SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY AT HAMILTON

[2023] FAI 32

HAM-B261-21

DETERMINATION

BY

SHERIFF F C M THOMSON

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

into the death of

ROBERT ALLEN

Determination

The Sheriff having considered the information presented at the inquiry into the death of Robert Allen, born 29 January 1987, finds in terms of section 26(1)(a) the Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (the "Act") as follows:

1. in terms of section 26(2)(a) that Mr Allen died at 23:19 hours on 20 May 2019 at Wishaw General Hospital;

2. in terms of section 26(2)(b) that no accident occurred;

3. in terms of section 26(2)(c) that the cause of death was 1a: Methadone and Quetiapine intoxication;

4. in terms of section 26(2)(d) that no accident occurred;

5. in terms of section 26(2)(e) that there are no precautions which could reasonably have been taken and which, had they been taken, might realistically have resulted in Mr Allen's death being avoided;

6. in terms of section 26(2)(f) that there were no defects in any system of working which contributed to Mr Allen's death; and

7. in terms of section 26(2)(g) that the following facts are relevant to the circumstances of Mr Allen's death:

(a) that whilst housed in the Segregation and Reintegration Unit, Mr Allen's cell should have been searched on a weekly basis;

(b) however, only three searches over a three month period were documented;

(c) that medical records did not fully document discussions with Mr Allen as regards the risks of HDAT or his refusal of monitoring;

(d) that NHS Lanarkshire staff within HMP Shotts were in possession of intelligence that Mr Allen was not taking medication as prescribed;

(e) that medication spot checks of Mr Allen's cell were not instructed; and

(f) that there is no information available to evidence what happened to the medication Mr Allen self-reported as not consuming.

RECOMMENDATIONS

In terms of section 26(1)(b) and 26(4) of the Act, there are no recommendations as to matters which might realistically prevent other deaths in similar circumstances.

NOTE

Introduction

[01] This inquiry was held into the death of Robert Allen. Mr Allen was a remand prisoner within HM Prison Shotts, who died on 20 May 2019 at the Wishaw General Hospital.

[02] The following parties were represented: the Crown in the public interest, represented by Ms Guy, Procurator Fiscal Depute; NHS Lanarkshire Health Board ("NHS Lanarkshire"), represented by Ms MacQueen, advocate; the Scottish Prison Service ("SPS"), represented by Ms Phillips, solicitor; and the Prison Officers' Association of Scotland ("POAS"), represented by Mr Rodgers, solicitor. Mr Allen's family were not legally represented but participated and attended hearings. In timetabling, it was sought throughout to allow sufficient time for Mr Allen's family to participate as fully as possible, whilst allowing the inquiry to progress expeditiously and efficiently.

[03] Preliminary hearings took place, by Webex videoconference, on 26 August, 21 October, 18 November, 15 and 22 December 2021 and on 8 February, 21 April, 15 June and 29 August 2022. The inquiry took place, by Webex videoconference, on 6 and 7 December 2022, with a hearing on written submissions on 21 June 2023.

[04] Parties agreed a significant amount of evidence in a Joint Minute of Agreement, covering *inter alia* the provenance of documents, the key primary facts about Mr Allen's illness and treatment and the circumstances of his death. This restricted significantly the requirement for oral evidence at the inquiry.

[05] The Crown led evidence at the inquiry from:

a. Dr Alistair Morris, Consultant Forensic Psychiatrist; and

b. Dr Duncan Alcock, Consultant Forensic Psychiatrist

[06] NHS Lanarkshire Health Board led evidence from Dr Laurence Tuddenham, Consultant Forensic Psychiatrist.

[07] No witnesses were led by any other party.

THE LEGAL FRAMEWORK

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

[09] Fatal Accident Inquiries and the procedure to be followed in the conduct of such inquiries are governed by the provisions of the Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. In terms of section 1(3) of the Act the purpose of an inquiry is to establish the circumstances of the death and to consider what steps, if any, may be taken to prevent other deaths occurring in similar circumstances. In terms of section 1(4) the purpose of an inquiry is not to establish civil or criminal liability. A determination is to be made which in terms of section 26(1)(a) and (2) is to set out findings in relation to: (i) when and where the death occurred; (ii) the cause or causes of such death; (iii) any precautions that could have reasonably been taken, and if so might

realistically have avoided the death; (iv) any defects in any system of working which contributed to the death; and (v) any other facts which are relevant to the circumstances of the death. Additional findings in relation to an accident are not relevant to this inquiry, as it is agreed that Mr Allen's death was not the result of an accident.

