SHERIFFDOM OF NORTH STRATHCLYDE AT KILMARNOCK

[2025] FAI 19

KIL-B178-24

DETERMINATION

BY

SHERIFF N K PATRICK

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

into the death of

BRENDAN REILLY

KILMARNOCK, 14 April 2025

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 Act"):

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

The death of Mr Reilly occurred on 11 June 2021 at 0829 hours within Cell D52, HM Prison Kilmarnock, Mauchline Road, Kilmarnock.

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

The cause of death was: 1a buprenorphine and etizolam intoxication.

(3) In terms of section 26(2)(g) of the Act, (other facts relevant to the circumstances of the death):

The prison policy and procedure relating to roll count was not complied with on the date of Mr Reilly's death.

Senior management were not aware of the lack of adherence to the prison policy and procedure in relation to roll count and there is no clear system for checking compliance with same.

The internal investigation into the death of Mr Reilly did not consider failure to comply with the policy and procedure on roll count as a relevant factor.

The recommendation following the Significant Adverse Event Review in relation to an operating procedure for ensuring effective communication for requesting an ambulance has not been implemented.

Recommendations

It is recommended that HMP Kilmarnock review the arrangements for ensuring and monitoring compliance with the roll count policies and procedures.

It is recommended that HMP Kilmarnock should comply with the recommendation made by the Significant Adverse Event Review, namely to implement an effective policy concerning communication for requesting an ambulance in emergency situations.

Note

The legal framework

[1] A Fatal Accident Inquiry must be held into the death of a person which occurred in Scotland if at the time of death the person was in legal custody.

[2] The purpose of this inquiry is to:

a) establish the circumstances of the death, and

b) consider what steps, if any, might be taken to prevent other deaths in similar circumstances.

[3] 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.

[4] The sheriff requires to make a determination setting out their findings as to the circumstances of the death, and any recommendations they consider appropriate. The circumstances are set out in section 26(2):

(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.

[5] The matters on which recommendations can be made are set out in section 26(4):

(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.

[6] Recommendations seek to set out what might realistically prevent similar deaths in the future. There must be a real or likely possibility that the matters recommended may prevent other deaths in similar circumstances, rather than a remote chance that a similar death in the future might be prevented.

Procedural history

[7] On 13 March 2024 notice was given to the sheriff by the Procurator Fiscal that an inquiry was to be held in relation to the death of Brendan Reilly.

[8] A preliminary hearing was fixed for 15 May 2024.

[9] The issues identified for the inquiry were:

1) To determine when and where the death occurred.

2) To determine the cause or causes of death; and,

3) To determine if there are any other facts which are relevant to the circumstances of the death. In particular, the Crown sought to explore at the Inquiry:

(a) The fact that Prisoner Officer's Scott McAnespie and Kevin Morris were in breach of SPS guidance in relation to the morning checks they carried out.

(b) Evidence addressing the procedures in place in Kilmarnock then and now regarding morning checks, and how management ensure compliance with the guidance.

(c) The issue of drugs supply within Kilmarnock Prison and policies/procedures in place to limit same, both then and now.

(d) What steps were taken following the receipt of intelligence suggesting that the deceased had sourced controlled drugs some time prior to his death.

(e) Evidence from James Gordon, Senior Addiction Nurse, to confirm the advice given to prisoners who are prescribed buprenorphine, in particular the dangers associated with same.

[10] The preliminary hearing took place at Kilmarnock Sheriff Court on 15 May 2024 and was continued to allow for further preparation until 28 May 2024.

[11] The inquiry commenced in Kilmarnock Sheriff Court on 21 June 2024. Further evidence was led in Kilmarnock Sheriff Court on 8 July 2024, in Dumbarton Sheriff Court on 29 July 2024, and in Kilmarnock Sheriff Court on 22 October 2024. Submissions were heard in Kilmarnock Sheriff Court on 26 November 2024.

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

- Ms Doran, Procurator Fiscal Depute,
- Mr Hood, for SERCO Limited,
- Ms Arnott, for the Scottish Ministers acting through the Scottish Prison Service, and
- Ms Raskin, on behalf of the next of kin of the deceased Brendan Reilly.

