SHERIFFDOM OF GRAMPIAN HIGHLANDS AND ISLANDS AT PETERHEAD

[2021] FAI 42

PHD-B136-19

DETERMINATION

BY

SHERIFF CHRISTINE P McCROSSAN

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

into the death of

SEAN FRANCIS TAGGART

Peterhead 24th June 2021

The Sheriff having considered the information presented at an inquiry into the death of SEAN FRANCIS TAGGART under the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (the Act) makes no recommendations in terms of section 26(1) of the Act. Formal findings under Section 26(2) are made as follows:

(1) Mr Taggart born on 14th December 1980 died at HMP Grampian, South Road, Peterhead on 10th March 2018, life being pronounced extinct at 0948 hours on that date;

(2) There was no accident which caused or contributed to Mr Taggart's death;

(3) The cause of Mr Taggart's death, confirmed by the findings of a post mortem carried out on 13th March 2018 was 1(a) complications of alcohol and drug use;

(4) Following a detailed investigation into the circumstances surrounding the admission of Mr Taggart into HMP Grampian and the prescribing to him of medication the sheriff finds and determines that there were no precautions which could reasonably have been taken, which if taken, might realistically have resulted in his death being avoided, nor were there any defects in the system of working which contributed to his death.

(5) That Mr Taggart suffered from alcohol and poly-drug addiction was a fact relevant to the circumstances of his death.

Background

[1] Mr Taggart was only 37 years old at the time of his death. All parties to this inquiry expressed their condolences to Mr Taggart's family and friends who have lost him to this addiction at such a young age. Sadly a significant period of his young life appears to have been blighted by this addiction. An all too common situation for many of the inmates admitted to the Scottish prison estate.

[2] The course of this inquiry has been protracted. To an extent this was due to the suspension of normal court business due to the global pandemic. In addition following a previous hearing in October 2019 the sheriff instructed that further enquiries be carried out. The cause of death had been identified as complications of alcohol and drug use. The pathologists stipulated a number of ways in which this could have led to Mr Taggart dying on the night of 10th March 2018 but they could not be specific. They identified early cirrhosis and cardiac enlargement; which combination placed

individuals at risk of sudden death at any time due to a fatal cardiac arrhythmia. They also noted that Mr Taggart was vulnerable to complications of alcohol withdrawal including seizures, albeit that the presence of significant amounts of sedative would tend to militate against this. They also stated that "*Toxicological analyses (sic) identified therapeutic levels of his prescribed medication (methadone, diazepam and mirtazapine). These drugs all share a sedative effect on the central nervous system and it is recognised that individuals may succumb to the fatal complications of the combined effect of these drugs, even If present in therapeutic or low levels*".

[3] Therefore whilst alcohol and drug use were long-term issues for Mr Taggart: evidenced by the findings of the post mortem; the drugs most recently ingested by him had been prescribed since his admission to HMP Grampian. These were the sedative drugs referred to in the post-mortem report. The Crown was asked to clarify certain matters with the pathologists. Dr McNamee, Forensic Pathologist provided an Affidavit. In this she confirmed that she could not be more exact about the exact mechanics of Mr Taggart's death, nor could she say with any certainty what effect the combination of medications had. The extent of both his drug use and alcohol consumption while at liberty were unknown, therefore his tolerance level could not be assessed nor whether the prescribed sedatives would be sufficient to manage his alcohol withdrawal. His death had not been witnessed therefore there was no information about signs or symptoms which could help to determine a more definitive cause of death; for example sudden collapse (cardiac arrhythmia) seizure (alcohol withdrawal) or deep snoring and unconsciousness (sedative drug intoxication).

[4] As the prescription drugs could not be ruled out as a contributory factor in Mr Taggart's death it was appropriate to obtain clarification on (i) the NHS prescribing regime on admission of prisoners with poly-drug/alcohol use and (ii) the extent to which observations, if any, could/should be conducted by Scottish Prison Service staff once the prisoner was settled in the prison hall.

[5] At that time the parties represented at the inquiry were (i) the Scottish Prison Service (SPS), (ii) the Prison Officers' Association (Scotland) (SPOA) and NHS Grampian. All parties, including the Crown, assisted the court greatly by carrying out these enquires thoroughly. This led to additional documentary productions being lodged, further evidence being obtained by way of Affidavit or oral evidence and a comprehensive Joint Minute being agreed and lodged. The terms of the Joint Minute are set out in the Appendix to this determination. This Joint Minute contains a comprehensive list of the productions lodged by the Crown and other parties.