[10] In terms of section 26(1)(b) and (4) of the Act, the inquiry is to make such recommendations (if any) as the sheriff considers appropriate as to: (i) the taking of reasonable precautions, (ii) the making of improvements to any system of working, (iii) the introduction of a system of working, and (iv) the taking of any other steps, to the extent in each case these might realistically prevent other deaths in similar circumstances.

[11] The procurator fiscal represents the public interest. An inquiry is an inquisitorial process and the manner in which evidence is presented is not restricted. The Court proceeds on the basis of evidence placed before it by the procurator fiscal and by any other party to the inquiry. The determination must be based on the evidence presented at the inquiry and is limited to the matters defined in section 26 of the Act. Section 26(6) of the Act provides that the determination shall not be admissible in evidence or be founded on in any judicial proceedings, of any nature. This prohibition is intended to encourage a full and open exploration of the circumstances of a death, while also reflecting the position that it is not the purpose of an inquiry to establish civil or criminal liability.

SUMMARY

Evidence

[12] As noted, the majority of evidence was agreed between the parties. The inquiry heard oral evidence from Dr Alistair Morris, Dr Duncan Alcock and Dr Laurence Tuddenham. An outline of their evidence is set out below.

[13] I considered all three witnesses to be credible and reliable and am grateful to them for assisting the inquiry.

Dr Alistair Morris

[14] As a visiting psychiatrist at HMP Shotts, Dr Morris was involved in providing treatment to Mr Allen on a regular basis from 19 December 2018 until his death.

[15] Dr Morris gave oral evidence in terms of his affidavit dated 20 July 2022.

[16] In relation to the prescription of high dose antipsychotic medication and the NHS Lanarkshire High Dose Antipsychotic Treatment (HDAT) Guidelines ratified in March 2018 (the "HDAT Guidelines") Dr Morris gave evidence of how he came to increase Mr Allen's medications in February 2019 following a deterioration in his mental state. That deterioration had been associated with two potentially psychotically-motivated incidents of serious violence by Mr Allen.

[17] To place matters in context, is agreed between the participants:

a. that on 14 February 2019, following an assault by him on a prisoner with a plank of wood, Mr Allen underwent a mental health review with Dr Morris, at

which point Dr Morris planned to increase Mr Allen's Quetiapine prescription to 300mg morning, and 450mg at night;

b. that on 19 February 2019 Mr Allen underwent a mental health review with Dr Morris, who noted that his presentation was largely unchanged despite the increase in his Quetiapine prescription. Dr Morris noted his intention to cross titrate to Olanzapine however Mr Allen was reluctant to do so. Dr Morris prescribed Olanzapine at a dose of 10mg a night; and

c. that on 27 February 2019, following an assault by him on a police officer, Mr Allen underwent a mental health review with Dr Morris where it was noted that he continued to express similar psychotic material, primarily ideas of reference and delusional mood. Dr Morris noted that Mr Allen lacked insight into his illness and had been intermittently complying with his medication. Dr Morris increased Mr Allen's prescription for Olanzapine to 20mg at night and advised him of his intention to refer to the State Hospital if he failed to comply or did not improve within one to two weeks; and

d. that on 16 April 2019 Mr Allen underwent a further mental health review with Dr Morris who noted that Mr Allen appeared to be significantly improved. He claimed to be compliant with his Olanzapine and Quetiapine and Dr Morris noted this appeared to be the most likely reason for his improvement. Dr Morris intended to continue both Olanzapine and Quetiapine, which were both at their maximum dose, for 4 weeks, then begin to titrate and stop one of the antipsychotic medications.

[18] As such, Mr Allen was by this time receiving "High Dose Antipsychotics" as that term is referred to in the HDAT Guidelines.

