SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2022] FAI 22

GLW-B848-21

DETERMINATION

BY

SHERIFF THOMAS HUGHES

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

into the death of

JAMES McCULLOCH

Glasgow, 10 June 2022

The Sheriff, having considered the information presented at an inquiry on 23 May 2022 under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 finds and determines:

(1) That in respect of paragraph (a) of section 26(2), James McCulloch born 18 July 1992, died on 17 March 2020. He was at that time a prisoner in HMP Barlinnie.

(2) That in respect of section 26(2), paragraph (c), the cause of death was unascertained.

(3) I have no findings to make under paragraphs (b), (d), (e), (f) or (g) of section 26(2) of the Act. I have no recommendations to make under section 26(1) (b).

NOTE:

Legal Framework

[1] This Inquiry was held under section 1 of the 2016 Act. This was a mandatory inquiry in terms of section 2(1) and (4) of the 2016 Act as Mr McCulloch 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 5 August 2021. A preliminary hearing took place at Glasgow Sheriff Court on 29 September 2021. Miss Allan, Procurator Fiscal Depute appeared for the Crown. Mr Devlin appeared for the Scottish Prison Service and Mr Rodgers for the Prison Officers' Association Scotland. The family of Mr McCulloch was represented by Mr Yuill. The matter was continued until 24 November 2021.

[3] The inquiry was held on 23 May, 2022. The same people appeared, apart from Mr Yuill. Members of Mr McCulloch's family were however in court and able to follow the inquiry proceedings. A joint minute of agreement was tendered on behalf of the parties and this was received by the court. Miss Allan read out the terms of the Joint Minute of Agreement. I also received an affidavit from Sean McFedries, who is the Head of Operations at HMP Barlinnie. That having been done, I appointed parties to lodge written submissions within 14 days and thereafter; made avizandum.

Circumstances

[4] The following narrative is taken from the terms of the agreed Joint Minute.

1. On 26 March 2018, James McCulloch, date of birth 18 July 1992 (hereinafter referred to as "the deceased"), was sentenced to a period of 4 years and 6 months imprisonment at the High Court of Justiciary, Glasgow, having earlier pled guilty to a contravention of Section 4(3)(b) of the Misuse of Drugs Act 1971. On 23 May 2019 the deceased received a further custodial sentence of 4 years' imprisonment following a Jury Trial at Hamilton Sheriff Court in relation to a contravention of Section 4(3)(b) of the Misuse of Drugs Act 1971. This sentence was to run consecutively to the previous sentence imposed. The deceased successfully appealed the second sentence imposed, which was reduced to a period of 3 years imprisonment to run consecutively to his first sentence. The deceased's earliest date of liberation was calculated as 24 January 2025, with a sentence expiry date of 24 July 2025 (all as shown at Crown Production Number 4 at pages 209-248).

2. At the date of his death on 17 March 2020 the deceased was a prisoner of HMP Barlinnie. He was accordingly in legal custody as at the date of his death.

Medical History and Treatment

3. The deceased arrived at HMP Barlinnie on 25 January 2018 having been remanded in custody in advance of his sentencing and following his guilty plea. The deceased was subject to an assessment by the healthcare staff as part of the prison admission process on 25 January and was seen by the Prison General Practitioner on 26 January 2018. The deceased was recorded to be no apparent risk of suicide and to have

no thoughts of deliberate self-harm. The deceased was also recorded as not using drugs at that time (as shown at Crown Production Number 3 at pages 22-23).

4. The deceased was transferred to HMP Shotts on 19 April 2018 before being further transferred to HMP Low Moss on 10 January 2019 and then onto HMP Edinburgh on 20 February 2019. He underwent admissions assessments at Shotts and Low Moss by prison healthcare staff who, at the time of each transfer, recorded that the deceased had no issues with physical or mental health, had no thoughts of deliberate self-harm, and to be no apparent risk of suicide. The deceased's only recorded prescription during this time was a topical cream for a skin condition. The deceased is recorded as having declined to be assessed on arrival at HMP Edinburgh. During his time at HMP Shotts and HMP Low Moss the deceased saw prison healthcare staff for minor ailments; including lower back pain in May and June 2018, and a lump under his arm in January 2019 (as shown at Crown Production Number 3 at pages 21-22).