[6] Affidavit Evidence was obtained from (1) Lesley Catherine McDowall, Interim Head of Health Strategy, SPS (2) Jennifer Watt, Substance Misuse Nurse at HMP Grampian and (3) Dr Tamara Mary McNamee, Forensic Pathologist.

[7] An evidential hearing took place on 26th March 2021 at which oral testimony was taken from (1) Donna Jepson, Senior Staff and Mental Health Nurse, NHS Grampian (2) Dr Graeme Strachan, GP Peterhead Medical Centre and (3) Dr Bruce Strachan, Peterhead Medical Centre.

[8] In advance of the evidential hearing on 26th March 2021 solicitors representing Dr Graeme Strachan made application to be allowed to participate in the inquiry. No objection was raised by any other party and this application was granted.

Relevant circumstances

[9] Mr Taggart appeared at Aberdeen Sheriff Court on 9th March 2018. This was following his apprehension by police in execution of a warrant. Following his appearance from court he was conveyed to HMP Grampian. It is clear from the Post Sentence Interview Form [Production 9] that Mr Taggart was due to return to court. He had been remanded for the purposes of obtaining an up to date Criminal Justice Social Work Report. While the word "depression" is entered under "mental health concerns" on this form he is not considered to be a suicide risk or be at risk of self-harm. He is noted as showing strong signs of alcohol withdrawal. Mr Taggart arrived at HMP Grampian comparatively early for admission – before 2pm.

[10] On arrival he was initially assessed by a member of SPS staff. This is in compliance with SPS procedure and is carried out in a private room within the reception area of the prison. The member of staff completes a form known as a Reception Risk Assessment (RRA) [Production 12]. The main purpose of this document is to flag up whether the prisoner is at risk of suicide or self-harm. The first section is completed by a staff member of the SPS. The prisoner then passes to the healthcare centre where he also undergoes a further risk assessment by the staff of NHS Grampian following which the remaining section of the RRA is completed. No concerns were raised about Mr Taggart

in this regard, although again he is noted as exhibiting signs of alcohol/methadone withdrawal.

[11] Healthcare provision at HMP Grampian is provided by NHS Grampian. The health centre is staffed by nurses on a round the clock basis. The GP practitioner services are contracted to Peterhead Medical Practice. The GP lead is a Dr Bruce Strachan, who gave evidence to the inquiry. All of the GPs within Peterhead medical practice contribute to the GP service at the prison on a rota basis. GP services are provided 8am to 6pm Monday to Friday. A GP also attends on a Saturday morning. At the time of Mr Taggart's admission to HMP Grampian Dr Graeme Strachan was in attendance. He did not see Mr Taggart. The procedure is that the nurse will carry out an initial assessment of the prisoner. Basic health checks, such as temperature and blood pressure are taken. The prisoner is asked to disclose what substances he has been taking prior to admission. A urine sample is also requested. This provides confirmation of what substances, if any, remain within a prisoner's system at the time of admission. The prisoner is also asked to confirm whether he has been prescribed any medication within the community. This latter information will be checked with the provider. Thereafter the prisoner must have a consultation with a GP within 24 hours. Generally any drug management or reduction programme will be initiated at that consultation. Also, as in the case of Mr Taggart, if the prisoner is on a community dispense (such as a daily dose of methadone) this will be initiated following this GP consultation.

[12] In Mr Taggart's case he was assessed by Ms Donna Jepson. Ms Jepson gave evidence at the inquiry. She is a highly experienced medical practitioner and has

worked at HMP Grampian for many years. She confirmed that as per procedure she carried out basic health checks on Mr Taggart. This is all recorded in the Admission Nursing Assessment [Production 6]. Ms Jepson is skilled in dealing with individuals who have substance misuse issues. She completed a form detailing Mr Taggart's substance misuse on admission. Mr Taggart's urine sample showed positive for benzodiazepines and methadone. He disclosed that he generally drank approximately 2 litres of spirit a day and while in the community was on a daily dispense from a local pharmacist of 30ml of methadone. He had not received his methadone that day as he had been in custody. Nurse Jepson also noted that he was suffering from withdrawals, whether that be alcohol or methadone. If admitted to prison in this condition Mr Taggart would have an uncomfortable, if not distressing night. Ms Jepson was of the view that he required some medication prior to his consultation the following day with a GP.