[19] In his evidence, Dr Morris indicated that he initially attempted to treat Mr Allen's psychosis by increasing the dose of the antipsychotic drug he was already prescribed (Quetiapine), but that this proved ineffective in resolving his psychotic symptoms. Following this, Dr Morris attempted to cross-titrate Mr Allen onto a different antipsychotic drug (Olanzapine).

[20] Mr Allen's compliance with his oral Quetiapine was reported by nursing staff to be poor; although he was thought to take it at times. It was therefore perhaps unsurprising that there was little improvement in his psychotic state when on the drug.

[21] Mr Allen presented as floridly unwell and was not complying consistently with Quetiapine. He continued to pose a significant risk of further serious violence driven by his psychosis, and was refusing to accept injectable medication to ensure compliance. It was Dr Morris' opinion that on the balance of risk, adding in a second antipsychotic drug (Olanzapine) was in his best interests, and the best interests of others at risk from his psychotically-motivated violence.

[22] It had been Dr Morris' hope and expectation that prescribing an additional antipsychotic with which he would comply would improve his mental state and facilitate his progress away from the prison's Segregation and Reintegration Unit (SRU) and the special security measures to which he was subject.

[23] It was Dr Morris' opinion that Mr Allen's poor compliance with medication was a significant factor in his failure to improve for a couple of months. Dr Morris

repeatedly tried to persuade Mr Allen to take a depot antipsychotic medication, to improve his compliance, but he declined.

[24] Dr Morris had no specific recollection of having seen the NHS Lanarkshire High Dose Anti-Psychotic Monitoring Form or Consent form and had not used those forms. However, there were similar guidelines in place across Scotland, which he was aware of, which explained the requirement to offer monitoring. It was routine to require monitoring prior to starting antipsychotic treatment, making changes in dosage and adding additional medication.

[25] Dr Morris did not have a specific recollection of a discussion with Mr Allen regarding consent for high dose antipsychotic monitoring. However, in his usual practice he would mention that high dose antipsychotic medication can lead to cardiac or metabolic side effects and would recommend undertaking an Electro Cardio Gram (ECG) to monitor baseline function and repeat this where necessary. While serious cardiac side effects were rare, he would continue to monitor patients clinically during subsequent appointments and would review the position if there were any relevant symptoms.

[26] In the months leading up to his death, Mr Allen refused to have an ECG completed. Mr Allen consistently refused to comply with physical health monitoring such as bloods and ECGs. It was not possible to get him to comply with these against his will in prison. His non-compliance with recommended investigations was reported by nursing staff.

[27] It was Dr Morris' opinion that the limit of care that could safely be provided to Mr Allen in a prison environment had been reached by 13 March 2019. This was in part due to the difficulty, in that environment, in monitoring his compliance and associated monitoring. This was why Dr Morris referred Mr Allen to admission at the State Hospital. In light of Mr Allen's refusal of monitoring it was not possible adequately to monitor Mr Allen in the prison environment, but equally it would not have been appropriate simply to stop his medication given the risk of psychotic violence. A Higher Specialist Trainee Doctor, a trainee Mental Health Officer (MHO) and a qualified MHO from the State hospital assessed Mr Allen, but the referral was not accepted.

[28] In relation to medical records, Dr Morris indicated that all his clinical decision-making was recorded by handwritten record in Mr Allen's paper psychiatric notes and that, frequently, nursing staff would make additional records of these decisions on the electronic "Vision" note system. Dr Morris indicated that what was recorded on Vision was usually a summary and that ideally discussions about physical monitoring should be recorded there, as should be any reference to any non-compliance.

[29] In relation to the co-administration of Methadone and high dose antipsychotic medication, Dr Morris stated that Methadone was always dispensed on a daily supervised basis.

[30] The co-administration of Methadone to Mr Allen would have been a factor when considering the prescription of high dose antipsychotic medicine, due to a potential increase in QTC interval. However, Mr Allen was consistently not complying with his oral antipsychotic medications as prescribed (Dr Morris having been told by nurses of

their suspicion and also as a matter of inference from Mr Allen not displaying any side effects consistent with the dose) and the risks inherent in his ongoing psychotic presentation were high. Dr Morris did have concerns in prescribing as he did but, weighing the risks both to Mr Allen (psychosis) and others (his violence), it was appropriate. A risk benefit analysis would have indicated that the co-administration of Methadone and high dose antipsychotic medicine should still have occurred.

