SHERIFFDOM OF NORTH STRATHCLYDE AT KILMARNOCK

[2024] FAI 44

KIL-B359-22

DETERMINATION

BY

SHERIFF C J BISSETT

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

into the death of

ANTHONY MCCARTHY

KILMARNOCK, 18 October 2024

Determination

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

> The late ANTHONY MCCARTHY, born 11 June 1991, prisoner in HM Prison Kilmarnock, died at approximately 8.18 am on 28 September 2020 within Cell 03, HM Prison Kilmarnock, Mauchline Road, Kilmarnock, KA1 5AA.

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

(i) Death occurred at approximately 8.18 am on 28 September 2020 within Cell 03, HM Prison Kilmarnock, Mauchline Road, Kilmarnock, KA1 5AA.

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

(ii) The cause of death was: cocaine, flubromazolam and synthetic cannabinoid receptor agonist intoxication.

Recommendations

No recommendations are made in terms of section 26(1)(b) of the Act.

Note

The legal framework

[1] This inquiry was held in terms of section 1 of the 2016 Act and was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. This fatal accident inquiry was a mandatory inquiry in terms of section 2 of the 2016 Act as the death of Mr McCarthy occurred while he was in legal custody.

[2] The purpose of this inquiry is set out in section 3 of the 2016 Act as being to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. It is not intended to establish liability, either criminal or civil. The Crown, in the form of the Procurator Fiscal, represents the public interest. The inquiry is an inquisitorial process and the manner in which evidence is presented is not restricted. The determination must be based on the evidence presented at the inquiry.

[3] In terms of section 26(2) of the 2016 Act the inquiry must determine certain matters, where applicable, namely:

(a) where and when the death occurred,

(b) when and where any accident resulting in the death occurred,

(c) the cause or causes of the death,

(d) the cause or causes of any accident resulting in the death,

(e) any precautions which

(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,

(f) any defects in any system of working which contributed to the death, or any accident resulting in the death, and

(g) any other factors relevant to the circumstances of the death.

[4] It is open to the Sheriff to make such recommendations as are appropriate in relation to matters set out in section 26(4) of the 2016 Act, namely:

(a) the taking of reasonable precautions,

(b) the making of improvements to any system of working,

(c) the introduction of a system of working,

(d) and the taking of any other steps,

which might realistically prevent other deaths in similar circumstances.

Introduction

[5] The inquiry was held under the Act into the death of Anthony McCarthy.

[6] Preliminary hearings took place on 22 July 2022, 27 September 2022, and 14 November 2022. The inquiry hearing took place on 22 March 2023. Written submissions were invited and submitted by parties' representatives thereafter.

[7] The representatives of the participants of the inquiry were:

(a) Mr Ali, Procurator Fiscal Depute,

(b) Mr Lothian, for SERCO Limited,

(c) Mr Bell, for the Scottish Ministers acting through the Scottish Prison Service, and

(d) Ms Bradley, on behalf of Agnes McGuire, mother of the deceased Anthony McCarthy.

[8] The sole witness at the inquiry hearing was James Cassidy, Head of Operations at HMP Kilmarnock, who also provided an affidavit.

[9] Parties lodged a substantial joint minute of agreement. I accepted the facts set out therein.

[10] The Crown lodged an inventory of documentary productions as follows:

1. Post mortem report

2. Death in Prison Learning Audit & Review (DIPLAR) Report

3. Photographs

4. Prison notes

5. Prison medical records

6. NHS medical records

7. Police Scotland Statement of Opinion Unit (STOP) Report

8. Drugs analysis findings

9. Supplementary prison medical records

[11] The Crown also lodged a label production, a CCTV recording taken between 1700 and 1800 hours on 27 September within C-Wing at HM Prison Kilmarnock.

[12] All participants, with the exception of Agnes McGuire, invited the court to make only formal findings in terms of subsections (a) and (c) of section 26(2) of the Act.

[13] Agnes McGuire invited the court to make additional findings in terms of subsections (e) and (f) of section 26(2) of the Act.

[14] All participants, with the exception of Agnes McGuire, invited the court to decline to make any recommendations in terms of subsection (b) of section 26(1) of the Act.