[13] Given the time of day Ms Jepson was able to consult with Dr Graeme Strachan who was still within the Healthcare Centre. Dr Graeme Strachan was content to rely on Ms Jepson's reporting of the situation. He did not consider it necessary for him to examine or consult with Mr Taggart. He explained that it is not uncommon, whether at HMP Grampian or at Peterhead Medical Centre for him to rely on the expertise of senior nurse practitioners. From the information provided to him by Ms Jepson he placed Mr Taggart on a drug reduction programme. He did so in terms of the UK Drug

Dependence and Misuse UK Clinical Management Guidelines [Production 13].[1] His evidence was that had Ms Jepson not sought him out on the Friday Mr Taggart would have been placed on the drug reduction programme on the Saturday at his GP consultation. Instead, due to his distress he could not be left until the following morning for a GP consultation, Ms Jepson quite appropriately sought appropriate medical intervention for him at the first opportunity.

[14] For her part Ms Jepson confirmed that had no GP been in attendance at HMP Grampian at the time of Mr Taggart's admission she would have required to call G- Meds for advice and authorisation to prescribe. G-Meds is the Grampian out of hours GP service for the entire community. The contract that HMP Grampian has with NHS Grampian does not provide access to GP services on a 24 hour basis; thus like other members of the community if a GP is required out with daytime hours a call has to be made for the out of hours service. Whether that is appropriate for a prison establishment which has responsibility for hundreds of vulnerable individuals 24/7, is not an issue for this inquiry. That factor had no impact on Mr Taggart's death. Significantly no evidence was presented to the inquiry to suggest that it was a common occurrence for nurses to have to call G-docs for assistance at the time of admitting prisoners. Ms Jepson confirmed that HMP Grampian would not admit a prisoner who

[1] Whilst the Guidelines within the prison were up to date, they were still referred to as SPS Guidelines. This appeared to be a legacy issue predating the contractual arrangements entered into with NHS Grampian. This factor had no bearing on the subject matter of the Inquiry.

appeared to be experiencing a medical emergency; either emergency services would be called to transfer the prisoner to hospital, or the prison escort would transfer him there.

[15] Mr Taggart was placed on a drug reduction programme to alleviate his withdrawal symptoms. This was a prescription of diazepam commencing at 30mg twice per day and reducing incrementally to zero over a period of approximately 17 days. He was given 30mg that evening. 30ml of methadone was also dispensed to him as it had been confirmed that he was on an opiate substitute programme within the community and this was the dosage he was receiving.

[16] Dr Graeme Strachan confirmed that the focus of the GP was to stabilise the patient. He advised the inquiry that approximately 75% of the population of HMP Grampian had substance misuse issues on admission. If the individual came in to prison with a history of substance abuse, he would likely be suffering from withdrawal. That had to be managed through a drug reduction programme. If the prisoner was on an opiate substitute programme on admission this would be continued throughout his incarceration unless he requested some intervention. The GP practice would not be the primary focal point for substance misuse work; if the prisoner wished any intervention he would be referred to the substance misuse team within the prison.

[17] Following his assessment Mr Taggart was admitted into HMP Grampian. He was transferred to Ellon wing where he was allocated single occupancy cell 32 in Section B, level 2. NHS Grampian did not communicate any circumstance to SPS that would alert them to any issue about Mr Taggart, specifically that he required any monitoring or special treatment. Nothing about his presentation or behaviour caused

prison officers to have any concern about his wellbeing or health. At 2050 a check was made on him by prison staff. Mr Taggart was in his cell sitting on a chair watching television. He advised the officer that he was feeling better. Normal lock up procedures were followed.

[18] At 0800 hours morning checks of the prisoners commenced. Mr Taggart was found to be lying on his back on the floor of the cell with his feet on the bed. He was showing no signs of life. The prison GP was called to attend immediately. Mr Taggart was pronounced dead at 0948 by GP Dr Stephen Morton. Nothing untoward had been noted during the night. There is no evidence available to the inquiry which can confirm his exact time or cause of death. The opinion of the pathologists is that he may have suffered a cardiac arrhythmia, a drug/alcohol withdrawal seizure, or he succumbed to the sedative effect of the prescription drugs.