5. On 17 July 2019, whilst within HMP Edinburgh, a 'code blue' was initiated following the deceased being found unresponsive within his cell during 'numbers checks'. Prison Officers found the deceased lying on the floor of his cell under his bed and a foil and lighter were observed on the bench of his cell. Staff suspected that the deceased had taken a substance and contacted an ambulance to attend. Naloxone was also administered. The deceased briefly responded to the Naloxone after a period of around 5 minutes - becoming aggressive and thrashing his arms and fighting with Prison Officers in an attempt to get up - before becoming unresponsive again. Paramedics thereafter conveyed the deceased to hospital following a second dose of

Naloxone. The deceased was admitted to the Royal Infirmary of Edinburgh where he was intubated and required mechanical ventilation and cardiovascular support within the Intensive Treatment Unit (ITU). The deceased was noted to have developed an Acute Kidney Injury (AKI) and a lower respiratory infection whilst in hospital. He was transferred to the Renal Unit for renal replacement therapy on 22 July 2019 before being discharged back to prison on 26 July 2019. The deceased was seen for consultation at the prison on 29 July 2019. At this time the deceased was recorded to be tearful and anxious but feeling positive about receiving drug misuse support in the prison (as shown at Crown Production Number 3 at pages 19-21 and 56-59).

6. On 1 August 2019 the deceased was transferred to HMP Glenochil. He was again subject to an admissions assessment at which time it was recorded that the deceased had never misused drugs, and that the incident on 17 July 2019 at HMP Edinburgh had been as a result of 'spiking'. It was further recorded that the deceased was anxious, both about home issues and his move to HMP Glenochil. The deceased was seen for a consultation on 6 August 2019. During this time the deceased is recorded as having advised that he "took an overdose after hearing news that his father has cancer" and that this was out of character for the deceased. On 13 August a referral was made for the deceased to the mental health team, however it was recorded that he declined his appointment for assessment on 15 August 2019. A further referral was then made on 19 August 2019 (as shown at Crown Production Number 3 at page 18-19).

7. The deceased was seen by the mental health triage nurse on 21 August 2019. It was recorded that this was a self-referral following the death of the deceased's father. It

was also noted that the deceased was not currently prescribed any medication and had no history of mental health input or previous self-harm or suicide attempts. The deceased was described as presenting well however his tone was flat, and he stated that he felt low and was having trouble sleeping. The deceased denied any illicit drug use. He was then seen by a member of the prison healthcare team on 27 August following a fight with another prisoner; at this time the deceased presented with a swollen nose and a small cut to the top of his nose but no other injuries. He had a follow-up review with the mental health triage nurse on 4 September at which time it was noted that the deceased had been placed on 'protection' within the prison following an assault and being labelled “a grass”. It was recorded that the deceased had ongoing poor sleep and low mood and was staying within his cell most of the day. The nurse recorded that she had arrange for the deceased to see the prison chaplain again, at his request (as shown at Crown Production Number 3 at page 18).

8. The deceased's annual case conference was held on 16 September 2019. One of the conclusions of the case conference was that a referral would be made to the Addictions Team for the deceased. This referral was made on 17 September 2019. On 19 September the referral was reviewed and deemed inappropriate due to the deceased being drug-free. The deceased was seen again by the mental health triage nurse on 27 September. During this review it was recorded that the deceased was showing no evidence of intoxication or withdrawal and he continued to deny any illicit drug use. The deceased also denied any thoughts of suicide or self-harm. The deceased advised that he had requested a transfer to HMP Low Moss (as shown at Crown Production

Number 3 at page 18 and Crown Production Number 4 at page 369).

