SHERIFFDOM OF GRAMPAIN HIGHLAND AND ISLANDS AT PETERHEAD

2020 FAI 28

PHD-B68-19

DETERMINATION

BY

SHERIFF CHRISTINE P McCROSSAN

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

into the death of

BRIAN DAVIDSON BUCHAN

Peterhead, 14 July 2020

The Sheriff, having considered the information presented at an inquiry under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act") finds and determines **that**: -

(1) In terms of section 26(2)(a) Brian Davidson Buchan, (Mr Buchan) born on 17 July 1963 died at HMP Grampian, South Road, Peterhead on 25 July 2017, life formally being pronounced extinct at 1516 hours on that date;

(2) In terms of section 26(2)(c) the cause of death was 1(a) methadone and benzodiazepine intoxication;

(3) In terms of section 26(2)(d) there were no precautions which could reasonably have been taken which, had they been taken, might realistically have resulted in Mr Buchan's death being avoided;

(4) In terms of section 26(2)(f) there were no defects in any system of working which contributed to the death of Mr Buchan;

(5) In terms of section 26(2)(g) relevant to the circumstances of Mr Buchan's death is the fact that at the time Ellon Hall, where he was accommodated within HMP Grampian, was short staffed by three prison officers.

Legal Framework and preliminary procedure

[1] This Inquiry was held under section 1 of the Act. This was a mandatory inquiry in terms of section 2(1) and (4) of the Act as Mr Buchan was in legal custody at the time of his death. The purpose of the Inquiry was to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances.

[2] The Procurator Fiscal issued notice of the inquiry on 25 April 2019. No next of kin was identified in this Notice. A preliminary hearing took place at Peterhead Sheriff Court on 19 June 2019 before a visiting sheriff. Parties intimated that they proposed to enter into a Joint Minute setting out those matters that were capable of agreement between them; with a proposal that the matter continue to a hearing on 3 July 2019. The parties who had indicated an intention to be represented at the hearing were The Scottish Prison Service (SPS), the Prison Officers' Association (Scotland)(SPOA) and Grampian Health Board (NHS Grampian). Neither the PF nor any of the parties

identified any issues they wished the inquiry to consider and were confident that all relevant information could be presented by way of a Joint Minute.

[3] The Hearing did not proceed on 3 July 2019. I had advised parties in advance that further enquiries were necessary in order that I could identify what the issues were in the case and to determine whether witnesses would need to be called to give evidence. Statements, lodged by the crown, which had been taken from prison officers and healthcare staff involved in the care of Mr Buchan from his admission to HMP Grampian on 13 July 2017 until his death on 25 July 2017, disclosed the following: (i) Mr Buchan had been placed on prescription medication on his admission to HMP Grampian, clarification of the prescription was required and confirmation that Professor Grieve who had conducted the post mortem was made aware of the exact details; (ii) it appeared that Mr Buchan may have been hoarding diazepam; investigation was required about how mediation was issued to prisoners, (iii) there was evidence indicating that Mr Buchan had come into possession of illicit drugs and drug paraphernalia; information was required outlining the policy and practice within HMP Grampian regarding the introduction of drugs into the prison estate, (iv) on the day of Mr Buchan's death there was a shortage of prison staff on duty within Ellon hall, information was required as to how this had been dealt with and whether it may have caused or contributed to the care of prisoners including Mr Buchan, (iv) while Mr Buchan had been placed under observation on the day of his death due to substance misuse concerns, the mandated observations were not carried out in accordance with the Care Plan; information was required about why this was so.

[4] It took some time for the parties to conduct the investigations that were required. Further preliminary hearings took place on 28 August, 25 September, 4 and 11 October, all 2019. By this date parties had conducted the further enquiries requested. This had led to the lodging by them of various documentary productions, Reports and Affidavits. These are all itemised in the Appendix and are referred to throughout this determination. Parties confirmed that a more extensive Joint Minute was to be lodged. The Crown indicated they would be calling three witnesses. In such circumstances a hearing was set down for 31 January 2020.

[5] At the hearing Mr Hanton represented the Crown, Mr Liam Smith appeared for the SPS, Mr Gillies appeared for the SPOA and Ms Watts, Counsel appeared for NHS Grampian.

Evidential hearing

[6] The following witnesses were called by the Crown to give evidence:

Linda Buchan, Staff nurse employed by NHS Grampian at HMP Grampian; senior nurse on duty at the time (referred to throughout this document as Nurse Buchan),

Professor James Grieve, MB ChB, FRCPath, FFFLM, Emeritus Professor of Forensic Medicine,

Derek Cunningham, First Line Manager, SPS employed at HMP Grampian,

no other party led any oral evidence.

Affidavit evidence was provided by the Crown from Kimberley Louise Lorimer, Health care support worker, employed by NHS Grampian and by SPS from Lesley Catherine McDowell, Head of Health Strategy at Scottish Prison Service and Stuart Campbell, Head of Operations, HMP Grampian. These Affidavits were lodged as Productions (see Appendix).

[7] The evidence was not in dispute, questions from parties other than the Crown were for the purposes of clarification only. Mr Gillies, on behalf of the SPOA initially objected to a question put by the Crown to Professor Grieve (detailed in paragraph [34]-[35], *infra*). I allowed the question, thereafter Mr Gillies further explored the answer provided by Professor Grieve, again not to seek to dispute his evidence but to obtain further clarity. I found all witnesses credible and reliable and accepted the evidence they provided to the Inquiry. I have not rehearsed their evidence *ad longum* in this determination, but refer to relevant sections where appropriate.