[31] In relation to the dispensing of medication, the clinical decision was to dispense Mr Allen's medication including his high dosage antipsychotic medication on a weekly basis, unsupervised. Given the anti-social traits of Mr Allen's personality, if he was told to take a medication and was supervised while doing so, it was reported to Dr Morris by nursing staff that this would make him less likely to comply. Dr Morris indicated that anti-social individuals did not like being told what to do by persons they perceived to be in authority, and would commonly refuse to do what they were asked to do, even if such compliance would be to their benefit.

[32] Conversely, when Mr Allen was given his medication on a weekly basis, it was thought by nursing staff that his compliance was better. Dr Morris' primary aim was to get Mr Allen to take medication in order to get him better and reduce the risk to himself and others. It was therefore Dr Morris' opinion that it was better to give medication to Mr Allen in his possession on a weekly basis, where he was reported to comply with some of it, rather than to give it to him on a supervised basis when he would not comply at all.

[33] Dr Morris was asked what should be done if it was suggested that an individual was not taking all medication, and specifically whether he could have instructed medication compliance checks ("spot checks") of medication. He indicated that this was not something that he had done before but that, generally, such checks might be initiated by nursing staff (who had more regular contact) if they had suspicions. Dr Morris accepted that SPS staff would not generally be aware of the details of medication as that was confidential medical information. In relation to Mr Allen, spot checks might have been counterproductive to his taking medication, given his anti-social traits and wariness of authority figures.

Dr Duncan Alcock

[34] Dr Alcock is a Consultant Forensic Psychiatrist.

[35] He gave evidence in terms of his report to the Procurator Fiscal Depute dated 25 January 2021, which he adopted.

[36] In relation to the prescription of high dose antipsychotic medication and the HDAT Guidelines, Dr Alcock opined that, given Dr Morris' opinion that Mr Allen was suffering from a psychotic illness, it was appropriate that he was then prescribed antipsychotic medication for the treatment of that illness. Further, having noted the apparent issues in relation to Mr Allen's compliance with medications, his commencement on Olanzapine and the plan as recorded by Dr Morris to withdraw one of the antipsychotic medications, having a plan to cross titrate Mr Allen from one antipsychotic medication to another again appeared appropriate. In oral evidence,

Dr Alcock confirmed that, in his view, Dr Morris' plan to add an alternative medication was appropriate, albeit that given the challenges in observing/monitoring Mr Allen and his other medications Dr Alcock (noting that it was never a black and white decision) would have erred towards reducing Quetiapine at a faster rate.

[37] Dr Alcock indicated that the HDAT Guidelines set out a number of matters that should be considered when prescribing high dose antipsychotic treatment. A NHS Lanarkshire high dose antipsychotic monitoring form should be carried out and consideration should be made to medications that may interact with the high dose antipsychotics prescribed through use of tool 4 of this guideline, prescription for Methadone being specifically mentioned. A patient consent form, as indicated in tool 5, should also have been completed. A range of physical health monitoring should have taken place prior to the commencement of high dose antipsychotic prescribing. Baseline monitoring would then have assisted with future monitoring requirements.

[38] In oral evidence, Dr Alcock accepted that the HDAT Guidelines were not mandatory, and that there could be occasions where it would not be possible to adhere to them. However, if they were departed from then a rationale should be given. If it was impossible to monitor a patient then that would not render it impossible to prescribe high dose antipsychotic medication, but it should be taken into account. By reference to Standard Operating Procedure for Psychotropic Monitoring at HMP Shotts Health Centre reviewed in April 2022 (and thus after the date of Mr Allen's death) and the guidance therein that "Any refusal [of psychotropic monitoring] should be documented on Vision and within the spreadsheet", Dr Alcock agreed that reflected

what would have been best practice, albeit implementing that recordkeeping was a challenge in prisons. The absence of a refusal of monitoring having been documented did not mean it had not been considered by the prescribing doctor. Dr Alcock did not doubt that Dr Morris had considered it at the relevant time.