9. On 31 December 2019 the deceased was transferred to HMP Barlinnie. On the same day the deceased was subject to a 'Talk To Me' assessment which is the Scottish Prison Service's suicide prevention policy. The deceased was noted to have been moved to Barlinnie in order to undertake the Pathways course within the prison. It was also recorded that the deceased had no issues with Barlinnie and presented as 'no apparent risk'. The deceased was initially housed within 'D Hall' before being moved to 'A Hall' on 3 January 2020. Between January and February 2020, the deceased was seen on several occasions by prison healthcare staff in relation to skin complaints. On 29 February 2020 he was seen in relation to skin wounds to his left hand and foot. In relation to these the deceased was transported to Glasgow Royal Infirmary and seen by three specialists before being returned to the prison later that evening with prescribed oral antibiotics. He was reviewed by prison healthcare staff on 1 March 2020, and then again on 2 March 2020 at which time the wounds were cleaned and dressed and he was prescribed a further course of antibiotics for a period of 5 days. The deceased had no further contact with healthcare staff until 17 March 2020 (as shown at Crown Production Number 3 at pages 17 - 18, Crown Production Number 4 at page 199, and Crown Production Number 5 at pages 392 and 395).

Events of March 2020

10. At around 0724 hours on 17 March 2020 the deceased left his cell. He was captured on Prison CCTV speaking to a member of staff and other prisoners before re-entering his cell at around 0727 hours. The deceased is seen to leave his cell again with a

dark towel at around 0749 hours and speaks to another prisoner outside cell 26. He briefly enters cell 26 before leaving and heading towards the shower area. The deceased is seen to return and walk towards his cell, before walking back to the shower area at around 0755 hours with another prisoner. The deceased exits the shower area at around 0809 hours carrying a chair which he takes into his cell. The CCTV captures the deceased hanging around outside his own cell before entering another cell for around 10 seconds and then returning briefly to his own cell. He then walks to the shower area again where he remains for around 1 minute, before returning with his towel to his cell at around 0813 hours. This is the last sighting of the deceased on CCTV (as shown at Crown Production Number 6 and Crown Label Number 1).

11. At approximately 0900 hours Prison Officers Christopher Doherty and Paul McCann began unlocking the cells on the third floor of A Hall in order that the prisoners could attend for exercise. Prison Officer Doherty attended at the deceased's cell, A3-21, where he unlocked and then entered the cell. The deceased was observed to be sitting on the floor of the cell in an upright position facing the cell door and with his feet lying out in front of him. PO Doherty attempted to gain a response from the deceased, however when he received no response from the deceased, he went to the cell door and called for the assistance of PO McCann who was unlocking cells in another section of the floor. PO Doherty then called for a 'code blue' requesting medical assistance via his radio. PO McCann attended at the cell and PO Doherty and PO McCann then placed the deceased into the recovery position until the arrival of healthcare staff. James Stewart, who was acting in the capacity of First Line Manager within the prison that morning,

attended at the cell, as did Prison Officer Bryan Johnstone (as shown at Crown Production Number 4 at page 166).

12. Prison Nurses Gillian McNally and Mary Quarishie attended at the cell in response to the 'code blue'. On their arrival at the cell the deceased was observed to be not breathing, to be cold to the touch with blue/purple lips, and to have fixed and dilated pupils. The deceased had no pulse and showed no evidence of respiration or cardio pulmonary activity. There were also signs of lividity on the deceased's body. CPR was commenced and an ambulance immediately requested. Attendance was also requested of the Prison GP. Supplementary oxygen was administered, and the prison defibrillator was used on the deceased. Shortly thereafter the Prison Doctor on duty, Dr Van Den Meersschaut, attended at the cell. The healthcare staff then observed a homemade smoking pipe (or 'tooter') within the cell and so an injection of Naloxone was provided to the deceased. Treatment continued until the arrival of paramedics at the cell at approximately 0920 hours. Medical treatment was continued by the paramedics and a further round of CPR provided. However, around 20 minutes after the commencement of CPR, it was agreed that the CPR was ineffective and that efforts should cease as there remained no signs of life' (as shown at Crown Production Number 3 at page 17 and Crown Production Number 4 at pages 177 - 179).