Joint minute

[8] At the conclusion of the evidence Mr Hanton read out the Joint Minute of Admissions. As it sets out the sequence of events in a helpful (albeit not exhaustive) chronological summary I begin by setting down the terms of the Minute as follows:

1. Brian Davidson Buchan (Mr Buchan), born 17 July 1963 was on remand at HMP Grampian, South Road, Peterhead, being allocated single occupancy cell 23, level I in Ellon Hall, D wing, following an appearance at Peterhead Sheriff Court on 13 July 2017 on an apprehension warrant,

2. Mr Buchan was placed on observations due to suspected substance misuse on 18 July 2017,
3. On 20 July 2017 Mr Buchan was subject to an initial substance misuse assessment at which time he admitted to smoking heroin while in the prison but expressed a wish to commence on a methadone programme to reduce his use of illicit substances. He was prescribed 30 ml of methadone daily at this time,
4. On 24 July Mr Buchan self-referred to the substance misuse service,
5. At about 0645 hours on 25 July 2017 Mr Buchan was checked in his cell and was found to be drowsy but responsive, requiring a shout to wake him,
6. Shortly thereafter Mr Buchan left his cell and was provided with 30 ml of prescribed methadone by medical staff, before returning to his cell,
7. At about 11:00 hours same day Mr Buchan was again checked in his cell and was found to be drowsy and having spilt coffee over himself. He was assessed by medical staff who noted he remained drowsy but had no other signs of substance misuse and, as a result he was placed on hourly observations,
8. Mr Buchan was further checked in his cell at about 12:00 hours, same day, and was found to be lying on the floor of his cell having been sick. He was assisted to his feet, sat on his bed and medical staff were called to assess him,
9. Shortly thereafter Mr Buchan was assessed by medical staff who found his blood pressure, pulse and oxygen levels to be acceptable. He denied taking

any illicit substance and was able to converse with his pupils appearing normal. However, due to ongoing concerns related to his drowsiness, he was placed on 15 minute observations,

10. Observation of Mr Buchan continued at 15 minute intervals until 1339, where he was seen to remain drowsy but responsive,
11. Notwithstanding that 15 minute checks were due to continue, no further checks were thereafter carried out until 14:45 hours, same day, at which time Mr Buchan was found to be lying on his bed unconscious and not breathing,
12. As a result, attempts were made to resuscitate Mr Buchan but, despite these lifesaving attempts, his life was pronounced extinct at 15:16 hours, same day, by Dr Dale Fenwick.
13. The death of Mr Buchan was reported to the Procurator Fiscal at Aberdeen on 27 of July 2017,
14. The body of Mr Buchan was subject to a post mortem examination by Professor James Henderson Kerr Grieve and Dr Tamara McNamee on 27 July 2017 at Aberdeen mortuary and it was their considered opinion that his cause of death was 1 (a) methadone and benzodiazepine intoxication,
15. Following an internal Scottish Prison Service investigation into the circumstances surrounding the death of Mr Buchan, disciplinary proceedings were raised against the officer involved. POA (S) productions 1 and 2 were prepared during the internal investigation and are notes prepared following observation of the CCTV confirming respectively (Production 1) the checks

carried out on Mr Buchan by officers on 25 July 2017 and (Production 2) the activities of Charles Stewart on 25 July 2017 from 1339 to 1445 and are true and accurate. However, due to the officer's previous exemplary disciplinary record and the competing pressures of the role on the day in question, a final written warning rather than dismissal was deemed appropriate. SPS Productions numbers 8 and 9 comprise the record of final written warning and outcome of disciplinary interview both dated 20 December 2017. They contain a true and accurate account of the matter considered and conclusions reached in relation to the said disciplinary matters,

16. SPS Production 12 is an email sent by the agent for the SPS to the other participants on 27 September 2019. This information was also provided to the court. This email contained information provided by Stewart Campbell following further queries raised by Sheriff McCrossan. This email is a true and accurate account of Stewart Campbell's responses,

17. Ellon Hall houses around 350 prisoners. A full complement of staff for the afternoon on Ellon Hall is 17 officers and 2 FLM's (First Line Manager). On the 25 July 2017 at the time of Mr Buchan's death, there were 14 officers and 2 FLM on duty in Ellon Hall. Therefore, the entire hall was short staffed by 3 officers. 2 members of staff were off sick and one was on a medically advised work programme where no prisoner contact was allowed. One of the officers who was off sick provided a medical certificate on 24 July 2017 confirming they would not be in attendance on 25 July 2017. The other

officer who was sick was absent from work on 24 July 2017 and it was not known whether he would be in attendance on 25 July 2017 until that morning. It was known on the date of Mr Buchan's death that the officer under the medically advised work programme would not be allowed prisoner contact.