[39] In relation to medical records, having reviewed the records there was no indication that a patient consent form was considered. There was no evidence that consideration was made in relation to obtaining baseline physical health monitoring or that this was offered to Mr Allen. From reviewing Mr Allen's records, it would appear that it was some time since he last had any blood tests or blood pressure check. Dr Alcock was unable to find evidence of a previous ECG, or evidence of any consideration for Mr Allen being on 200% of the maximum antipsychotic dose alongside the medication Methadone, which potentially could have had a cumulative effect in relation to Mr Allen's ECG.

[40] In relation to the co-administration of Methadone and high dose antipsychotic medication, Dr Alcock agreed in evidence that this was not unusual. However as noted it would have been a factor in deciding whether to reduce Quetiapine at a faster rate.

[41] In relation to the dispensing of medication, Dr Alcock in his report noted that "it would appear that there has been a clear decision made in relation to whether or not [Mr Allen] should have supervised medication at the time of his death" but makes no further comment on the appropriateness of that. In oral evidence, Dr Alcock indicated that, on reflection, daily dispensation of medication would have been preferable (as Mr Allen was already receiving Methadone daily) to take unsupervised. He accepted

however that it would still have been possible for Mr Allen to stockpile medication in this scenario.

[42] Dr Alcock indicated that consideration should be given to the checks in place at the time of Mr Allen's death in relation to the supervision of his medications. His understanding was that cell checks were to be carried out weekly, that unless there was specific information in relation to a prescribed medication a search for such was not the norm and that, if there was a concern, then an NHS colleague would be asked to accompany SPS staff during the search. Dr Alcock opined that, given Mr Allen's previous history of repeated episodes of intoxication with substances unknown including several incidents where he required a medical emergency response, there would appear to have been reasonable grounds for considering that any searches conducted on Mr Allen's cell should have included an NHS colleague in order that they would have been able to identify that Mr Allen had in his possession the correct quantity and type of prescribed medications. Further, the presence of an NHS colleague during these searches could also have had a deterrent effect on Mr Allen potentially hoarding his medications for later use in order to achieve intoxication.

[43] In oral evidence, Dr Alcock considered that it would be open to NHS staff to request searches. If it was known that a prisoner was not taking medications that would be a reasonable basis for seeking a search on a weekly basis. In cross examination, Dr Alcock disagreed that an NHS presence in searches would have deterred Mr Allen from taking medication. On the contrary, it would have supported him as they would have been able to engage with him. Dr Alcock accepted that prior to Mr Allen's death

there was no evidence that he was stockpiling, but noted that some cell searches had not been recorded.

[44] In relation to the SPS Code Red/Blue Policy, in his report Dr Alcock stated that upon discovery of Mr Allen in his cell on 20 May 2019 prison staff acted quickly, within the security regulations required by his level of risk, to provide him with emergency care. Dr Alcock noted that a communication appears to have gone out in relation to obtaining a nursing response to the medical emergency but this communication did not follow the SPS Policy in stating that this was an emergency code blue. (This is consistent with what is agreed by joint minute). It appeared that nursing staff, despite this, attended very quickly to the incident. Dr Alcock did not consider that the failure to communicate the type of code contributed to Mr Allen's death.

[45] In oral evidence Dr Alcock, was taken to the affidavit of Lesley McDowall, Head of Health Strategy at SPS, where it is explained that "The reason why we have two medical emergency codes is to assist and inform Scottish Prison staff as to the type of incident they are attending. So for example the majority of Code Blue incidents involve hangings so that indicates to operational staff that they will require to access the fish knife from the crash pack. A Code Red incident informs staff that blood may be involved and there is a bio-hazard and therefore they will require gloves. Irrespective of whether it is a Code Blue or Code Red incident the response by the NHS is exactly the same and they take exactly the same equipment." Dr Alcock considered that it was hard to see the rationale for two codes and that there was no such distinction in the State Hospital. In cross examination, he stated that there seemed to have been confusion

about whether which code applied in Mr Allen's case, but accepted that there was no impact on the treatment Mr Allen received.

Dr Laurence Tuddenham

[46] Dr Tuddenham is a Consultant Forensic Psychiatrist.

[47] He gave evidence in terms of his report to the NHS Scotland Central Legal Office dated 13 June 2022, which he adopted.