[19] Dr Graeme Strachan who commenced Mr Taggart on the drug reduction programme and prescribed methadone to him, acted wholly appropriately in doing so. It was his professional judgement that Mr Taggart required an immediate prescription otherwise he would have continued to suffer from symptoms of withdrawal and have had a distressing first night. The methadone was to address his opiate withdrawal and the diazepam would have a sedative effect therefore alleviating the symptoms of withdrawal from other drugs, whether that be cocaine, benzodiazepines and /or alcohol as well as providing some protection against alcohol withdrawal seizures. Whilst this process was compliant with the UK guidance [Production 13] Dr Strachan confirmed that he does not follow this slavishly but will always apply his own professional

judgement to each situation. He commenced Mr Taggart on methadone as this was a continuation of the prescription he had been receiving in the community. He was aware of the additive and possible synergistic sedative effect of these drugs; however this did not alter his view that the prescription was appropriate: indeed there was no alternative. As a matter of fact it was a standard prescription for poly-drug users on admission to the establishment. The only difference in Mr Taggart's case is that he was commenced on it immediately due to his poor presentation, rather than following the consultation with the GP the day after admission.

[20] It was clear from the input of both Dr Graeme Strachan and Dr Bruce Strachan that an unfortunate fact is that the underlying risk to life for Mr Taggart had been created by his historic poly-drug use; as indeed is the case for other prisoners commenced on the drug reduction programme. It was clear from the evidence before the inquiry that the purpose of the drug reduction programme was to mitigate those risks to prisoners on admission to HMP Grampian. At the time of prescribing the GPs could not know the particular tolerance levels of individuals nor whether they had any underlying conditions (unless known to them and disclosed to the GP). For example Dr Bruce Strachan was asked whether any test could be carried out to confirm whether Mr Taggart had any alcohol in his system, which may interact with any prescribed drugs. He confirmed that an accurate assessment could only be achieved by the taking of a blood sample. This was not practical as it did not give an immediate result. Therefore the prescribing GP could only do their best with the information available to them at the time.

Observations/Monitoring

[21] The inquiry was interested to learn whether on his first night in the prison Mr Taggart should have been subjected to monitoring by SPS staff given the nature of the prescription he had been given. It was clear that SPS had not been notified by NHS Grampian that there was any requirement to monitor Mr Taggart and his presentation did not cause any concern. The UK Guidelines point out the importance of carrying out regular reviews of prisoners on such drug reduction programmes. It is the procedure for NHS Grampian to keep such prisoners under regular review. Had Mr Taggart survived he would have attended his first GP consultation on his first full day within the prison, within 24 hours of admission. Thereafter his medication is dispensed twice a day by qualified medical staff who are able to assess his presentation. Further he is subject to the ordinary observations of prison staff should his condition visibly deteriorate.

[22] To have any prospect of having realistically prevented Mr Taggart's death the overnight observations would have required to be virtually continuous as any of the events which could have caused Mr Taggart's death (seizure, drug intoxication, and cardiac arrhythmia) would be sudden onset with death following almost imminently. Mrs McDowall in her Affidavit confirmed that the only circumstance in which SPS would carry out constant observations on a prisoner is where he was an immediate risk of suicide and had the means to complete the act. A prison officer would observe that prisoner in order to prevent him from harming himself. However she went on to explain: "if *a prisoner is so ill that they require constant observation to determine if their health*

condition was deteriorating that would not be a matter for SPS staff. The NHS would either have to put that prisoner out to hospital for continual observation or provide that cover themselves. SPS are not medically trained or qualified and so it would not be their role to observe somebody due to a medical condition".

[23] Dr Bruce Strachan confirmed that HMP Grampian has no hospital facilities within the healthcare centre, so any prisoner requiring such continual observation would require to be evacuated to a hospital. The medical staff did not know, nor could they reasonably have known, that his condition was such that he was at a heightened risk. The medical staff had no reason to believe his condition was likely to deteriorate as it did and thus had no reason to request he be subject to any special treatment. As stated above to have any realistic prospect of altering the outcome for Mr Taggart that special treatment would require to be continuous observation. That could not be carried out within HMP Grampian. No evidence was led which would suggest Mr Taggart presented as having to be taken to hospital.

[24] Mr Taggart was not unique in the prison establishment. The drug reduction programme was common for prisoners. A very considerable number would be on it at the same time and generally for a number of weeks: with no requirement to be under continual observation. As a matter of fact the risks associated with the combination of prescription drugs was likely to be considerably less than the prisoners were exposed to while in the community taking non-prescribed drugs.