Summary of evidence

From the information provided to the inquiry I was able to make the following relevant findings:

[9] On his reception into HMP Grampian on 13 July 2017 Mr Buchan was processed through the standard admission procedure. He was not considered to be at risk of self-harm but was identified as a substance misuser. He disclosed that he regularly took street drugs namely benzodiazepines and also smoked heroin. He regularly took large quantities of alcohol. In fact in the few days prior to his arrest he had been admitted to Aberdeen Royal Infirmary Accident and Emergency Department due to an accidental overdose of alcohol. He had discharged himself. The urine test taken during his initial healthcare assessment disclosed traces of opiates. Mr Buchan was noted as displaying signs of alcohol withdrawal. He was placed on a drug reduction programme. Crown Production B (see Appendix for details) shows that this involved a combined prescription of dihydrocodeine (DHC) and diazepam. The initial dosage was 120 mg of DHC and 30mg of diazepam twice daily, on a reducing basis over a period of 17 days (to

end of July). Professor Grieve confirmed this as a standard prescription regime on admission to prison for individuals with substance misuse issues.

[10] On 15 July 2017 Mr Buchan self-referred himself to the substance misuse service within the prison. On that date he was also referred to the smoking cessation team. He was issued with nicotine lozenges. On 17 July 2017 Mr Buchan received a warning for concealing diazepam. Thereafter he attended for his initial substance misuse assessment on 18 July 2017. However the assessment was not completed as Mr Buchan presented as being under the influence of substances and was returned to Ellon Hall and placed on substance observations. His assessment was rescheduled for 20 July. He attended on that date and his assessment was completed. The report in the Vision record (Crown Production 5) notes Mr Buchan as being much better. He apologised for his condition at the last consultation, was noted as being very upset and expressing a desire to get his life back together and become drug free. He disclosed that he was a user of large amounts of illicit drugs namely heroin, crack cocaine and Valium. He disclosed that he had been smoking heroin in the halls.

[11] Following that consultation Mr Buchan's prescription was altered. He was commenced on the opiate substitute methadone at a daily dose of 30ml. The DHC was immediately discontinued. By that date his daily dose of diazepam had reduced to 15mg morning and evening. The notes in the Vision Record confirm that the intention was to review Mr Buchan in 7 days.

[12] Mr Buchan re-referred himself to the substance misuse service on 24 July 2017. It is not known what prompted him to do this. A meeting was scheduled with the

substance misuse service for 25 July at 12 noon but prior to that Mr Buchan had been placed on observation under the Management of an Offender at Risk due to any Substance Policy (MORS).

[13] On 25 July 2017 Mr Buchan's prescription was dispensed to him sometime after 9am. (The Joint Minute states he received his morning medication shortly after 0645 but witness Nurse Buchan advised the court that while dispensing commenced around that time she arrived at Mr Buchan's Hall around 9am.) By that date Mr Buchan's dose of diazepam had reduced to 10 mg morning and evening. Nurse Buchan confirmed that Mr Buchan did not appear under the influence of any substance when she issued his medication to him and it was dispensed without any concern. She and witness Mr Cunningham explained the precautions followed to ensure so far as possible that a prisoner received the correct medicine and consumed it immediately. She had no reason to suspect anything out of the ordinary with Mr Buchan that morning.

[14] Thereafter, shortly before 11 am Nurse Buchan was called to Ellon Hall by prison officers concerned that Mr Buchan may be under the influence of a substance. At the point of concern being raised by a prison officer the MORS policy is initiated. The policy provides in paragraph 6, page 2 that:

> "*upon identifying an offender who is suspected of being at risk due to a substance (due to intelligence or presentation), the member of staff should complete the observation referral (appendix A) and notify healthcare staff, provide the offenders details (name, number, location, date) and describe how the offender is presenting.*"

Crown Production B is the Care Plan document which was initiated for Mr Buchan on the day of his death. Appendix A which was completed by the officer on duty, reported Mr Buchan as having slurred speech, being unsteady on his feet and being drowsy.

[15] As per the procedure Nurse Buchan undertook an assessment of Mr Buchan. It was her responsibility at that point to provide an appropriate Care Plan. Following her examination of him she had no concerns about Mr Buchan, but she deferred to the officers who had observed him over a longer period. The Care Plan requires to specify how often observations are to be carried out and what form those observations are to take (verbal or visual), how long the observations are to be carried out for, and when the offender will be reviewed by healthcare staff. At that time she placed Mr Buchan on hourly observations, to be reviewed after 24 hours. She specifically asked Mr Buchan if he had taken any illicit substance. He denied doing so. In the Vision record (Crown Production 5) written up retrospectively she describes Mr Buchan as "vehemently" denying having taken anything.

[16] Approximately an hour later, at around noon, Nurse Buchan was called back to Ellon Hall due to ongoing concerns about Mr Buchan. He had been found by prison officers to be lying on the floor and had been sick. By the time Nurse Buchan got to the Hall Mr Buchan was sitting on the bed. She spoke to him. She did not consider his condition to have changed. On this occasion she checked Mr Buchan's blood pressure, recorded his oxygen levels and checked his pulse. She confirmed these readings did not cause her any concern. She was not able to recall the exact readings. She confirmed that she had noted them down at the time on the back of the disposable glove she was

wearing. It was not standard practice to record readings in this manner but she explained that when one was called as a matter of urgency to a situation it was not uncommon for notes to be jotted down on whatever was available – on this occasion it had been a disposable glove, on other occasions she had used a post-it note. She explained that her normal practice was thereafter, once she returned to the health centre, to transfer the information to the prisoner's medical records. However on this occasion she believes she must have absent-mindedly disposed of the glove on her way back, as she did not have the necessary information to record in the Vision notes later when completing same. Nurse Buchan advised the inquiry that it was not unusual to be called to attend to another prisoner while on the journey back to the healthcare centre. However she was absolutely clear that had the readings been abnormal she would have recalled the specifics. I accepted this evidence without reservation. While it was clearly not best practice, it was a situation which was understandable in the environment in which she worked. It did not contribute in any way to the death of Mr Buchan and in all the circumstances I have no further comment to make on this.