[48] In relation to the prescription of high dose antipsychotic medication and the HDAT Guidelines, Dr Tuddenham was of the view that Mr Allen was appropriately prescribed antipsychotic medication during his time in prison, and that this was reviewed regularly by visiting psychiatrists and the dose or particular medication varied according to his mental state.

[49] In particular, Mr Allen was prescribed high dose antipsychotic medication for a period of about 3 months before his death as a result of two antipsychotics being prescribed simultaneously, with a view to discontinuing one of the antipsychotics; however he was probably not complying with both medications for a significant proportion of that period. In Dr Tuddenham's opinion, the decision to cross titrate was reasonable, and prescribing maximum doses for a time limited period was also reasonable given the risks of relapse, which included psychotically-motivated assaults on prisoners and prison staff.

[50] The HDAT guideline provided guidance for monitoring antipsychotics which included increased monitoring compared to standard monitoring for patients on or

above the licensed maximum dose of an antipsychotic. The minimum standard for ECG monitoring referred to in the HDAT guidelines in high dose antipsychotic treatment included performing an ECG "after dose increases with high dose antipsychotic treatment (at a steady state)" – in practice this would be about 1 month after entering high dose. Mr Allen should have been offered an ECG during the period when he was prescribed high dose antipsychotics.

[51] In oral evidence, Dr Tuddenham accepted that ECG monitoring could only be undertaken with the consent of the patient and, given his regular refusals, it seemed unlikely that Mr Allen would have accepted. In Mr Allen's case the clinical decision to prescribe was reasonable, even though it was not possible to monitor him. Additionally, had an ECG been undertaken this would have been no more than coincidental given the cause of Mr Allen's death not being one of sudden cardiac arrest.

[52] In relation to medical records, Dr Tuddenham opined that if Mr Allen had previously refused routine monitoring of antipsychotics, such as yearly blood tests and an ECG, this refusal should have been documented in his records. It was important to know that monitoring had been discussed. There was no record of physical monitoring for antipsychotics being considered in his Vision notes, hand written psychiatric records or psychiatric correspondence.

[53] In relation to the co-administration of Methadone and high dose antipsychotic medication, Dr Tuddenham opined that Methadone had been prescribed appropriately for Mr Allen and it appeared to help him reduce his illicit opiate misuse. Further, the

prescription of high dose antipsychotic treatment at the same time was also appropriate in view of Mr Allen's psychotic illness and the associated risk of violence.

[54] In relation to the dispensing of medication, Dr Tuddenham opined that the clinical decision to prescribe unsupervised antipsychotic medication during the time period preceding Mr Allen's death was based on the risks and benefits of this approach and, while there might be a range of opinion, was a reasonable decision. There was a significant risk of further violence related to mental illness if Mr Allen's mental state was not treated, and there was evidence to suggest that he was more likely to take his medication if it was not supervised.

[55] In relation to the possibility of daily dispensing, unsupervised, this would have been fairly uncommon and Mr Allen would still have been able to stockpile medication.

[56] In relation to spot checks, in his report Dr Tuddenham indicated that these were used to detect if prescribed medication was being used/stored appropriately, or alternatively stockpiled or diverted. These could be used if medical/nursing staff are concerned about compliance. There were no references to any spot checks in Mr Allen's Vision records. It may have been helpful if spot checks had been used during the 3 month period that Mr Allen was in the SRU before his death. He had told staff he was not complying with antipsychotic medication himself on more than one occasion, so a spot check would have provided useful information to cross check his self-report and/or detect excess medication that might be of concern. However these were not a precaution that would realistically have resulted in Mr Allen's death being avoided because the prison mental health team knew that he might not be complying with all of his

antipsychotic medication; finding an excess amount of antipsychotic medication would probably not have resulted in a change to supervised administration, although any excess medication would presumably have been confiscated.

[57] In oral evidence, Dr Tuddenham accepted that the potentially negative impact of spot checks on the nurse/patient relationship were a consideration but would not prevent these being undertaken if there were issues with unsupervised dispensing. He accepted that increased spot checks would likely have resulted in a reduction in Mr Allen's compliance, albeit checks could have been done sensitively.

Submissions

1. Findings under subsection 26(1)(a)

[58] All participants, other than Mr Allen's family, made equivalent submissions as to the findings which should be in made in respect of the circumstances mentioned in subsections 26(2)(a) to (f) inclusive.