Evidence

[13] Parties lodged a substantial joint minute of agreement.

[14] The Crown lodged a substantial inventory of documentary productions. A limited number of these productions were referred to during the inquiry.

[15] The Crown also lodged a label production, a CCTV recording taken during the roll count procedure on the day of Mr Reilly's death at HM Prison Kilmarnock.

[16] Evidence was led from the following witnesses:

- Prison Custody Officer Scott McAnespie
- Prison Custody Officer Kevin Morris
- Pamela Swan, Deputy Governor, HMP Kilmarnock
- Dr Gillian Wilson, Consultant Forensic Pathologist

- James Gordon, Addiction Charge Nurse, HMP Kilmarnock
- John Fleming, Senior Manager, HMP Kilmarnock
- James Cassidy, Senior Manager, HMP Kilmarnock
- Frank Slokan, Criminal Justice Lead, Scottish Prison Service

Background

[17] At the date of his death Mr Reilly was a prisoner of HM Prison Kilmarnock housed in Delta wing. He had been sentenced to life imprisonment on 21 December 2005, and his sentence was backdated to 4 July 2005. He was transferred to HMP Kilmarnock on 20 October 2011 from HMP Addiewell. Accordingly, he was in legal custody at the time of his death.

[18] HMP Kilmarnock at that time was run independently of the rest of the prison estate in Scotland by a private company, Serco Limited, on behalf of the Scottish Prison Service under a contract with the Scottish Ministers. It transferred to the Scottish Prison Service following the expiry of the contract on 17 March 2024.

Relevant medical history

[19] Mr Reilly had been stable on Buvidal, an opiate replacement therapy, prior to his death. He engaged with his addiction caseworker whilst in prison and no concerns had been highlighted since Mr Reilly commenced on Buvidal. He attended healthcare within the prison on a regular basis for planned appointments, including with the Addiction Services for his opiate replacement injections.

[20] Mr Reilly had been taking anti-psychotic medication until December 2019. In January 2020 he was reviewed by a psychiatrist, at which time there were no concerns and it was agreed that he did not require any ongoing mental health support. Mr Reilly's mental health relapsed in April 2020 and the previously prescribed antipsychotic medication was recommenced.

[21] Buvidal contains the active substance buprenorphine. It is a prolonged release version of the opioid buprenorphine and is used to treat opioid dependence in patients who are also receiving medical, social and psychological support. Prior to his death, Mr Reilly last attended for drug addiction therapy on 27 May 2021 when he was given a 96mg Buvidal injection to the left side of his abdomen. Mr Reilly was also prescribed Olanzapine, Lansoprazole and paracetamol at the time of his death. His next monthly Buvidal injection was due on 24 June 2021.

[22] Drug screening was last obtained on 6 and 29 April 2021 whereby Mr Reilly only tested positive for buprenorphine, which was prescribed to him.

Evidence regarding prison security procedures

[23] Evidence was led that the circulation of illegal substances within the prison environment is one of the biggest challenges for the management of prisons. The manner in which substances enter the prison environment is continually evolving which means that systems and processes have to flexible enough to identify and adapt to changing patterns. At HMP Kilmarnock a variety of systems and processes were in place to address this issue:

- The scanning of mail with highly technical security equipment to detect drugs
- A process for the opening and checking of mail
- An extensive search process for visitors entering the prison involving a mobile phone detection device, handheld metal detectors, physical pat downs and/or searches, and the swabbing of hands to detect any physical contact with illegal substances
- Drug detection dogs
- Multiple daily perimeter patrols to counteract items coming over perimeter fences
- CCTV
- Fence tamper alerts
- Intelligence led additional measures involving police assistance
- Process for mass movement of prisoners involving pat downs and metal detection
- Random and intelligence led daily cell searches

[24] I was told that all of these processes and procedures are kept under continual review to meet the ever-evolving challenge of preventing the introduction of drugs into the prison environment.

[25] It was not submitted by any of the parties that any inadequacies in these procedures was a factor in the death of Mr Reilly.