[17] Again, at this time, while she herself had not observed anything to cause her concern she deferred to the officers who did have. As stated above they had found him lying on the floor. He was also reported to have been sick. Her instruction therefore was that the observations be stepped up to every 15 minutes.

[18] Appendix B of the Care Plan (within Crown Production 8, referred to as Document B) sets down guidance for operational staff. If 15 minute observations are required than an officer must carry out a visual observation every 15 minutes and obtain

a verbal response from the offender every 60 minutes. Visual observations are where the officer is observing to ensure that there is no change to the offender's presentation. If a verbal response is required from the prisoner the officer must obtain a clear and coherent response to a request for name, spin number and date of birth. The observations are to be recorded in the Observation Log which is retained at the central desk in each Hall.

[19] No entries are recorded in the Observation Log from the time at which Mr Buchan was placed on increased observation at 1200 until 1445 - the time at which Mr Buchan was found by prison officer Charles Stewart (Officer Stewart) to be unresponsive. Notwithstanding this, the subsequent SPS internal investigation very quickly ascertained - from CCTV footage examined - that the responsible officer, Officer Stewart, had carried out observations between 12 noon and 1339. A timetable thereafter drawn up as part of the investigation outlines the frequency and nature of the observations carried out by him over that period. There was no dispute between the parties that these checks did comply with the mandated regularity and at each check the officer got a verbal response from Mr Buchan. The CCTV footage also discloses that during the period from 1339 to 1445 when no checks were carried out, the officer was fully engaged in other duties with other prisoners and colleagues.

[20] When Officer Stewart checked Mr Buchan at 1445 he found him to be unresponsive. He immediately called for the duty nurse. A Code Blue was put out, which is the emergency response to be followed when a prisoner is found not breathing or having difficulty breathing. Officer Stewart commenced CPR, thereafter, despite all

attempts being made by health care staff and emergency services, Mr Buchan's life could not be saved. His life was pronounced extinct at 1516 hours. Officer Stewart who found Mr Buchan and initiated CPR was reported to have been very distressed by events. For his part, in the DIPLAR report (Death in Prison Learning, Audit & Review, SPS Production 4) Mr Buchan was described as a likeable, cooperative individual; who caused no trouble within the establishment.

Submissions and Issues for determination

[21] I have set down at the outset of this determination the findings about the time, place and cause of Mr Buchan's death. The Act also requires me to consider whether there were:

> *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, (section 26(e));*
>
> *any defects in any system of working which contributed to the death or any accident resulting in the death, (section 26(f)), or*
>
> *any other facts which are relevant to the circumstances of the death (section 26(g)).*

I have also outlined my findings under these sections at the outset of this determination. My reasons for arriving at these findings are set out in the following paragraphs.

[22] Parties, including Mr Hanton for the Crown, invited me to restrict myself to formal findings only in this case. Mr Smith and Mr Gillies identified issues that had arisen during the course of the inquiry; namely the availability of illicit drugs within the

prison, the discovery of a syringe within Mr Buchan's cell, the working with reduced staff numbers on the day of Mr Buchan's death and the missed observations during the period 1339 and 1445. Both referenced the evidence which had been led on these issues respectively submitting that it did not support the making of any recommendations. No evidence had been led of any defect in any system of working which contributed to Mr Buchan's death. While it was unfortunate that the observations had not been carried out in accordance with the Care Plan, even had they been it cannot be said this would realistically have resulted in the death being avoided. Ms Watt highlighted that no concerns had been raised in evidence about the treatment of Mr Buchan by her client, NHS Grampian. I will deal in the first instance with the issues that had been raised in advance of the hearing and dealt with by the parties in their submissions, as follows:

(i) ***Illicit drugs within the prison establishment***

[23] Firstly the issue of illicit drugs being available within prisons. The remit of this inquiry in this respect is not to conduct a full scale enquiry into the availability of drugs within prisons in Scotland. Such an enquiry would require to be a fully funded public enquiry with input from many government agencies and other interest groups. My remit is restricted in this case to the particular circumstances of Mr Buchan's death. There is evidence to indicate that during the period of his incarceration Mr Buchan supplemented his prescription medication with illicit drugs. For reasons which I set out at paragraphs [41] to [48] I make no finding as to whether he had in fact been under the influence of an illicit substance at the time of his death. However even had my

finding been otherwise, I find no defect within the system operated by HMP Grampian that could be said to have caused or contributed to Mr Buchan's death. It is clear from the comprehensive evidence provided by Mr Stuart Campbell that the prison, in common with other establishments within the Scottish prison estate, operates as robust a system as possible to control the introduction and supply of drugs - with the resources available to them. No evidence was led to suggest further precautions which SPS might reasonably have taken which might realistically have altered the situation within the prison.