[15] Agnes McGuire invited the court to make a recommendation in terms of subsection (b) of section 26(4) of the Act.

Summary of facts

[16] The deceased was in legal custody at the time of his death.

[17] At the date of his death on 28 September 2020 the deceased was a prisoner of HM Prison Kilmarnock, having been transferred to the prison on 4 September 2020 from

HM Prison Low Moss. The deceased had been in the Segregation and Reintegration Unit ("SRU") at Low Moss since 30 June 2020.

HM Prison Kilmarnock

[18] HMP Kilmarnock was at that time operated independently of the rest of the prison estate in Scotland by a private company, Serco Limited, with a discrete management chain, directly employed staff group, and its own policies and procedures. Serco had responsibility for the operation of the prison, recruiting and managing staff resource and, with some exceptions, implementing its own policies. HMP Kilmarnock was subject to monitoring and audit by Scottish Prison Service Controllers.

[19] HMP Kilmarnock contains 504 cells and in September 2020 had 500 contracted prisoner places available. The prison population is made up of male remand, short and long-term adult prisoners. Prior to Mr McCarthy's death, it was most recently inspected by His Majesty's Inspectorate of Prisons in Scotland between 7 and 18 November 2016. HMIPS next carried out an inspection at HMP Kilmarnock between 18 and 29 October and 16 and 17 November 2021. This report found that the prison met the nine inspection standards, achieving either a "satisfactory" or "generally acceptable" rating.

Prison security procedures

[20] Substance abuse within the prison environment is one of the biggest challenges for the management of prisons. The changing nature of substance abuse in prisons means that systems and processes have to flexible enough to identify and adapt to

changing patterns. At HMP Kilmarnock, these systems and processes were constituted by various control documents: the Standard Operating Procedures, Security Management Procedures and the Security Manual. These mirrored those in place within prisons run by the SPS. The prison is subject to regular audits by SPS to assess its performance against these procedures.

[21] At HMP Kilmarnock, a Security Manager oversees a Dedicated Search Team and a dog unit, searching staff and visitors as well as conducting intelligence-led cell searches.

[22] When prisoners are received into the prison to start their sentence, they undergo a full drug screen via a urine sample which is tested for drugs. Transfers from other prisons are not automatically tested. This testing is carried out by NHS staff. Prison officials do not have access to prisoners' medical records and are not told the results. Similarly, any drug used disclosed to medical practitioners is treated as confidential.

[23] Mandatory drug testing of prisoners was removed in 2007. It is only used when a prisoner is under suspicion of using illicit drugs, based on intelligence received, or when a prisoner is being considered for progression to the open estate. A prisoner could therefore spend their entire sentence without being tested for drugs. Addiction prevalence testing is carried out annually within Scottish prisons to assess the prevalence of drug use within the prison population. For one month of the year all prisoners arriving in custody, or being liberated from custody, are tested for drugs.

[24] All prisoners entering the prison (whether new admissions, transfers from another prison, or returning from court or hospital appointments) are required to sit on

a body orifice security scanner (BOSS) chair, before passing through the SentryHound metal detector and being subjected to a strip search.

[25] All new employees are tested for drugs before commencing employment, as are existing prison staff, on a randomised basis.

[26] Everyone coming into the prison is subject to search procedures. Outer clothing is removed and x-rayed before visitors are made to walk through a SentryHound device which can detect ferrous metals. If indicated, a visitor would be subjected to a full body search by a same sex member of staff, including use of a hand wand detection device and a rub down search. In practice, this was performed on 95% of visitors and 90% of staff. Further random searches and intelligence led searches would be carried out. In September 2020, an Ion Scan 400 scan machine which sampled swabs from hands and clothing to test for traces of narcotics was deployed on a random or intelligence-led basis. This machine has since been upgraded to an Ion Scan 600 which, unlike the previous machine, can also detect psychoactive substances.