13. The deceased's life was pronounced extinct at 0930 hours on 17 March 2020 (as shown at Crown Production Number 4 at page 159).

Police Investigation

14. Following the death of the deceased Police Scotland were notified and the

deceased's cell was locked and secured with the deceased still inside. Detective Constable Paul Fraser and Detective Sergeant Jaswinder Juttla attended at the prison alongside a crime scene examiner at approximately 1200 hours and conducted a systematic search of the deceased's cell. The 'tooter' was seized from the cell and general view photographs were taken by the crime scene examiner of the deceased and the cell. The deceased's body was then removed from the prison to the mortuary at Queen Elizabeth University Hospital, Glasgow, escorted by Police Officers Andrew Muir and Evelina Luksyte (as shown at Crown Production Number 4 at pages 174 and 181).

15. The 'tooter' was later sent for analysis for any controlled substances or residue by Detective Constable Paul Fraser. A Rapid Restricted Analysis Drug Report was thereafter provided which confirmed that residue on the 'tooter' had been examined and was found to contain 4F-MDMB-BINACA, a Synthetic Cannabinoid Receptor Agonist (as shown at Crown Production Number 8 and Crown Production Number 10).

STOP Unit

16. Police Scotland's STOP Unit were requested by Crown Office and Procurator Fiscal Service to provide a report on the background and use of 4F-MDMB-BINACA. Their Statement of Opinion is contained within Crown Production Number 11. Some parts of this Statement of Opinion are detailed as follows, at pages 452 - 453:

> "Synthetic Cannabinoids (SCRAs, Synthetic Cannabinoid Receptor Agonists) were a popular Psychoactive Substance ('legal high') on the market prior to the inception of the Psychoactive Substances Act 2016 {PSA 2016}. The PSA 2016 was effective in closing down the high street shops that were responsible for selling Psychoactive Substances including the synthetic Cannabinoid range. However a small range of online outlets continued to sell them...There are hundreds of different synthetic

Cannabinoids...

The effects of using these products can be similar to the effects of natural Cannabis but there have been reports of users having effects similar to stimulant type drugs...

The methods of smuggling the synthetic Cannabinoids into the prison estate is many fold and the perpetrators of this are limited only by their own imagination...

The vast majority of synthetic Cannabinoids I encounter at present are recovered from the prison environs. The synthetic Cannabinoids recovered from the prisons now in general terms (possibly due to the smoking ban) take the appearance of pieces of paper that have been impregnated with a solution of active ingredients and then allowed to dry and subsequently sent into the prison as letters/pieces of correspondence. The synthetic Cannabinoid solution has also been recovered impregnated into items of clothing...

These articles can then be used to ingest the synthetic Cannabinoids in numerous ways including eating the paper, soaking the paper/items of clothing in water and drinking the solution, adding small pieces of the paper into vape type equipment and smoking it."

Post Mortem

17. A post mortem examination was conducted on 27 March 2020 at the Queen Elizabeth University Hospital, Glasgow, by Consultant Forensic Pathologists, Dr Gillian Wilson and Dr Gemma Kemp and the cause of death was recorded as:-

1a. Unascertained.

18. The conclusions section of the Post Mortem Report is contained at pages 6 and 7 of Crown Production Number 2 and states as follows:-

"At post mortem examination there were no significant injuries to the body.

Internally again there were no signs of trauma.

The heart was normal and the lungs showed congestion and oedema. The liver showed moderate fatty change which maybe due to the increased body habitus with the body mass index in the range of obesity.

The initial toxicological analyses for alcohol, prescription drugs and drugs of abuse gave negative results. Further analyses were undertaken for synthetic cannabinoid receptor agonists and 4F-MDMB-BINACA and its metabolite was detected consistent with use prior to death. 4F-MDMB-BINACA has been detected in Scottish prisons since February 2019. In addition, 4F-MDI\IIB-BINACA has been widely detected in post-mortem and driving under the influence of drugs {DUID} casework in the United States. 4F-MDMB-BINACA is appearing with increasing frequency as a contributory factor in deaths, creating morbidity and mortality risks for drug users.