[24] However I would refer parties to the determination in Fatal Accident Inquiry ALO-B83-17, an inquiry into another drug related death within a prison. The circumstances were markedly different from the circumstances of Mr Buchan's case. While there is evidence here that Mr Buchan may have taken illicit drugs while in prison, in ALO-B83-17 the deceased had smuggled into prison (secreted within his body) a very significant quantity of class A drugs. Mr Stewart Campbell outlines in his Affidavit the role of the police in providing relevant intelligence to identify when such an event is likely. In ALO-B83-17 Sheriff Mackie in his determination suggests that the police may be able to play a more proactive role in the subsequent investigation of such activities. No evidence was led at this inquiry to confirm whether the suggestion made by Sheriff Mackie had been taken forward or explored in any way. I simply draw parties' attention to the suggestion in the event that it is a route that may assist SPS in the difficult task they have.

(ii) Staff shortage

[25] The Joint Minute contained details of the staff shortages on the day of Mr Buchan's death. Mr Cunningham gave evidence to the inquiry about this matter. There was a shortage of three staff in Mr Buchan's Hall. As was common when the prison faced a shortage of staff on any particular day contingency steps were taken. The prison cannot close down because of a shortage, but numbers are allocated to ensure a minimum number of officers in any particular area. Mr Cunningham explained that attempts are made to claw back the missing numbers by requesting that those officers working stay on beyond the end of their shift. The prison operates a system of TOIL (*time of in lieu)* to encourage this. The safety and welfare of the prisoners is the priority and therefore if there are reduced staff numbers then alterations have to be made to certain activities and delays can occur in moving prisoners. At the time of Mr Buchan's death no formal written policy governed the situation. SPS Production 13 is the policy that is now in existence. This policy formalises what was to all intents the practice that was in place at the time. There is no evidence that the system operated by the prison to manage staff shortages (over which they had very limited, if any, control) was defective in any way or specifically on the day of Mr Buchan's death.

[26] Notwithstanding this, the evidence indicates that the shortage of staff is likely to have played a significant part in the failure to carry out the observations mandated in Mr Buchan's Care Plan. I make this point as it is relevant in assessing whether there were any precautions which could reasonably have been taken which might realistically have resulted in Mr Buchan's death being avoided. The following facts demonstrate the

impact of the staff shortage: Officer Stewart, the officer actually tasked with the responsibility of carrying out the observations on Mr Buchan, was the officer who had agreed to stay on beyond the end of his shift on this day. There was no evidence that fatigue compromised Officer Stewart's ability to carry out his duties. However it is clear from the record of the CCTV evidence that the failure to carry out observations was not due to any indolence on the part of this officer. Quite the contrary - throughout the entire period he was engaged in other duties and was observed to be working diligently with other prisoners. Mr Cunningham in his evidence said of Officer Stewart: *'he is very diligent – probably one of the most diligent prison officers we have.'* Indeed in the disciplinary correspondence (Production No 9 lodged by SPS) outlining the outcome of the disciplinary process, the Prison Governor makes the following points:

> *"having checked the CCTV footage provided for the significant period from 1200 to 1445 on 25th July 2017 and all the statements provided within the Conduct Investigation Units report; it is clear that Charles carried out his observations diligently from 1200 to 1339. Thereafter he is actively involved in prisoner management and support of his colleagues in other areas of Level 1 Ellon. My observations identify the practice of a good prison officer."*

[27] The position presented by Officer Stewart in the investigation is clearly accepted by the Prison Governor, as he states:

> *"I have also taken into account his complete honesty and openness throughout the length of this process."*

Officer Stewart's position was set down as follows:

> *"his failure to carry out the observation was not as a result of idleness or failing to understand the requirements placed upon him. It was simply the pressure of competing demands within his role and the area in general. In his own words "time became compressed" and "I felt I had only checked him a couple of minutes ago."*

[28] Notwithstanding these findings SPS considered it appropriate to issue Officer Stewart with a penalty for his failure "*to fulfil his requirement to carry out 15 minute observations on Mr Buchan during the period 1339 to 1445 on 25 July 2017".* The letter stated dismissal was considered "*given the breach of standards and the consequences of Charles' inaction."* It is not for this inquiry to comment on whether Officer Stewart was in breach of any SPS standards, however such a finding and in particular the reference to consequences, necessarily infers that the carrying out of the mandated observations on Mr Buchan was a precaution that could reasonably have been taken, and had it been taken Mr Buchan's death might realistically have been avoided. The evidence supports neither of those propositions.

[29] On the contrary the evidence demonstrates that Officer Stewart, who was described by Mr Cunningham as "*probably the most diligent we have",* was wholly engaged in other duties during the time observations should have been carried out. He was dealing with the "*pressure of competing demands within his role and the area in general".* The Governor characterises what he witnesses as "*the practice of a good prison officer".* The evidence demonstrates to the inquiry that it was not a failure on Officer Stewart's part to prioritise but rather an inability to do so due to the other expectations of his role at that time. The area was short of three members of staff. He was doing his diligent best to carry out his duties. In these circumstances the carrying out of the mandated observations was not a precaution which could reasonably have been taken by Officer Stewart in the circumstances prevailing on that day.

[30] As stated above I am satisfied that SPS do all that can reasonably be done to mitigate the impact of staff shortages on the day to day safe and efficient running of the prison. That being said, the evidence before this inquiry has demonstrated that the shortages on 25 July 2017 did impinge on the ability of individual officers to carry out their duties. In this case the shortage demonstrably inhibited Officer Stewart from being able to carry out a vital function.