[27] All vehicles entering and exiting the prison are searched in a vehicle lock. Sometimes trained drug dogs are used. Perimeter patrols are carried out throughout the day. CCTV monitoring occurs on a continuous basis. There are more than 300 CCTV cameras covering the prison interior and the immediate surroundings. The CCTV feeds are monitored by two members of staff. If required, the movements of individuals can be monitored.

[28] All mail coming into the prison is x-rayed under secure conditions by a dedicated member of staff. It is then further screened by deployment of a drug dog.

Any suspicious mail is then subject to a Rapiscan Itemiser test, which detects both narcotics and psychoactive substances. Since 2020, following a change in SPS policy, mail can be withheld at the discretion of the Director if there is reasonable suspicion that it contains any illicit substance. The prisoner will instead receive a photocopy. In the course of 2022, some 265 items of mail thus identified were prevented from entering the prison. (This compares with the seizure of 757 items in the inspection year 2020/21 covered by the HMIPS full inspection report, lodged as production number 8 for Serco Limited).

[29] Prisoners are subject to cell searches, on a random or intelligence-led basis. Before the coronavirus emergency, twelve cells would be picked at random for search the following day. In September 2020 this number had been reduced to nine. A dedicated intelligence team, gathering information from various sources within the prison, may receive intelligence prompting them to direct that a certain prisoner's cell should be searched. Cell searches are carried out by two members of the DST, during which a systematic search through furnishings and fittings would be followed by the prisoner undergoing a strip search.

[30] All prisoners are given a rub down search on returning from activities in other parts of the prison away from their own wing, such as work visits or healthcare appointments, and any items they carry with them are searched. In September 2020, due to coronavirus measures, prisoners did not generally leave their own wings.

Anthony McCarthy's prison records

[31] The deceased was not known to prison addiction services. The deceased had reported drug and alcohol misuse previously. He denied ongoing substance abuse. On being transferred to the prison from Low Moss he was not drug screened, as the healthcare team would not routinely carry out drug screening on transfers unless there was a clinical reason to do so. Since 2019, the deceased had been subject to six mandatory drug tests whilst incarcerated within different Scottish Prison Service institutions. All returned a negative result.

[32] According to PR2, the database for holding information about prisoners shared by the SPS and by Serco, Anthony McCarthy was placed on MORS ("Management of Offender at Risk Due to Any Substance") on 28 June 2020 at Low Moss. This meant he was placed under observation at that time due to concerns about possible substance misuse. An intelligence note within his prison records dated June 2020 suggests that a fellow prisoner at Low Moss had been smoking crack within Mr McCarthy's cell and was later found to have banked certain items internally. An intelligence note from May 2020 shows that Mr McCarthy was under suspicion of having arranged the supply of a controlled drug to his relative within the prison. An incident report made on 17 January 2020 states that a prison officer at Low Moss found Mr McCarthy concealing pieces of paper and vape capsules in his hand. The paper was tested and found to contain "Spice 9", a synthetic cannabinoid. There are earlier intelligence notes referring to his potentially being concerned in the supply or use of controlled drugs, in

February 2020, April 2018, and December 2017; together with an incident report from November 2009.

Anthony McCarthy's reception to HM Prison Kilmarnock

[33] On his arrival at HM Prison Kilmarnock, the deceased underwent an assessment by healthcare staff, during which he reported pre-existing medical conditions, including mental illness. When asked, he denied having thoughts of self-harm and suicide and was noted as being at no apparent risk of susceptibility to either. Accordingly, the deceased was not placed onto the Talk to Me - Prevention of Suicide in Prison Strategy.

[34] On 5 September 2020, he attended the General Practitioner, Dr Paul Dunlop. He was examined by Staff Nurse Katharine Edwards on 8 September 2020. Neither had any concerns about his presentation or appearance.

[35] Dr Lesley Zachary, Principal Clinical Forensic Psychologist at the prison, received a letter, dated 7 September 2020, from Dr Ashleigh MacDougall, Clinical Psychologist at Low Moss, reporting the deceased's involvement with the psychology department at Low Moss and the treatment he had received there. Dr MacDougall formally discharged the deceased from her caseload and invited Dr Zachary to continue the deceased's psychological assessment. In September 2020, the waiting list for psychological assessment was 12 weeks. The deceased died before any clinical psychology assessment took place. He continued to be categorised as "no current risk of harm".