[26] There was limited evidence led in relation to the specific role of intelligence in dealing with the challenge of illegal substances circulating in the prison. The Deputy Governor was asked whether there was intelligence in June 2021 suggesting that Mr Reilly was using etizolam. She indicated she would only have been informed of particular pieces of intelligence if they were "significant", but this was graded "very low". She said that generally intelligence was managed by the intelligence unit who would assess and grade it. Whether senior management were informed, or particular action was taken, would depend on the overall assessment including the grading and whether the information was corroborated.

Evidence regarding the events surrounding the death

[27] The inquiry heard from members of prison staff whose role it was to care for Mr Reilly in prison. I was told that Mr Reilly was housed in cell 52 of Delta wing. He had been offered a job in the visit hall shop on 10 June 2021. He spoke with his parents that same day and told them about the job. He mentioned feeling tired but did not complain of feeling ill or having any other issues. He was last seen on 10 June 2021 at around 1830 hours after evening lock up.

[28] On the morning of 11 June 2021 the morning roll count procedure was undertaken by Prison Custody Officers McAnespie and Morris. During the roll count procedure, captured on CCTV, no issue was identified by the officers in relation to Mr Reilly. Both witnesses accepted they did not receive any verbal response from Mr Reilly and took the view that he was still asleep. The officers accepted this was not in

accordance with the roll count procedure which requires officers to obtain a verbal response from all prisoners during the process.

[29] Mr Reilly had an alarm clock in his cell which was usually set for around 7.00am, which was later than the roll count procedure, he would normally rise when that alarm went off to get ready for attending his work placement. Accordingly, notwithstanding the requirements of the roll count procedure, both officers did not identify any cause for concern in relation to Mr Reilly's wellbeing. The information from the roll count procedure was relayed in accordance with the normal procedures and thereafter the morning unlocking of the cell doors commenced.

[30] As Prison Officer McAnespie was making his way along unlocking the cell doors, at some point after he had already unlocked Mr Reilly's cell he noticed that an alarm clock was still going off. He made his way in the direction of the alarm and opened Mr Reilly's cell door. He said his name and got no response. After receiving no response a second time he made his way into the cell and put an arm on his shoulder to rouse him. When there was no response, he did an initial check for breathing or a pulse and could identify neither.

[31] The officers described the procedure to be followed where a cardiac or respiratory arrest has been identified. A code blue will be called via the prison radio system by the person first on the scene. This call was made in relation to Mr Reilly at 0817 hours. PCO McAnespie commenced chest compressions. An ambulance was called at 0819 hours. The code blue was then attended by several prison nursing staff. Nurse McQueen was the first to attend and set up the defibrillator. PCO McAnespie

continued chest compressions during this time before Nurse McQueen placed the defibrillator on Mr Reilly's chest. Nurses Jorgenson and Sharpe had also attended and Nurse Jorgenson set up oxygen. No output was ascertained from Mr Reilly and nursing staff observed residue in his mouth. The defibrillator did not recommend a shock as there was no shockable rhythm identified. Chest compressions continued but the defibrillator continued to state that no shock was required.

[32] Senior Prison Nurses Ann Walker and Dianne Jamieson also attended. There was a delay in carrying out oral suctioning as there was no suction machine in the emergency bag and Nurse Jamieson had to obtain one from another house block. When the machine arrived Mr Reilly's nose and mouth were suctioned but the residue remained within. His skin was also grey and blue in appearance and his limbs were cold to the touch and limp. All nursing staff agreed at 0829 hours that CPR should cease.

[33] Dr Paul Church, GP was asked to attend to certify Mr Reilly's death and arrived at 0930 hours. Life was pronounced extinct as at the time of cessation of resuscitation at 0829 hours. Police Scotland were thereafter notified of the death and Mr Reilly's cell was locked.

[34] Police Scotland were informed of Mr Reilly's death at 0954 hours and arrived at HMP Kilmarnock at 1004 hours. CID officers and a scenes of crime photographer also arrived and went to Mr Reilly's cell.