[31] In this connection the DIPLAR report (SPS Production 4) had also highlighted possible time pressures on officers required to carry out observations. The following is an extract from Section 11 of the Report:

> *"Findings/Conclusions" : The staff involved made some suggestions regarding the MORS process, ……. making the MORS observation paperwork more portable so as Officers could carry this on their person when carrying out observation, as opposed to having to go to the main desk following every observation."*

This was clearly a factor on the day of Mr Buchan's death as the MORS form was not completed. This in itself did not contribute to Mr Buchan's death therefore was not examined at the inquiry. However given the clear pressure on Officers' time this would appear to be a suggestion worthy of consideration.

[32] Further, it is my view that, even had Officer Stewart been able to carry out the mandated observations, this cannot be said to realistically (in the sense of having been likely to) have avoided Mr Buchan's death. I base this finding on the evidence of Professor Grieve as set out in the following paragraphs.

Observations

[33] As outlined in the Joint Minute the mandated 15 minute observations were not carried out between 1339 and 1445. At 1445 Officer Stewart found Mr Buchan lying on his bed unconscious and not breathing. Despite attempts made by prison officers, healthcare staff and the emergency services Mr Buchan's life could not be saved and he was pronounced dead at 1516 same day.

[34] Professor Grieve was asked by the Crown to provide an opinion as to whether Mr Buchan's life could have been saved had life-saving measures been applied earlier. Initially the representative for SPOA objected to this line of questioning on the basis that Professor Grieve was not an expert in this field and thus not qualified to answer such a question.

[35] I allowed this particular question. Professor Grieve had concluded the death was due to drug poisoning based on his examination and interpretation of the toxicology findings. His evidence (see paragraphs [41] to [48] below) about the levels of drugs within Mr Buchan's system, the properties of such drugs and their potential effect on individuals, had not been objected to, nor had his opinion evidence about whether the levels were consistent with additional drug taking over and above the prescription levels. Professor Grieve is a highly qualified medical practitioner who has specialised in pathology for the last 25 years. I was satisfied that he was qualified to explain to the court the process involved when the human body succumbs to the effects of methadone/benzodiazepine poisoning; what, if anything, can be done to halt and reverse the process, and at what stage it is too late to successfully intervene.

[36] Relevant to this particular line of inquiry was Professor Grieve's evidence that the window of opportunity to render assistance to someone slipping from unconsciousness to death is very small. There is generally a visible deterioration in a person's demeanour, from - at one end of the scale - being fully conscious and ambulant, through to being deeply asleep but rousable; to lapsing into unconsciousness (often associated with very heavy and pronounced snoring).

[37] A person moves from unconsciousness to death in a very short period of time as the lack of blood to the brain leads to fatality very quickly; Professor Grieve described the period as "seconds to minutes". It was his view that unless assistance was rendered as soon as a person slipped into unconsciousness it would generally be too late.

[38] Professor Grieve explained that the necessary intervention is to administer an antidote which can reverse the effects of the opiate on the brain. In HMP Grampian the antidote is not stored in the Halls but in the medical centre and can only be administered by healthcare staff. He advised that the antidote itself is quite a dangerous drug in its own right so it is very important that a proper diagnosis is made before it is administered to anyone. In response to questions from representatives of SPS and SPOA he confirmed that the necessary step of summoning healthcare staff all added to the time taken to administer life-saving measures. I did note that the **Drug Misuse and Dependence Guidelines** (see paragraph [45] below) encourage the training of non-medical staff in the use of opiate antidotes due to the importance of administering them without delay. These of course are guidelines and not Rules, and they specifically enable local protocols to diverge from the guidelines so long as they provide

commensurate protections. The MORS policy confirms that the antidote is not retained within the Halls. No evidence was led before the inquiry to suggest that this was not complaint with the guidelines.

[39] It is clear from Professor Grieve's evidence that speed is of the essence in situations of this nature. His evidence (which was not disputed and which I accept) was that Mr Buchan could have lapsed into unconsciousness and died within a matter of a few minutes. The Crown, SPS and SPOA submitted that, that being so, it was not open to me to make a finding that the carrying out of the observations in accordance with the policy would realistically have resulted in Mr Buchan's death being avoided. I accept that. For obvious reasons no evidence was before the inquiry to confirm at what time between 1339 and 1445 Mr Buchan may have begun his descent through these stages and by what time it would have been too late to render life-saving assistance to him, nor indeed whether he could have been saved. Therefore while it can be said that Mr Buchan's chances would have been greater had the mandated 15 minute observations been carried out, and it is *possible* his death could thus have been avoided, I cannot make a finding that it is *likely* it would have been.

[40] No evidence was led at the hearing to suggest that the Care Plan set up for Mr Buchan was inadequate. It was clearly compliant with the MORS policy. No evidence was led seeking to impugn in any way the MORS policy or to suggest more frequent observations could or should have been carried out on Mr Buchan. While the policy appears to allow the frequency of observation to be a matter of discretion in each case (paragraph 6, bullet point 4 : *Healthcare staff will provide an appropriate Care Plan*