[59] These were:

a. That in respect of subsection 26(2)(a) it be found that Mr Allen died at 23:19 hours on 20 May 2019 at Wishaw General Hospital;

b. That in respect of subsections 26(2)(b) and (d) no finding be made;

c. That in respect of subsection 26(2)(c) it be found that the cause of death was 1a: Methadone and Quetiapine intoxication; and

d. That in respect of subsections 26(2)(e) and (f) no findings be made.

[60] For the Crown, it was submitted that findings be made under subsection 26(2)(g) (other facts relevant to the circumstances of the death) in relation to the following matters:

a. that Mr Allan was prescribed high dose antipsychotic medication but the NHS Lanarkshire High Dose Antipsychotic guidelines were not followed;

b. that Mr Allen's medical records in places did not accurately reflect the full interaction with staff;

c. that Mr Allen was dispensed his medication in person on a weekly basis;

d. what checks were done to ensure that Mr Allen required Methadone, and why was he prescribed Methadone alongside Olanzapine and Quetiapine;

e. cell searching and medication spot checks;

f. the SPS Code Red/Blue policy.

[61] For NHS Lanarkshire, SPS, and POAS it was submitted that no findings should be made under section 26(2)(g).

[62] For Mr Allen's family, no submissions were made in respect of the findings which should be made in respect of the circumstances mentioned in sections 26(2) (a) to (d). However, in summary, the inquiry was invited to consider, for the purposes of section 26(e) to (g) the following submissions:

a. that, given HDAT and Methadone in combination were the cause of Mr Allen's death, the record keeping system and lack of communication between psychiatric and addictions teams resulted in a decision being made to combine

Quetiapine and Methadone, which can be potentially life-threatening with the advice given being to avoid the combination as the risk outweighs the benefit;

b. that the process of cross-titrating was not correctly followed. According to the antipsychotic dose conversion calculator to convert from 750 mg of Quetiapine to 50mg Olanzapine would be carried out over 10 days, taking less Quetiapine each day whilst introducing Olanzapine. In Mr Allen's case Dr Morris put him on a dose of Olanzapine at 10mg in late Feb and increased it to 20 mg in April. It was kept at this level until he died on the 19th May. At the same time he was still also prescribed 750 mg Quetiapine, so was on the maximum dose of each for a far longer period than would be recommended;

c. that, had daily dispensation in combination with frequent/weekly cell searches been implemented, Mr Allen would never have been in possession of a lethal amount of prescribed drugs, and as such this would have prevented his death. The lack of cell checks gave Mr Allen the opportunity to store medications. Given the past evidence of Mr Allen storing up and taking larger amounts of medication for intoxication it was inappropriate for him to have been given a zip bag of medication in his hand weekly;

d. that given the medical records showed Mr Allen having willingly had an ECG in December 2016 (which showed an increased QTC), and another in October 2017 (where his QTC was not checked) there was no evidence to show Mr Allen would not have been willing to consent to regular ECGs; and

e. that when Dr Morris applied to have Mr Allen transferred to the state hospital he was of the opinion that Mr Allen was unable to be properly treated within the prison system. Had this transfer occurred, Mr Allen's death could have been avoided.

2. Recommendations under section 26(1)(b)

[63] For the Crown, it was submitted that recommendations be made as follows:

a. NHS Lanarkshire should consider whether the High Dose Antipsychotic Treatment Standard Operating Procedure that has been implemented at HMP Shotts should be simplified to reduce the possibility for human error;

b. The Scottish Prison Service should consider whether it is necessary to have two different emergency codes, red and blue, or it should be amended to one emergency code to avoid confusion when both breathing difficulties and bodily fluids are involved;

c. NHS Lanarkshire should review their policy to ensure medication spot checks are conducted when staff are aware of information that a patient is not consuming medications as prescribed and ensure excess medication is removed;

d. The medication administration model within HMP Shotts should be reviewed for individuals presenting with acute mental health issues as part of their risk management plan;

[64] For NHS Lanarkshire, SPS and POAS it was submitted that no recommendations be made.

[65] For Mr Allen's family, no specific recommendations were proposed.