[25] Notwithstanding that there are risks associated with the combination of these prescribed drugs, I am satisfied that the decision to prescribe them was one wholly

within the professional remit of the GP attending Mr Taggart. He acted appropriately by following the procedure set out in the available guidance documentation and by application of his own professional judgment to the circumstances. The risk to Mr Taggart had he not obtained this prescription was likely to have been greater. The GP was not in a position to eliminate risk to Mr Taggart given his long history of poly-drug use and his underlying medical condition. There was no indication that his condition gave any cause for concern to NHS Grampian or SPS on the night he passed away. His situation was on all fours with many other prisoners within the establishment, who were also on the same or similar drug reduction programmes. It was not possible to subject all of these prisoners to monitoring throughout the duration of their drug reduction programme. SPS were not qualified to carry out such a task. It could not be done by NHS Grampian within the prison establishment. In any event there was no evidence to suggest that NHS Grampian were not dealing with the risk appropriately by reviewing prisoners in accordance with the terms of the UK guidance. There were no precautions which could have been taken which might have realistically avoided Mr Taggart's death; there was no defect in any system.

[26] Accordingly having examined all the relevant circumstance surrounding Mr Taggart's tragic death, the Inquiry has no recommendations to make which might realistically prevent other deaths in similar circumstances.

Finally I add my condolences to those expressed by the parties in this case. The family and friends of Mr Taggart have the sympathy of the court in respect of his untimely death.

Appendix

SHERIFFDOM OF GRAMPIAN, HIGHLANDS AND ISLANDS

AT PETERHEAD

SECOND JOINT MINUTE OF AGREEMENT BETWEEN THE PARTIES

IN THE INQUIRY INTO THE DEATH OF SEAN FRANCIS TAGGART UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC. (SCOTLAND) ACT 2016

Hanton, Procurator Fiscal Depute for the Crown, McCormack, Solicitor acting for Grampian Health Board, Wallace, Solicitor acting for the Prison Officers' Association, Middleton, Solicitor acting for the Scottish Prison Service, and Mawby, Solicitor acting for Dr Graham Strachan concur in stating to the Court that the following Is agreed and should be admitted in evidence that:-

1. Sean Francis Taggart (born 14 December 1980) was a prisoner at HMP Grampian, South Road, Peterhead, being allocated single occupancy Cell 32 in Section B on Level 2, having been apprehended by police executing a warrant and pending an appearance at Aberdeen Sheriff Court scheduled for 9 March 2018.
2. Following his appearance at Aberdeen Sheriff Court on 9 March 2018, the said Sean Francis Taggart was conveyed back to HMP Grampian where, on arrival, an admission assessment was carried out by nursing staff.

3. At 2050 hours, same day, a check was made on the said Sean Francis Taggart who was spoken to by prison staff and was seen to be sitting on a chair within his cell watching television at which time he advised that he was feeling better. There were no concerns for him at this time.
4. At 0800 hours on 10 March 2018 morning checks of the prisoners were commenced and the door to the said Sean Francis Taggart's cell was opened and he was found to be lying on his back on the floor of the cell with his feet on the bed at which time assistance was called to the cell.
5. The said Sean Francis Taggart was displaying no signs of life and a General Practitioner was called to attend.
6. Life was pronounced extinct at 0948 hours, same day, by prison General Practitioner Dr Stephen Morton.
7. The death of the said Sean Francis Taggart was reported to the Procurator Fiscal at Aberdeen on 11 March 2018.
8. The body of the said Sean Francis Taggart was subject to a post mortem examination by Andrea Denise Chapman, Consultant Pathologist, and Tamara Mary McNamee, Registrar in Forensic Pathology, on 13 March 2018 at Aberdeen Mortuary and it was their considered opinion that the cause of his death was due to l(a) Complications of alcohol and drug abuse.
9. On 1 November 2011, the responsibility for the provision of healthcare to prisoners transferred from the SPS to the NHS. Since then individual regional NHS health boards have been responsible for the delivery of health care services

within prisons in Scotland which fall within their geographical ambit for the provision of medical care.