[36] At the time of his death, the deceased was prescribed various medication: anti-depressants, anti-psychotics, a painkiller, an anti-reflux drug and a steroid nasal spray to combat rhinitis.

After reception

[37] Upon the deceased's reception to the prison, he was placed into B wing. Following his being assaulted by another prisoner on 12 September 2020, he was re-located to F wing on 13 September 2020. The deceased assaulted another prisoner there on 15 September. He was also involved in incidents of indiscipline toward prison staff, including threatening behaviour. He was removed that same day to the SRU, it being recorded on the PR2 system that Mr McCarthy was engaged in a "power struggle" with other prisoners in his new location within the prison. It is not unknown for this to happen when a prisoner moves to a different location.

[38] On 17 September, the deceased was relocated to C Wing, where he occupied cell C03. He remained there until his death. During this period, he was never seen to be under the influence of any intoxicating substance.

[39] Mr McCarthy's transfer to HMP Kilmarnock coincided with the second wave of coronavirus in Scotland. Visits to prisoners by family and friends were suspended between March and August 2020, when they resumed subject to certain restrictions. On 25 September 2020, the Scottish Government ordered that all prisons in Scotland be closed to visitors due to rising national infection rates of COVID-19. This order was not

lifted until 28 September 2020. In the week before his death, Mr McCarthy made 54 telephone calls to family and friends.

[40] At 5.10pm on 27 September, CCTV within the hall communal area of C wing captured the deceased engaged in conversation with a fellow prisoner, during which he passed an item to the deceased. The deceased can be seen to drop something on the floor and pick it up, before moving his hands to the waistband of his trousers. There being no reason to monitor him closely beforehand, it was only after Mr McCarthy's decease that this footage was viewed.

[41] The nightshift staff who commenced duty on the evening of 27 September were therefore unaware of this occurrence. They had no cause to check on the deceased during the course of that night. He did not activate the cell call system.

His death discovered

[42] The following morning at around 7.51am, during morning roll count, Anthony McCarthy was found lying dead on the floor of cell C03 by a prison custody officer. She alerted another prison custody officer, who by means of "medical code blue" radio alert summoned assistance. Within two minutes, four nurses stationed at the prison attended at cell C03 to render assistance. They immediately requested that an ambulance attend. Attempts at Cardiopulmonary Resuscitation commenced and continued until the arrival of the paramedics at 8.14am but were unsuccessful.

[43] Although there were obvious signs that life was extinct, CPR continued to be attempted until 8.18am, at which time Mr McCarthy was pronounced dead.

[44] The scene within cell C03 was preserved until the arrival of a scenes of crime officer and detectives of the Police Service of Scotland. Photographs were taken of the cell interior and Mr McCarthy's remains. Detectives seized several items from cell C03, including four blue tablets, a paper wrap with brown paper inside, a kettle with a sock inside, a plastic pen modified for use as a pipe and a quantity of prescribed medications. Forensic examination identified the tablets as containing a benzodiazepine and the paper, Spice, a synthetic cannabinoid. Police were unable to establish from whence these were obtained.

Post mortem analysis

[45] A post-mortem examination of the deceased was carried out on 7 October 2020 at the Queen Elizabeth University Hospital, Glasgow by Julie McAdam, Forensic Pathologist, during which blood samples and a urine sample were obtained. No evidence of significant injury to his body or natural disease was discovered which could account for his death. Analysis of the blood samples revealed evidence of cocaine use shortly before death, flubromazolam (a benzodiazepine) and a synthetic cannabinoid receptor agonist, 5F-MDMB-PICA.

[46] Dr McAdam concluded that the death of the deceased was drug related. The potential interactions between the drugs detected was unascertainable. The exact contribution of each drug in the death of the deceased was unascertainable. She recorded the cause of death as: cocaine, flubromazolam and synthetic cannabinoid receptor agonist intoxication.