Deaths have been described associated with synthetic cannabinoid receptor agonists but the precise pathophysiological mechanisms by which death occurs remain obscure; however, the following have been described clinically: seizures, cardiac arrhythmias and increased blood pressure. In the Glasgow Forensic Pathology department, synthetic cannabinoid receptor agonists have been implicated in several deaths albeit in those cases other drugs were also present.

Given the circumstances of a pipe being found in the cell and the lack of any underlying natural disease, it would appear that use of synthetic cannabinoids may have caused the death but this cannot be stated with any certainty. Toxicological analyses are not exhaustive and new substances are frequently created so there is the possibility that a new substance was present that cannot be tested for presently. If further intelligence is gained ie if a specific substance is suspected further testing could be potentially be undertaken.

In cases such as this in a young person where there is no cause of death, there is the possibility that death was due to a fatal cardiac arrhythmia and, in the absence of identifiable gross or microscopic cardiac disease, this raises the possibility of an underlying channelopathy, which can lead to conditions such as long QT or Brugada syndrome. These conditions can be inherited."

[5] I had the benefit of considering an affidavit from the witness Sean McFedries. Since July 2018 he has been the Head of Operations at HMP Barlinnie. He has overall security of the jail

and its prisoners and the management of its operations function. He referred to the unfortunate circumstances of Mr McCulloch's death and provided the court with a detailed note of all precautions which are taken for the safety of prisoners within the establishment and the security efforts made to limit the misuse of drugs within the prison. He outlined the pre-admission procedure for the reception of prisoners. Searching regimes are in force. All new admissions are taken through the Talk To Me process. This is the SPS suicide prevention strategy. Prisoners serving custodial sentences may be subject to body search, body scanners and the strip searches with a view to detecting illegal drugs. The prison has access to a dog unit for screening purposes. The staff always monitor and observe the prisoners and perimeter checks are regularly carried out to detect illegal substances entering into the prison. Cell searches are regularly carried out and there has been a substantial investment in a Rapiscan Itemiser which is a scanner that can detect a range of substances from any surface, including paper. This assists with scanning mail and other items of property coming into the establishment and allows the officers to detect any traces of illicit substances. Visitors entering into the establishment are subject to search. Prisoners have access to medical treatment and mental health services. SPS also focus on rehabilitative measures to deal with drug prevention. In conclusion the officer told the court that everything was being done to prevent drugs being introduced and thereafter used within the prison. However there is a substantial demand for drugs within prisons and dealers have the opportunity of being able to sell drugs in prison at very high value. As a result no matter how much effort and expenditure is been made by SPS it is still extremely difficult to keep drugs out of the establishment. Substantial resources and effort are continually being committed to deal with what he referred to as an extremely

challenging task. Whilst the prison officers do all they can to prevent drugs from entering into the establishment, it is impossible to stop all the drugs all of the time. He concluded by saying that "there is not a jail fix for this issue."

Submissions for the parties

[6] The Crown invited me to make the mandatory formal findings only, i.e. to determine when and where the death of James McCulloch occurred, and the cause or causes of Mr McCulloch's death in terms of Sections 26(2)(a) and (c) of the 2016 Act.

[7] It was submitted that Mr McCulloch's death did not result from an accident and therefore the Crown made no submissions in terms of Sections 26(2)(b) and (d) of the 2016 Act. There are no reasonable precautions which might have prevented the death, and no defects in any system of working which contributed to the death. There are no other facts which are relevant to the circumstances of Mr McCulloch's death and therefore the Crown also make no submissions in terms of Sections 26(2)(e), (f), and (g).

Scottish Prison Service

[8] On behalf of the Scottish Prison Service it was submitted that as confirmed within paragraph 5 of the Joint Minute, there was one instance prior to his death whereby Mr McCulloch was suspected of taking a substance. This was on 17 July 2019. Naloxone was administered and Mr McCulloch was subsequently admitted to the Royal Infirmary of Edinburgh.