10. Production 1 for the Crown is a true and accurate copy of the Full Post-Mortem Report dated 29th March 2018 prepared by Dr AD Chapman and Dr TM McNamee, is to be treated as equivalent of the principal, and contains a true and accurate account of Dr Chapman's and Dr McNamee's post-mortem examination on 13th March 2018 and the pathologists' findings and conclusions.
11. Production 2 for the Crown is a true and accurate copy of the Toxicology Report dated 22nd March 2018 prepared by Dr Duncan Stephen and Dr William Simpson, is to be treated as equivalent of the principal, and contains a true and accurate account of the results of the analyses carried out by Dr Stephen and Dr Simpson of the forensic samples taken from the deceased.
12. Production 3 for the Crown is a set of true and accurate copy Photographs provided to Police Scotland by the Scottish Police Authority, to be treated as the equivalent of the principals, the photographs truly and accurately showing the deceased and the deceased's cell at HMP Grampian subsequent to his death on 10th March 2018.
13. Production 4 for the Crown is a true and accurate copy of the CCTV Timings Sheet, to be treated as the equivalent of the principal, and is true and accurate record of the images, and the timings of those images, recorded on HMP Grampian CCTV system.

14. Production 5 for the Crown is a true and accurate copy of the Medical Records for the deceased provided to Police Scotland by NHS Grampian, is to be treated as equivalent of the principal, and contains a true and accurate account of the secondary clinical care and treatment provided to the deceased by NHS Grampian.
15. Production 6 for the Crown is a true and accurate copy of the Admission Nursing Assessment and is be to be treated as equivalent of the principal.
16. Production 7 for the Crown is a true and accurate copy of the G4S Personal Escort Record, is to be treated as equivalent to the principal, and contains a true and accurate account of the information in relation to the deceased obtained and recorded by G4S.
17. Production 8 for the Crown is a true and accurate copy of the Record of Events.
18. Production 9 for the Crown is a true and accurate copy of the Post Sentence Interview Form, is to be treated as equivalent to the principal, and contains a true and accurate account of the information in relation to the deceased obtained and recorded by the Social Worker.
19. Production 10 for the Crown (Discharge Summary Report) is a true and accurate copy of the general practitioner records for the deceased provided to Police Scotland by NHS Grampian, is to be treated as equivalent of the principal, and contains a true and accurate account of the primary clinical care and treatment provided to the deceased by NHS Grampian.

20. Production 11 for the Crown is a true and accurate copy of the Prescription Recording Sheet and is to be treated as equivalent of the principal.
21. Production 12 for the Crown is a true and accurate copy of the Reception Risk Assessment and is to be treated as equivalent of the principal.
22. Production 13 for the Crown is a true and accurate copy of the Scottish Prison Service Drug Misuse and Dependence Operational Guidance referred to by Dr Graham Strachan in his witness statement dated 8th March 2021 and is to be treated as equivalent of the principal.
23. Production 1 for the Scottish Prison Service is a true and accurate copy of GMA 011A/09 - Policy for the supply of medicines to prisoner patients.
24. Production 2 for the Scottish Prison Service Is a true and accurate copy of the National Memorandum of Understanding between The Scottish Ministers, acting through the Scottish Prison Service and NHS Scotland dated October 2011.
25. Production 3 for the Scottish Prison Service is a true and accurate copy of the Health Board Provision of Healthcare in Prisons (Scotland) Directions 2011.
26. Production 4 for the Scottish Prison Service Is a true and accurate copy of the Healthcare Markers Policy.
27. Production 1 for NHS Grampian Is a true and accurate copy of Drug Misuse and Dependence: UK Guidelines on Clinical Management
28. Production 2 for NHS Grampian is a true and accurate copy of Standard Operating Practice "Management of an Offender at Risk due to any Substance" version 0.2, review date 29.01.2019

29. The following affidavits or signed witness statements are appended to this joint minute:

    a. Affidavit of Dr Tamara Mary McNamee dated 13111 November 2019

    b. Affidavit of Lesley McDowall dated 19 March 2021

    c. Affidavit of Jennifer Watt dated 23rd March 2021

and it is agreed that they can be admitted as evidence and considered equivalent to parole evidence

In respect whereof

PROCUTOR FISCAL DEPUTE

ADVOCATE FOR GRAMPIAN HEALTH BOARD

SOLICITOR FOR PRISON OFFICERS' ASSOCIATION

SOLICITOR FOR THE SCOTTISH PRISON SERVICE

SOLICITOR FOR DR GRAHAM STRACHAN