Post mortem examination

[35] Undisputed evidence was led detailing the post mortem examination and the cause of death. The examination was carried out by Dr Gillian Wilson, Forensic Pathologist on 9 July 2021 at the Queen Elizabeth University Hospital, Glasgow. Blood samples and a urine sample were obtained for toxicological analysis. No evidence of significant injury was found and internally there were no signs of trauma. There were also no signs of significant underlying disease that could have caused or contributed to Mr Reilly's death.

[36] Toxicological analysis detected buprenorphine and its metabolite in the blood and urine of the deceased. The levels of buprenorphine at post mortem may have been therapeutic however it can have toxic effects especially when taken with similar drugs including benzodiazepines. Etizolam is a potent illicit benzodiazepine and it was detected at a level higher than that which is reported to be therapeutic.

[37] Etizolam and buprenorphine have toxic effects including progressive respiratory depression (very slow and shallow breathing), coma, and ultimately death.

[38] The primary cause of death was established as: 1(a) buprenorphine and etizolam intoxication.

Evidence regarding the findings of the Significant Adverse Event Review

[39] A Significant Adverse Event Review (SAER) was undertaken into the circumstances of Mr Reilly's death by NHS Ayrshire and Arran. The purpose was to identify opportunities for learning and improvement of healthcare systems.

[40] The SAER noted that the ambulance called for at 0819 hours never arrived. The prison Duty Manager requested at 0954 hours that the Scottish Ambulance Service (SAS) was called for an update on the ambulance. It was established that the original call to SAS had been disconnected, and that SAS had attempted to call the prison back three times at 0825 hours and 0826 hours but were put through to a mailbox which was full.

[41] The SAER noted that during resuscitation attempts there was no suction machine within the emergency equipment bag and a suction machine had to be retrieved from another houseblock.

[42] The SAER review team made two recommendations:

1. A new Local Operating Procedure between Serco, HMP Health Care and SAS should be developed to ensure effective communication for requesting an ambulance in emergency situations, within 3 months from the acceptance of the report.
2. Evidence should be provided of reinforced guidance for the daily checking of emergency equipment and weekly audit of compliance for the subsequent 3 months from the acceptance of the report. The healthcare team should source and purchase alternative suction machines for each houseblock.

Evidence regarding the findings of the Death in Prison Learning, Audit and Review

[43] A Death in Prison Learning, Audit and Review (DIPLAR) is the Scottish Prison Service process for reviewing deaths in custody and provides a system for recording any

learning and identified actions. A DIPLAR was carried out in relation to the circumstances of Mr Reilly's death. The DIPLAR resulted in five learning points/recommendations and recorded them as action points:

1. [SERCO/NHS] communicate with the Scottish Prison Service on procedure for requesting an ambulance in pursuance of GMA 60A/16 and in light of Local Operating Procedure - CPR Decision Making published locally by the NHS in order to define procedure.
2. Role count checks – visual and verbal response must be sought [by prison officers].
3. Weekly audit of emergency bag daily checks by the NHS.
4. All nursing staff to complete e-learning module and practical element on the confirmation of death.
5. Confirm arrangements relating to "Confirmation of Death" between Serco, Scottish Prison Service and NHS Ayrshire and Arran (which reflects arrangements in place in all joint Health Boards).

[44] Points 4 and 5 of the DIPLAR learning points/recommendations were not explored in the inquiry.

[45] The DIPLAR did not identify the failure to comply with the prison policy in relation to roll count as a relevant factor. In her evidence the Deputy Governor, Pamela Swan, expressed surprise at this and agreed that it ought to have been identified as a risk.

Evidence regarding action taken in relation to SAER/DIPLAR

SAER point 1/DIPLAR point 1

[46] Pamela Swan, Deputy Governor, gave evidence to the effect that the responsibility for implementing a DIPLAR action plan would sit with the compliance unit consisting of an Assistant Director, a Team Leader and two administrative support staff. There would be a monthly meeting between the compliance unit and the Governor, Deputy Governor or a Director at which a monthly update on implementation would be required.