Drugs involved

[47] Cocaine is a class A controlled drug under the Misuse of Drugs Act 1971. It is a stimulant drug, the effects of which are not necessarily dose dependant. Its adverse effects include increased heart rate and blood pressure, cardiac arrhythmia, seizure and, potentially, sudden death. The use of cocaine is widespread throughout society and it has been detected and recovered within Scottish prisons.

[48] 5F-MDMB-PICA is a synthetic cannabinoid receptor agonist and is a class B controlled drug under the Misuse of Drugs Act 1971. The effects of this drug can be similar to those of natural cannabis but some users report effects similar to stimulant type drugs, such as increased heart rate and blood pressure and agitation. In some cases the effects can be sedation and dissociation. The use of synthetic cannabinoids in Scotland is predominantly among the prison population. Generally, it finds its way into prisons on pieces of paper that have been impregnated with an active solution and dried, before being passed off as normal correspondence. It has even been detected on items of clothing sent into prisons. The substance can be ingested by eating pieces of the impregnated paper or smoking them using vape equipment. Alternatively, the paper or clothing may be steeped in water and the solution drunk. It has been detected and recovered within Scottish prisons.

[49] Flubromazolam is a benzodiazepine, classed as a class C controlled drug under the Misuse of Drugs Act 1971. It's ability to supress the central nervous system so as to produce strong sedative effects and even amnesia mean that it is regarded as posing a

higher risk to users than other "designer" benzodiazepines. Flubromazolam is predominantly sold in tablet form as "street diazepam" throughout Scotland and has been detected and recovered within Scottish prisons.

Crown submissions

[50] Only formal findings, in terms of section 26(2)(a) and (c) of the 2016 Act are required. These should reflect the evidence agreed by the joint minute. Mr McCarthy's death did not result from an accident and therefore no submissions in terms of sections 26(2)(b) and (d) of the 2016 Act are offered. There being no other facts relevant to the circumstances of Mr McCarthy's death to be considered, no submissions are offered in terms of section 26(2)(g).

[51] In terms of sections 26(2)(e) and (f), there are no identifiable precautions which might realistically have avoided the death of Mr McCarthy. There are no identifiable defects in any system working which contributed to his death.

[52] At no time did he present as being under the influence of any substance. There was therefore no indication that he should be subject to special monitoring. While CCTV recorded him receiving an item from another prisoner on the evening of his death, this was only noticed on the following day. At the time of his death therefore, there was no intelligence indicating any reasonable precautions such as the sale search for welfare check. There were therefore no reasonable precautions which had they been taken might realistically have prevented his death.

[53] HMP Kilmarnock utilised various systems and methods to prevent drugs entering the prison. These measures are comprehensive and subject to regular review given the changing trends and patterns of drug use. It is this regular review that led to the introduction of a new scanner to trace psychoactive substances. This diligence, which exceeds the contract it for requirements of SPS, suggests that there is no defect identifiable in any system of working concerned.

Submissions on behalf of SERCO Limited

[54] Only formal findings, in terms of sections 26(2)(a) and (c) of the 2016 Act are required. Mr McCarthy's death did not result from an accident and therefore no submissions in terms of sections 26(2)(b) and (d) of the 2016 Act are offered. The death did not arise from an accident, therefore sections 26(2)(b) and (d) are not relevant for the purposes of this inquiry. No findings are proposed regarding sections 26(2)(e) to (g). No recommendations in terms of section 26(1)(b) are appropriate.

[55] The findings in terms of sections 26(2)(a) and (c) should follow the narration of events in the first joint minute and reflect the conclusions of the post mortem examination.

[56] No findings are appropriate in terms of section 26(2)(e). There was no evidence before the inquiry that any reasonable precautions might realistically have avoided the death. Given the evidence - that Mr McCarthy was not known to prison addiction services; had passed all six drug tests which he had undergone since 2019; that on or about 22 September 2020 he was categorised by the Mental Health Multidisciplinary

Team as "no current risk of harm"; that he denied ongoing substance abuse; and that no point in the period between his return to C wing and his death did he appear to be under the influence of any substance nor gave prison staff reason to monitor him - there was nothing which reasonably ought to have alerted prison authorities to the possibility that he had come into possession of the drugs he took prior to his death. No evidence was led to the effect that any reasonable precautions were not taken, let alone any which might have prevented the death.