[9] As confirmed within paragraph 8 of the Joint Minute, Mr McCulloch attended his annual case conference on 16 September 2019. One of the conclusions from the case conference was that a referral would be made to the Addictions Team for the deceased. This referral was made on 17 September 2019. On 19 September 2019, the referral was reviewed and deemed inappropriate due to the deceased being drug-free. The deceased was seen again by the mental health triage nurse on 27 September 2019. During this review it was recorded that the deceased was showing no evidence of intoxication or withdrawal and he continued to deny any illicit drug use. The deceased also denied any thoughts of suicide or self-harm.

[10] Crown Production 5 is the Death in Prison Learning, Audit & Review Report ("DIPLAR"). The multi-agency meeting took place on 1 September 2020 to review the care and treatment provided to Mr McCulloch. Within Section 2 of the DIPLAR it states that "Mr McCulloch was seen by the prison social worker on 6th February 2020, as a routine discussion following transfer from Glenochil. He presented well and there were no obvious signs or evidence of recent drug misuse."

[11] It is widely reported and known that illicit drugs find their way into and circulate within the prison establishment. This occurs despite robust efforts to combat and prevent this. This is not a problem unique to HMP Barlinnie. The Affidavit from Sean McFedries is particularly useful to the Inquiry in regard to this issue. The Affidavit provides a detailed overview of the measures employed by the SPS at HMP Barlinnie. Mr McFedries' evidence as to the efforts employed by HMP Barlinnie to prevent drugs entering the prison was of benefit to this Inquiry. There are extensive operations employed by prison authorities to halt and disrupt the supply of illicit drugs into the prison estate. Of note, Mr McFedries described a constant

battle to meet the challenges posed by those who would seek to introduce drugs to the prison. He described the various methods by which such substances may enter the prison estate along with the preventative and disruptive actions taken by the prison.

[12] There is a duty on the SPS to take all reasonable precautions to prevent deaths which result from or may be connected with the use of illicit substances. As explained by Mr McFedries, there are robust and clear policies and operating procedures in place in respect of the prevention and detection of drugs within the prison establishment.

[13] Crown Production 2 contains the Post Mortem Report. The examination was conducted on 27 March 2020. The cause of death was recorded as 1a: Unascertained. It follows that there is no definitive causal link between the drugs found within Mr McCulloch's system and his death.

[14] It was submitted that that there were no precautions which could reasonably have been taken and there were no defects in any system of working which contributed to the death of Mr McCulloch.

[15] On behalf of the POAS, Mr Rogers also asked me to make the mandatory formal findings only. In particular however he further made reference to section 26(2) (e). Although it is acknowledged that any precaution will inevitably be a hypothetical one, and that the benefit of hindsight may be applied, the court was invited to make no finding. The court had to consider how the terms of the section ought to be interpreted.

[16] Carmichael on *Sudden Deaths and Fatal Accident Inquiries* (3rd Edn) at paragraph 5.75 on page 174, provides, "…what is envisaged is not a 'probability' but a real or lively possibility that the death might have been avoided by the reasonable precaution."

[17] This has clearly been informed by Sheriff Kearney's determination of 17 January 1986, in the death of James McAlpine, referred to at paragraph 8.99 on page 334 of Carmichael:

> "In relation to making a finding as to the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided (section 6(1)(c)) it is clearly not necessary for the court to be satisfied that the proposed precaution would in fact have avoided the accident or the death, only that it might have done, but the court must, as well as being satisfied that the precaution might have prevented the accident or death, be satisfied that the precaution was a reasonable one. The phrase 'might have been avoided' is a wide one. It means less than 'would, on the probabilities have been avoided' and rather directs one's mind in the direction of the lively possibilities."

[18] Although this determination pre-dates the 2016 Act, it does remain instructive, given the clear parallels between the 2016 Act and its predecessor, The Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976.