[47] On being asked about the procedure for requesting an ambulance Ms Swan said that there was not a dedicated line for SAS to contact the prison. Her understanding was that control would call 999 in the event of a similar situation, but she did not know if there was a single point of contact should the SAS require to call back. She indicated that she did not know if this part of the DIPLAR action plan had been implemented. She indicated that she would immediately be checking on her return to duty what the position was with regards to implementation of the SAER and DIPLAR recommendations in relation to this issue.

DIPLAR point 2

[48] This is explored in more detail under roll count procedure/policy.

SAER point 2/DIPLAR point 3

[49] The absence of the suction machine at the relevant time was categorised in the SAER as an "indirect system of care/service issue". This is described as "lessons can be learned but were unlikely to have affected the outcome".

[50] It was a matter of agreement that expert medical opinion concluded that the lack of suction device in the emergency bag did not impact the overall outcome of Mr Reilly's death. It was also agreed that since the death various steps have been taken in relation to this issue including a daily review and audit by the healthcare leadership team of emergency equipment, a daily emergency bag checklist and the purchase of two new suction units and a carriage charge unit for the devices.

Evidence regarding the roll count procedure/policy

[51] Evidence was led examining Crown Production 18, the standard operating procedure (SOP) for roll count.

[52] Both Prison Custody Officers gave evidence that the SOP relating to roll counts set out the procedure that should have been followed during roll count. The procedure requires that during roll count Prison Custody Officers were to "see the face of and get a response from the prisoner". Furthermore, both officers should receive such a response. They had both been trained on this and they were fully aware of the requirements. The officers described a quick process where they would conduct the roll count in pairs with one officer opening the door and checking the prisoner(s) were present and the other checking off the names on the roll count sheet.

[53] It was a fairly normal occurrence for the procedure set out in the SOP not to be followed. PCO McAnespie said that sometimes it was not necessary to physically enter the cell to get a response as the prisoner may be standing in front of the door or saying hello or a prisoner may wiggle their feet or say good morning. He agreed with a suggestion that many prisoners were still asleep during morning roll count. PCO Morris described a discretionary approach to the procedure indicating that he would make a judgment on whether he needed to get a verbal response based on several factors such as how well he knew the wing or the prisoners and whether there was a need for caution in relation to any particular prisoner. PCO Morris said "if every prison officer woke every prisoner up you are in for a long shift".

[54] The CCTV of the morning of Mr Reilly's death showed that the procedure was not followed and it was accepted by both PCOs that they did not get any verbal response from Mr Reilly. Both PCOs confirmed they had assumed he was still asleep within his bed and did not take any steps to obtain a verbal response or to rouse him during the roll count. Neither thought there was any issue as it was his normal routine to rise later when his alarm went off. Both PCOs accepted that their actions were not in line with the SOP.

[55] In relation to training on the roll count procedure both PCOs said that the initial training, including in relation to roll count, was good but that ongoing training could be improved. Reference was made to refresher training by way of reading a document or eLearning being somewhat tedious.

[56] In relation to the current training on roll count, evidence was led from Frank Slokan, who works at the Scottish Prison Service College. He spoke to the online training that he created in relation to locking and unlocking. Said training was developed following the outcome of another Fatal Accident Inquiry and postdates Mr Reilly's death. Prior to the introduction of this online training there was no national compulsory refresher training for locking and unlocking, it was part of initial staff training but thereafter any refresher was within the remit of local prison establishments.

[57] The locking and unlocking training developed by Mr Slokan now forms part of a mandatory annual training package for all prison officers. The training includes step by step guides and photographs to illustrate how the locking and unlocking procedure works in practice. The training requires the completion of questions following each section which must be completed to demonstrate understanding. If an officer fails the online assessment they require to retake it until a pass is achieved. In addition, there is a register of when each prison officer must complete the training and the system will flag to a manager if a prison officer has not done so timeously.

Crown submissions

The Crown sought:

[58] Formal findings, in terms of section 26(2)(a) and (c) in relation to when and where the death occurred, and the cause of death.

[59] No findings in terms of sections 26(2)(b) and (d) of the 2016 Act as the death did not result from an accident.

[60] No findings in terms of sections 26(2)(e) and (f), as there were no identifiable precautions which might realistically have avoided the death of Mr Reilly. There were no identifiable defects in any system of working which contributed to his death.