[57] No findings are appropriate in terms of section 26(2)(f). On the evidence, the systems of working at HMP Kilmarnock, so far as they relate to prevention of illegal substances entering or circulating within the prison, are reasonable and appropriate. There is no evidence of any defects in any such systems of working. Comparison of the figures provided by James Cassidy for mail seizures during 2022 with those given in the HMIPS full report for years 2020/21 (757) suggests that these systems are proving successful in discouraging the entry of drugs into the prison by mail.

[58] In respect of findings under section 26(2)(g), the reduction in the number of daily random cell searches is of no account. This number was mandated by SPS as a reaction to the Covid emergency, designed to protect the health of everyone within the prison estate. Intelligence-led cell searches were not restricted. This is reasonable and proportionate, given finite prison resources and the Article 8 rights of the prison population, in the absence of any evidence that the system is defective.

[59] The CCTV footage capturing the deceased being passed an item on the evening before his death not having resulted in any reaction by the prison before his death,

cannot justify a finding under this section either. That this transaction went unnoticed until review of the footage the following day is not evidence of inaction by the prison. It is self-evident that two operators cannot monitor live footage from 300 cameras simultaneously.

[60] The systems employed by HMP Kilmarnock for detecting illegal substances and preventing them from entering or circulating within the prison are multi-faceted and well-developed. They are reviewed and updated regularly to meet changing and emerging threats. They are the same as those in place across the rest of the prison estate in Scotland.

Submissions on behalf of the Scottish Ministers acting through the Scottish Prison Service

[61] The evidence before the Inquiry does not disclose any substantive issues to consider in terms of section 26(2) of the 2016 Act. This death was not an accident and therefore sections 26(2)(b) and (d) are irrelevant. Only formal findings require to be made, in terms of section 26(2)(a) and (c).

[62] Standing the evidence about the measures employed at HMP Kilmarnock to reduce the amount of drugs entering the prison, which measures are subject to continuous review, the fact that Mr McCarthy was not known to addiction services within the prison and had tested negative in the six mandatory drug tests carried out since 2019, within the prison estate. He had not been subject to the MORS policy, employed where prisoners are suspected of drug use.

[63] There is no evidence which indicates a defect in a system of working which may have caused or contributed to his death.

Submissions on behalf of Agnes McGuire, mother of the deceased

[64] Findings in terms of sections 26(2)(a) and (c) should follow the narration of events in the first joint minute and reflect the conclusions of the post mortem examination. This death was not an accident and therefore sections 26(2)(b) and (d) are irrelevant.

[65] In terms of section 26(2)(e), the evidence supports a finding that a reduction in the number of cell searches, from twelve to nine, within HMP Kilmarnock could reasonable be considered deleterious to the detection of drugs within the prison and, therefore, prevention of their consumption.

[66] In terms of section 26(2)(f), the reduction in the number of daily cell searches, particularly where a number of the prisoners on C-Wing (not including the deceased) were on observation constitutes a failure in the system of working. Plainly, had cell C03 been searched, drugs and drug paraphernalia were there to be recovered. Further, the two staff monitoring CCTV within the prison might reasonably have been expected to take action upon viewing the footage of the deceased being passed something by a fellow prisoner. That they did not constitutes a failure in a system of working.

[67] Recommendations ought to be made in terms of policy and prevention within the prison system generally, aimed at preventing other deaths in similar circumstances.

Improvements to the relevant systems of working ought to be made in terms of section 26(4)(b) of the 2016 Act.

Conclusions

[68] I am grateful to parties for their detailed submissions upon the evidence which have assisted me in making my determinations in this matter.

[69] I concur with the submissions made by all parties that Mr McCarthy's death was not the result of an accident. He had no significant illness and there was no evidence of significant injury to his body. His death was a result of intoxication through ingestion of cocaine, flubromazolam and a synthetic cannabinoid receptor agonist.