[19] Further guidance can be found in Sheriff Holligan's determination of March 2004, arising out of the death of John Kell. Sheriff Holligan opines:

> "Causation does have a role. In particular the provision of section 6(1)(c) and (d) seem to me to proceed on the basis there will be, in most cases, a process or event which falls to be examined in order to see what led to an accident. Having established such process or event, it is then possible to see what steps might have been taken to avoid the outcome or what defects there were. In my opinion, the provisions of Section 6(1) (c) and (d) fall to be applied objectively and with the benefit of hindsight. Section 6(1) (e) gives some support to this interpretation. There might be circumstances that might be relevant to the death but might not have been established to have a causal link".

This passage is also referenced in Carmichael, at para 11.20 pages 421-422.

> "In order for the court to make a finding under subsection (e) there must have existed a 'lively possibility' that any such precaution might have prevented the death, and that said precaution be "reasonable."

[20] It was submitted that the Inquiry heard no evidence which may suggest there existed a "lively possibility" that Mr McCulloch's death may have been avoided. The Joint Minute of

Agreement, signed by parties, details Mr McCulloch's limited involvement with the Addictions Team. He does not appear to have been considered a drug-user, nor at risk of self-harm or suicide. In any event, as the cause of Mr McCulloch's death remains unascertained, it is submitted no firm conclusion can be reached as regard drugs within the prison environment, and Mr McCulloch's death.

S26 (2) (f) – Any defects in any system of working which contributed to the death

[21] I was again referred to the aforementioned guidance by Sheriff Kearney where in relation to defects in any system of working the Sheriff states:

> "In deciding whether to make any determination (under section 6(1)(d)) as to the defects, if any, in any system of working which contributed to the death or any accident resulting in the death, the court must, as a precondition to making any such recommendation, be satisfied that the defect in question did in fact cause or contribute to the death. The standard of proof and the rules of evidence (apart from the consideration that evidence did not require to be corroborated) is that applicable in civil business (1976 Act section 4(7)) and accordingly the standard of proof is that of the balance of probabilities."

[22] It was submitted that none of the evidence before the Inquiry suggests there existed a defect in any system of working which can be said to have contributed to Mr McCulloch's death. Mr McCulloch was not being monitored under Talk to Me at the time of his death, nor was he receiving treatment for any substance-related issues. Given Mr McCulloch's cause of death could not be ascertained, it was submitted it cannot be stated whether drugs played any part in his death, thus no conclusion can be drawn from the fact drugs were found in his system post-mortem.

Conclusion.

[23] I accept the submissions made on behalf of the Crown. I also accept the submissions made for the Scottish Prison Services. It was clear having considered the evidence that there were no precautions which could reasonably have been taken and there were no defects in any system of working, which contributed to Mr McCulloch's death. The submissions for the POAS helpfully set out the authorities for the consideration and interpretation of section 26(2) (e) with relevant references to Carmichael on *Sudden Deaths and Fatal Accident Inquiries (*3rd edition) and the determinations by Sheriff Kearney into the death of James McAlpine, and Sheriff Holligan in respect of the death of John Kell. I accept the submission that there was no evidence to suggest the existing lively possibility that Mr McCulloch's death may have been avoided and also that there was no defect in the working system which contributed to his unfortunate death. No submissions were made by any party that any accident resulted in Mr McCulloch's death or that any precautions could reasonably have been taken which might realistically have resulted in Mr McCulloch's' death being avoided (section 26(2)(b)(d) and (e)); or that any defect in any system of working had contributed to his death (section 26(2)(f)). Nor were any submissions made to indicate that any other facts relevant to the circumstances of Mr McCulloch's death fell to be included in my determination (section 26(2) (g)). No submissions were made that I should make any recommendations under section 26(1) (b).

[24] I am satisfied that in all the circumstances formal findings should be made in this case. I have set out those formal findings above.

[25] In conclusion I wish to express my thanks for the assistance provided by all the parties into this enquiry and I offer my sincere condolences to the bereaved family of the late Mr James McCulloch.