(Appendix C) which should include : how often the observations are to be carried out and what form of observation, i.e. verbal or visual.) the most frequent observation period referred to within the MORS standard Care Plan is that of 15 minutes. That may indeed be the case for prisoners remaining in their cell; if it is, then on the basis that MORS is a nationally applied policy agreed between SPS and NHS Health Scotland, it is reasonable to assume there are sound risk assessed reasons for that. While Professor Grieve's evidence to the effect that Mr Buchan could very well have slipped away within a matter of minutes raises a question in this regard; by itself it does not indicate that the policy is deficient. Had this evidence been anticipated in advance I would have sought to have the relevant SPS staff (in this case Miss McDowell) specifically explain how the MORS policy is applied to such a risk. At the conclusion of the hearing I did consider calling on the parties to lead further evidence on this point, in order that I could consider whether recommendations should be made for similar cases. I determined against such a course. Whilst the sheriff has inquisitorial powers under the Act, I concluded I had gone as far as was appropriate in terms of section 20(2). Whilst appreciating that the purpose of any recommendations made under section 26(4) is that they might realistically prevent other deaths in similar circumstances, I considered that my requiring the crown or other parties to bring forward further evidence at this stage in the inquiry was not appropriate, when the evidence would not affect my findings in respect of the death which was the subject matter of this Inquiry.

Prescription medication

[41] During the course of Professor Grieve's evidence it became clear that there was a possibility that Mr Buchan had died, not as a result of his supplementing his prescription drugs with illicit drugs, but simply from a reaction to his prescription drugs alone.

[42] The following excerpts from the "Conclusion" section of the post mortem report are relevant in this regard:

> *"1 From the circumstances of the case as related to us, our autopsy findings and the Analyst's report (**Crown Production 2)** we are of the opinion that this man died of methadone and benzodiazepine intoxication.*
> *2 The blood methadone level was relatively high, but within the documented therapeutic range. It must be remembered that subjects who are regularly administered methadone (and other opiate/opioid drugs) develop tolerance to the substances and require larger blood concentrations to produce the desired sedative effect. We are aware that this man was prescribed methadone as part of his treatment for opiate addiction. However, toxicological analyses have revealed considerable amounts of benzodiazepines including diazepam and its active metabolites, N-desmethyldiazepam, Oxazepam and temazepam. The diazepam level was at (or marginally above) the upper limit of the documented therapeutic blood concentration, and the combined effects of all of the benzodiazepines would be considerable. Again, it is conceded that regular users of benzodiazepines develop tolerance to these drugs. We are not aware that the subject was prescribed diazepam. (**Professor Grieve was advised in advance of the Hearing of the diazepam prescription issued to Mr Buchan.)***
> *Methadone and benzodiazepines, both being central nervous system depressants will exert at least additive, and likely synergistic, effects in producing fatal respiratory depression."*

[43] Reference is made in paragraph 3 of the Conclusions to the finding of cocaine and its active metabolite in Mr Buchan's urine. The report states that this suggested cocaine use prior to death and likely during the period of incarceration. Professor Grieve explained that where he found evidence of cocaine use, due to its particular properties, he would never definitively rule it out as a contributory factor in a fatality,

but he considered in this case death was likely attributable to methadone and benzodiazepine intoxication.

[44] Prior to the evidential hearing Professor Grieve had been provided with the full details of the prescription medicine issued to Mr Buchan from his admission to HMP Grampian, up until the date of his death. His view remained, as expressed in the post mortem report, that the levels in his system were above the therapeutic level. At the hearing he was asked by the Crown if he could confirm whether the prescription levels of diazepam could account for the quantities of this drug and its metabolites in Mr Buchan's system at the time of his death. Professor Grieve's position was: *"it is difficult to be definitive but it is a very high amount."* He went on to say that it was a level higher than one would expect for a therapeutic dose but again repeated that he could not give a definitive view.

[45] His evidence in respect of the methadone was that the level was consistent with therapeutic levels, however he reiterated the point made in his report that an individual's tolerance to methadone varies. He emphasised the point by saying that methadone at a dose of 30ml would probably kill him. He went on to explain that methadone and benzodiazepam, both being CNS (Central Nervous system) depressants will exert at least additive if not synergistic effects in producing fatal respiratory depression. No party contradicted this evidence. I accepted it. It was also supported by the document lodged by NHS Grampian, namely **Chapter 4 of the "Drug Misuse and Dependence: UK guidelines on clinical management"**. This document was not spoken to by any witness at the hearing and thus I am not in a position to make any findings

based on my interpretation of its content; but I can observe that it accords with the evidence of Professor Grieve. In particular it highlights the issue raised by Professor Grieve about the variance in tolerance levels in individuals and the potential risks involved when combining methadone with benziodiazepam, particularly in the early stages. The document explains (in paragraph 4.4.2.1) how methadone's long but variable half-life (again spoken to by Professor Grieve) can cause delayed toxicity which may only become apparent after several days of treatment, and which can be affected by factors such as other drugs taken.

[46] Mr Buchan may have supplemented his prescription medication that day. There is evidence that he had done so since his admission; but there is no clear evidence of this occurring on 25 July 2017. Professor Grieve could not be definitive that the levels of drugs in Mr Buchan's system were not all from therapeutic use. I acknowledge his view that the levels were very high and above what one would expect to see but he also highlighted in his evidence (supported by the Drug Misuse guidelines) the potential toxicity of Mr Buchan's prescription medication. In such circumstances I cannot make a finding that it was more likely than not that Mr Buchan died as a result of supplementing his prescribed medication with illicit drugs.