[61] Findings in terms of section 26(2)(g) that the following issues of concern were relevant to the circumstances of the death as they may affect the public interest;

- The evidence led at the inquiry established that the prison policy relating to roll count was not complied with
- The prison's internal death investigation did not consider failure to comply with the prison policy as a relevant factor
- Ongoing training
- Action plan following review of Significant Adverse Event not implemented

[62] Recommendations in terms of section 26(1)(b) in the following terms:

- HMP Kilmarnock should, without delay, implement the recommendation made by the Significant Adverse Event Review in relation to a policy concerning the Scottish Ambulance Service inability to reach any personnel within the prison institution, and therefore the prison must, with immediate effect implement an effective policy concerning communication for requesting an ambulance in emergency situations. The Contractual Compliance Unit within HMP Kilmarnock should be compelled to report on this matter to the Governor of HMP Kilmarnock within 3 months of this determination.

- HMP Kilmarnock should, without delay, implement a review of their training, particularly the ongoing training for Prison Custody Officers. Specifically, the prison should consider the implementation of further in-person training and to continually ensure that all such Prison Custody Officers remain fully cognisant and appreciative of strictly adhering to prison policy, including those relating to roll-count

Submissions on behalf of SERCO Limited

SERCO sought:

[63] Formal findings, in terms of sections 26(2)(a) and (c) of the 2016 Act only.

[64] No findings in terms of sections 26(2)(b) and (d) of the 2016 Act as the death did not result from an accident.

[65] No findings in terms of sections 26(2)(e) to (g) and no recommendations in terms of section 26(1)(b).

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

The Scottish Ministers sought

[66] Formal findings, in terms of sections 26(2)(a) and (c) of the 2016 Act only.

[67] No findings in terms of sections 26(2)(b) and (d) of the 2016 Act as the death did not result from an accident.

[68] No findings in terms of sections 26(2)(e) to (g) and no recommendations in terms of section 26(1)(b).

Submissions on behalf of the next of kin of the deceased

Ms Raskin sought:

[69] Formal findings in terms of sections 26(2)(a) and s26(2)(c).

[70] No findings in terms of sections 26(2)(b) and (d) or sections 26(2)(e) and (f).

[71] Findings in terms of section 26(2)(g) that the following issues were relevant to the circumstances of the death:

- The policies in relation to the sharing of intelligence about drug use on the part of prisoners
- The arrangements for a dedicated phone line between the Scottish Ambulance Service and HMP Kilmarnock as highlighted in the Significant Adverse Event Review
- The lack of adherence to the roll count procedure and the training in relation to same

[72] Recommendations in the following terms:

- HMP Kilmarnock should, without delay, implement the recommendation made within the Significant Adverse Event Review in relation to a designated phone line between HMP Kilmarnock and the Scottish Ambulance Service to allow for the Service to reach prison personnel without delay should an emergency arise.

- HMP Kilmarnock should, without delay, implement necessary changes to the way in which their training is conducted, in particular in relation to learning regarding locking/unlocking procedures. There should be emphasis on the importance of receiving a verbal response from prisoners at all points of checks throughout the day. Training should be changed to both online and simulated, role play learning to allow potential custody officers practice before implementing in their employment. Given the numerous Fatal Accident Inquiries which have been called in the last decade in relation to a lack of verbal response, more checks should be carried out by senior staff to ensure that roll counts are being performed properly and to the standard they should be.
- HMP Kilmarnock should invoke change in the way intelligence is passed on to prison custody officers relating to prisoners with previous vulnerabilities, regardless of the grade of the intelligence. This would allow them to be made aware of any potential possibilities of prisoners using illicit drugs and allow them to practice their training from "Talk To Me".

Consideration of submissions

[73] Having considered the evidence and submissions I have come to the following conclusions:

[74] Mr Reilly's death was not the result of an accident. His death was a result of intoxication through ingestion of etizolam combined with buprenorphine.

[75] The recommendation in the Significant Adverse Event Review in relation to arrangements for a dedicated phone line between Scottish Ambulance Service and HMP Kilmarnock has not been implemented. This issue was also highlighted in the DIPLAR action plan. There was no clear explanation in any of the evidence led as to why this had not been actioned. This issue should be addressed as a matter of urgency.