DISCUSSION AND CONCLUSIONS

1. Findings under subsection 26(1)(a)

[66] Having considered parties' submissions carefully, I have made formal findings in terms of sections 26(2)(a) and (c) and no findings in respect of sections 26(2)(b) and (d).

[67] For the avoidance of doubt, I do not consider that any findings can be made in respect of sections 26(2)(e) or (f). I do not consider that, if there were precautions that could have been taken or defects in any system of working, these might realistically have avoided Mr Allen's death or contributed to his death.

[68] That leaves the question of whether any findings should be made in terms of section 26(2)(g), which envisages findings being made of "*other facts relevant to the circumstances of the deat*h". It allows findings to be directed at such circumstances even if there is no finding that, on the balance of probability, they contributed to the death. Unlike sections 26(2)(e) and (f) there is no requirement for a causal connection. As such, it is considerably wider in scope. I agree with the submission by the Crown that it envisages comment being made in relation to any matter legitimately examined in the inquiry where that appears to be in the public interest.

[69] In Mr Allen's case, the "circumstances of the death" were that he died of Methadone and Quetiapine intoxication. It is accordingly relevant to consider how he came to be in possession of those drugs in sufficient quantities to result in intoxication.

[70] I agree in part with the submission made by the Crown that areas were identified in the course of the inquiry which should be addressed in terms of section 26(2)(g).

[71] In relation to the prescription of high dose antipsychotic medication and the HDAT Guidelines, I am satisfied on the evidence that Mr Allen was prescribed medication appropriately, and co-administered Methadone and high dose antipsychotic medication, with a plan to cross-titrate, within the range of reasonable clinical decisions and notwithstanding the difficulties in monitoring him as recommended by the HDAT Guidelines. Further, I am satisfied that Dr Morris sought appropriately to refer Mr Allen to the State Hospital, even if that referral was then refused on the basis of Mr Allen's then presentation.

[72] In relation to record keeping, there is no doubt that in retrospect it has been difficult to vouch the entirety of what occurred in relation to two matters in particular. First, the discussions with Mr Allen as regards the risks in his receiving antipsychotic medication absent recommended monitoring, and his refusal of the latter, appear not always to have been fully documented. Secondly, while Mr Allen's cell should have been searched on a weekly basis while he was housed in the Segregation and Reintegration Unit, only three searches over a three month period were documented.

[73] In relation to the dispensing of medication and spot checks, I accept that the decision to dispense medication to Mr Allen weekly, unsupervised was appropriate in all the circumstances and within the range of reasonable clinical decisions. There was evidence that to do so otherwise might have been counterproductive and reduced

compliance. Daily dispensing would not have removed the risk of Mr Allen stockpiling medication.

[74] However, in light of it being known or at least reasonably suspected that Mr Allen may not have been taking all of his medication, I do consider it relevant to comment on the procedures in relation to medication spot checks. It appears that NHS Lanarkshire staff within HMP Shotts were in possession of intelligence that Mr Allen may not have been taking medication as prescribed. Medication spot checks of Mr Allen's cell were not instructed. It is not clear what happened to the medication which Mr Allen self-reported as not consuming. Spot checks may potentially have assisted in determining whether the antipsychotic medication found was consistent with Mr Allen's self-report and/or whether he was storing medication. I accept however that the potential negative impact on the nurse/patient relationship would be a consideration (although not a bar) in deciding whether to instruct spot checks and, for completeness, also that this was not a precaution that would realistically have resulted in Mr Allen's death being avoided, for the reasons given by Dr Tuddenham.

[75] I make no finding in respect of the SPS Code Red/Blue policy.

2. Recommendations under section 26(1)(b)

[76] In terms of section 26(1)(b), any recommendations must such that they might realistically prevent other deaths in similar circumstances. I do not consider that that test or causal connection is met. Accordingly no recommendations can be made.

However, I am mindful that this determination will be considered by the relevant authorities and that note will be taken of the findings made above.

[77] For completeness, I accept the submissions made by NHS under reference to the determination in the *Inquiry into the death of Lauren Wade* [2023] FAI 13 that evidence from the significant adverse event review cannot inform the current inquiry.

[78] That concludes the determination. It remains only for me to join with all parties in offering my sincerest condolences to the family of Mr Allen.