[47] If indeed Mr Buchan's fatal respiratory depression was as a result of his prescription medication alone then of course the issues for consideration by the inquiry would be quite different from those covered above; in particular, the focus of the inquiry would be on (i) the system of assessment and prescribing of methadone and benzodiazepine drugs to prisoners on admission to HMP Grampian; (ii) the system of

monitoring and review of such prisoners, particularly during the early stages when the risk is highest, and (iii) whether there are any precautions which could reasonably have been taken and which had they been taken might realistically have avoided Mr Buchan's death from his prescription drugs. Chapter 5 of the Drug Misuse and Dependence Guidelines would be relevant, dealing as it does with prescribing to individuals in custody.

[48] Evidence on these matters was not available because, despite best efforts by all concerned, these issues were not anticipated in advance of the hearing. I do not consider it would be appropriate for me to instruct parties now to produce evidence to allow these issues to be investigated. This would in effect amount to a wholly new inquiry which could not be justified, particularly as it would not alter my findings in relation to Mr Buchan's death.

Section 26(2)(g)

[49] I hesitated about whether it was appropriate to make a finding under section 26(2)(g) in respect of the staff shortage on 25 July 2017. On the one hand I did find that this is what prevented Officer Stewart from carrying out the mandated observations; but at the same time I found that, even had he done so, this would not realistically have prevented Mr Buchan's death. However Section 26(2)(g) allows an inquiry to highlight any other facts relevant to the circumstances of the death. It is relevant that the Care Plan, devised under the SPS MORS policy, mandated an officer to carry out 15 minute observations on an at risk prisoner but, due to a shortage of staff

within the prison, said officer was not able to carry out those observations. While Mr Buchan's life may not realistically have been saved had the observations been carried out, his chances were clearly diminished if the observations did not take place.

[50] Accordingly, in terms of Section 26(2)(g) of the Act, the finding of this Inquiry is, that relevant to the circumstances of Mr Buchan's death is the fact that HMP Grampian, Ellon Hall, was on 25 July 2017 short of 3 members of staff.

Recommendations

[51] I have no recommendations to make in respect of this finding under section 26(2)(g). I am satisfied that on 25 July 2017 SPS had done all they could to ameliorate the effect of the staff shortage which was something beyond their control. There was no evidence before the Inquiry to suggest that staff shortages were a regular issue at HMP Grampian. If indeed that is the case then that would be a matter of general concern, as the facts of this case demonstrate. However this would not be a matter for an inquiry of this nature to examine or make any recommendations about; rather an inquiry with a specific remit would require to be instructed. An inquiry of this nature can however legitimately highlight the impact this factor has on prisoner care where this is evidenced, as in this case.

Condolences

[52] The notice of inquiry indicated that Mr Buchan was not survived by any next of kin. However on admission to HMP Grampian Mr Buchan listed friends on his visitor

list. I will not identify them by name here but I take this opportunity to extend my condolences to them.

Appendix A

Crown Productions

1 Post Mortem Report prepared by Professor James Henderson Kerr Grieve MB ChB, FRCPath, FFFLM. Emeritus Professor in Forensic Medicine and Dr Tamara Mary McNamee, Forensic Pathologist Registration ST4

2 Toxicology Report prepared by Dr D W S Stephen and Mr James J Allison

3 Police Scotland Record of CCTV Viewing

4 Police Scotland Book of Photographs of deceased

5 Discharge summary report (4 pages) NHS Grampian – referred to as VISION record

6 Admission assessment for Mr Buchan carried out on 13 July 2017 in brackets six pages)

7 Prescription recording sheet in respect of the deceased Mr Buchan (3 pages) referred to as Kardex (lodged at hearing as "A" document)

8 Appendix A to E from Scottish Prison Service (SPS) Management at Risk of Offender at Risk (MORS) due to a Substance policy, (Lodged at hearing as "B" document)

9 Affidavit of Kimberley Louise Lorimer, Health care support worker, employed by NHS Grampian.

Scottish Prison Service (SPS) productions:

First inventory

1 Management of an Offender at risk (MORS) due to any substance – Policy and Guidance document

2 MORS documentation relating to Mr Buchan

3 GMA 060 Aa/16—Code Red/Code Blue policy

4 Death in Prison Learning, Audit & Review (DIPLAR) relating to Mr Buchan

5 HMP Grampian Standard Operating Procedure 909 regarding Prisoner Observations dated 9 June 2019

6 HMP Grampian Standard Operating Procedure ACT 028 regarding MORS dated 29th January 2019

7 HMP Grampian Standard Operating Procedure PM003 regarding Issuing of Medication dated 10 May 2019

8 Record of Final Written Warning dated 20 December 2017

9 Outcome of Disciplinary Interview dated 20 December 2017

Second inventory

1 Affidavit of Lesley Catherine McDowell, Head of Health Strategy at Scottish Prison Service, dated 22nd August 2019

2 Affidavit of Stuart Campbell, Head of Operations, HMP Grampian, dated 28th August 2019

Third inventory

1 Email from the agent for the SPS (Liam Smith) to the other participants dated 27 September 2019

2 HMP Grampian-Standard Operating Procedure Regime Restrictions Protocol

Scottish Prison Officers Association, Scotland (SPOA) Productions:

1 Document confirming the checks carried out on Brian Buchan on 25/07/17

2 Document confirming the timeline of Charles Stewart's activities on the 25/07/17 from 1339 - 1445

Grampian Health Board, Productions

1 "Drug Misuse and Dependence: UK guidelines on clinical management", Prepared by Clinical Guidelines on Drug Misuse and Dependence Update 2017 independent Expert Working Group, Chapter 4