[76] In relation to the failure to adhere to the roll count procedure and the training in relation to same, there was considerable evidence led about these issues. The lack of compliance with the roll count procedure on the part of the PCOs did not contribute to the death but even if it did it was not a defect in the system of working. Rather, it was a situation where individual officers were not following a clear established process on which they had been trained. It was a proactive decision on their part to apply their own discretion to the policy. PCO Morris was very frank in his evidence that regardless of policies there is an element of "jail craft" whereby officers will adapt their ways of working based on various factors such as their knowledge of the prisoner, the wing, the need to maintain a harmonious environment and the need for some tasks to be undertaken with speed. There was a failure to adhere to the policy in relation to roll count and this was fully accepted by both PCOs in their evidence. This is a factor relevant to the circumstances of the death.

[77] I do not consider that more face to face or interactive training in relation to roll count would assist. Whilst the PCOs did comment that refresher training in the wider

sense could be done in more effective ways other than eLearning there was no evidence to suggest that the PCOs did not know what the established policy was and the procedure they were required to follow. Quite the opposite, they knew what the procedure was and chose to depart from it.

[78] The training on this process now sits with SPS and since Mr Reilly's death it has been revised and forms part of mandatory annual refresher training. I do not consider a further review of the training would assist, particularly given that there was evidence it is kept under review anyway. Rather, the issue lies in the lack of any kind of checking system to monitor compliance with the roll count procedure. It was apparent from the evidence of the Deputy Governor that there is a lack of awareness at a senior level that PCOs operate the roll count policy in a discretionary manner. There is no clear established system in place to monitor compliance with the procedure set out in the policy and address lack of compliance by individual officers. Checks should be introduced to ensure compliance with roll count procedures and policy.

[79] Notwithstanding the fact that based on the evidence, compliance with the roll count procedure would not have prevented Mr Reilly's death this is a matter of huge significance, particularly as it has been a feature of concern in other similar inquiries as referred to in the Crown submissions. Accordingly the failure of the DIPLAR to identify this as a risk factor is of concern and is a factor relevant to the circumstances of the death.

[80] I do not consider that there are any other precautions which could reasonably have been taken, and were not, which might have prevented access to illicit substances.

The scale of the challenge of preventing prisoners obtaining drugs was summed up in the evidence of Mr Fleming who said that when they shut down one avenue another one opens up and individuals will resort to whatever works to get things into the prison. No submissions or suggestions to the effect that there are some additional precautions that should be taken were made.

[81] I am not satisfied that there was evidence to establish that the policies in relation to intelligence sharing about drug use on the part of prisoners are relevant to the circumstances of the death. PCO Morris expressed surprise at the cause of death of Mr Reilly and was clear in his evidence that he did not consider him to be an active drug user. However, there was no indication that he would have done anything differently had he been provided with this information as his treatment of Mr Reilly was based on knowledge of his routine and his recent interactions with him which had given no cause for concern. Similarly, all of Mr Reilly's engagement with healthcare professionals gave no cause for concern.

[82] The intelligence that was available in relation to Mr Reilly potentially using etizolam was of a very low grade. The evidence in relation to how intelligence is handled was very limited, the Deputy Governor confirmed however that intelligence is managed by the intelligence unit which includes assessing and grading it and where appropriate taking action when it is of sufficient weight. There was no evidence led that suggested any particular policies in relation to intelligence were either inadequate or had not been complied with. For these reasons I do not consider that there is a basis for

a recommendation to review or alter the policies in relation to the handling of intelligence.

Conclusions

[83] In all of the circumstances I am satisfied that there were no further precautions which could reasonably have been taken which might realistically have resulted in the death of Mr Reilly being avoided.

[84] Having carefully considered all of the evidence before the inquiry and for the reasons set out, I have made the findings as detailed at the commencement of this determination.

[85] I offer my condolences to Mr Reilly's family and thank them for their indication at the conclusion of the inquiry that they felt the circumstances surrounding his death had been fully explored.