[70] That Mr McCarthy died in consequence of his ingesting three different illegal drugs within his prison cell, demonstrates the scale of the challenge faced by prison authorities to prevent such substances entering and circulating within the prison estate. They do so because of determined, ever more inventive attempts to circumvent prison security, in which attempts prisoners such as Anthony McCarthy actively collude.

[71] In the submissions made on behalf of Mr McCarthy's mother, Agnes McGuire, it is suggested that keeping the number of daily, random cell searches at twelve instead of nine is a precaution which could reasonably have been taken and might realistically avoided the death occurring. On the evidence before me, I do not accept that this precaution could reasonably have been taken, as it would have been contrary to the SPS policy introduced in 2020 to combat the spread of Coronavirus. Any assessment of that policy is beyond the remit of this inquiry.

[72] Also, there is no evidence before me that the reduction of the number of daily, random cell searches had an adverse impact upon the detection of drugs or drug use within the prison generally. Nor can I speculate that it prevented detection of the drugs in Mr McCarthy's possession at the time of his death. At best, it lengthened the odds of his cell being the subject of a random search sometime before he died. Of course, such a search may not have detected any illicit drugs. They may not have been in his possession until the evening of 27 September, when apparently he was passed something by a fellow prisoner. The line of argument advanced on behalf of Ms McGuire seems entirely speculative. There is no basis in the evidence to suggest that this precaution, were it reasonable to have been taken, might realistically have resulted in Mr McCarthy's death being avoided.

[73] Further, for these reasons the reduction in the number of daily random cell searches does not constitute a defect in a system of working, as these submission suggest. They go on to argue that the failure by the prison staff monitoring CCTV within the prison to observe the transaction between Mr McCarthy and another prisoner when it occurred, and immediately pass this information to the intelligence team, is also a defect in a system of working. On this point, I agree with the submissions made on behalf of Serco Limited. Without a specific reason to follow Mr McCarthy's movements via CCTV that evening, it is hardly a defect in the system that neither operator observed the incident while monitoring the feeds from some 300 cameras.

[74] The submissions made by SPS state that Mr McCarthy was not subject to MORS procedures, the procedures common to all Scottish prisons for the monitoring of

prisoners suspected of being at risk from drug abuse. That is correct. He had however been subject to such measures shortly before his transfer from HMP Low Moss. The PR2 system records the reasons for this, providing intelligence and incident reports that show Mr McCarthy was suspected of the possession and distribution of drugs within Low Moss in 2020. On one view, these records ought to have prompted a drug screen test on his reception at Kilmarnock. That he had consistently provided negative drug test results on six occasions since 2019 supports the opposite view. I am satisfied that the prison were justified in following the routine policy for transferred prisoners in not requiring a drug screen test in his case.

[75] At no time following his reception to Kilmarnock did Mr McCarthy's conduct give rise to a suspicion that he was using drugs. On reception, he made no disclosure of illicit drug use. Nor at subsequent medical appointments on 5 and 8 September. His denials of ongoing substance misuse, made in confidence to medical professionals, were not disclosed to the prison authorities. They were nevertheless consistent with his presentation to those authorities. No intelligence was received to indicate that Mr McCarthy was in possession of, or at risk from, consumption of illicit drugs. Therefore, no system of working relative to the detection and prevention of drugs misuse within the prison can be said to have been defective on these facts.

[76] That Mr McCarthy had access to the substances that killed him, is eloquent of the failure of the precautions taken by the prison to prevent this. I am not persuaded however that there are any other precautions which could reasonably have been taken and were not. Significant time, care and expense continues to be spent by the prison

authorities to prevent the entry of illegal drugs. They are doing all that might reasonably be done, given finite resources, the need to respect the human rights of prisoners and visitors to the prison estate and the widespread availability of these substances in society generally. It can be hoped that continued advances in technology will allow them to win the war against substance misuse within the prison estate, a war in which Mr McCarthy was an unfortunate casualty.

[77] The evidence does not suggest any other facts which are relevant to the circumstances of his death. Having carefully considered all of the evidence before the inquiry, I conclude that only formal findings in terms of sections 26(2)(a) and (c) of the Act are justified and no recommendations are to be made in terms of section 26(1)(b).