.3.3 referred to states

> "When conducting checks staff ensure that they physically account for each prisoner. Appropriate steps must be taken to confirm the presence and identity of each prisoner by seeing the face of and getting a verbal response from each prisoner in their cells/dormitories."

[85] The procedures within HMP Glenochil for locking and unlocking procedures, both at the time of Mr Boyd's death and at the time of the inquiry, are set out in a

document entitled Standard Operation Procedure: Prisoner Numbers Checks - Completing & Recording (reference number SOP 403). That states

> "When participating within Prisoner Numbers Checks, Officers should ensure that they physically account for each prisoner. Appropriate steps must be taken to confirm the presence and identity of each individual in custody and receive a response from them. This is the case for all Numbers Checks."

Under reference to the morning check upon taking upon duty, the document states "Residential Officers systematically check each prisoner in cell, ensuring that they receive a response."

[86] As can be seen, the HMP Glenochil SOP only refers to confirming the presence and identity of each prisoner and receiving a response from them. That is a lower requirement than that set out in the national guidance. There is no reference in the SOP to seeing the face of a prisoner nor of ensuring that the response received is verbal. Conflicting language between the national guidance and the SOP should be avoided. It should be clear to all residential officers, whether they are referring to the national guidance or to their local operating procedures, what they are to do. That guidance should be consistent. The circumstances this inquiry dealt with is a very example of an officer's actions being in accordance with the SOP but not with the national guidance. Whilst I have made no finding that the outcome would have been different in this case had the national guidance been followed, there could be similar circumstances in future where the difference is critical and where ensuring the national guidance is followed might realistically prevent a death. Accordingly, I make a recommendation that:

(1) The Scottish Prison Service should review the Standard Operation Procedure: Prisoner Numbers Checks - Completing & Recording (reference number SOP 403) for HMP Glenochil to align the language contained within it to that contained within the Scottish Prison Service's Governors and Managers: Action (GMA 016A/16) notice.

[87] Finally, I do not consider it appropriate to make a recommendation that all morning number checks should be corroborated, with 2 officers present for each cell check, as I was invited to do by the Procurator Fiscal Depute.

[88] Mr Logan, the acting Unit Manager at HMP Glenochil, referred in his affidavit to the locking and unlocking procedure at HMP Glenochil involving two prisoner officers attending each cell door so that both can ensure each prisoner is alive and well. However, Officer Mackie, a residential officer of 14 years' experience at HMP Glenochil at the time he gave his evidence, indicated that he had always worked in the manner of 20 June 2020, with one officer checking one side of cells in the hall and another checking the cells on the other side. The SPS national guidance and the HMP Glenochil SOP do not require two officers to check each prisoner for morning checks (only the evening check requires two officers with the second officer acting as a double check to ensure the door is locked and secured).

[89] There was no evidence led about any benefits to the welfare of prisoners in mandating that two officers be present in the morning, rather than one officer, to see a prisoner's face and obtain a verbal response. The only obvious benefit of having a second officer present would be to ensure that the first officer was performing the role

correctly. There was uncontested evidence given in the affidavit of Ms Cruickshanks, SPS Head of Operations and Public Protection, about the negative impact such a requirement would place upon prisons. Prisons tend to have lower staffing levels in the mornings to commit to locking and unlocking procedures due to the morning routine which often includes the numbers check, morning unlock, prisoners receiving their medications, prisoners attending court, prisoners attending work within the prison and other movements. Requiring two officers to be present in each cell during the morning numbers check would cause resources to be deployed from elsewhere in the prison. That would have a negative impact on the regime in the prison and potentially what a prison could offer. No evidence was led as to how these substantial difficulties could be overcome.

[90] Rather than deplete prison resources by having one officer check another is performing their role correctly, the more efficient way to ensure national guidance is followed during locking and unlocking procedures is to ensure that all officers undertaking that role are fully trained. As I have noted, steps have now been taken by SPS for that to be so.

Conclusions

[91] I consider that only formal findings in respect of section 26(2)(a) and section 26(2)(c) of the Act should be made. There was no accident in the present case and so no findings are appropriate under sections 26(2)(b) and (d) of the Act. For the reasons I have stated, no finding is made in terms of section 26(2)(e) or (f) of the Act.

[92] In terms of section 26(2)(g) of the Act, for the reasons stated, the other fact which is relevant to the circumstances of the death is that Officer MacDonald, the prison officer who carried out a check on Mr Boyd at 0752 hours on 20 June 2020, was then acting in a temporary role as a residential officer but had not been given formal training for that role, including on locking and unlocking procedures for a numbers check of prisoners.

[93] The only recommendation I consider appropriate, in terms of section 26(1)(b) of the Act, is that:

(1) The Scottish Prison Service should review the Standard Operation Procedure: Prisoner Numbers Checks - Completing & Recording (reference number SOP 403) for HMP Glenochil to align the language contained within it to that contained within the Scottish Prison Service's Governors and Managers: Action (GMA 016A/16) notice.

[94] I am grateful to all parties for their agreement of evidence and provision of affidavits which reduced the number of witnesses who were required to give evidence.

[95] I conclude matters by expressing my condolences to the family and friends of Mr Boyd.