SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2026] FAI 31

GLW-B2011-24

DETERMINATION

BY

SHERIFF D N TAYLOR

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

into the death of

NEIL HAND

GLASGOW, 23 June 2026

The sheriff, having considered all of the information presented at the inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (hereinafter referred to as "the Act") that:

Statutory findings

1. In terms of section 26(2)(a) of the Act, Neil Hand, born on 17 April 1989, then a prisoner within HM Prison Low Moss, 190 Crosshill Road, Glasgow, died at some point between 5.05pm on 26 October 2019 and 5.08am on 27 October 2019 within cell 26, Section A, Kelvin Hall 2, HM Prison Low Moss, Glasgow.

2. In terms of section 26(2)(b) and (d) of the Act, there was no accident which caused or contributed to Mr Hand's death.

3. In terms of section 26(2)(c) of the Act, the cause of death was:

3.1 Methadone, Flualprazolam, Etizolam, Buprenorphine, Amitriptyline and Pregabalin intoxication.

4. In terms of section 26(2)(e) of the Act, there were no precautions which could reasonably have been taken which might realistically have resulted in the death being avoided.

5. In terms of section 26(2)(f) of the Act, there were no defects in any systems of working which contributed to the death.

6. In terms of section 26(2)(g) of the Act, the following facts are relevant to the circumstances of the death:

(i) HMP Low Moss should have had a system in place at the time of Mr Hand's death of monitoring prisoner visits by the use of CCTV and trained operators for the purpose of detecting the transfer of drugs from visitors to prisoners.

(ii) Since 2019 there have been significant changes to the way in which addiction services operate within HMP Low Moss. The introduction of an MDT (Multi-Disciplinary Team), the adoption of MAT (Medication Assisted Treatment) standards and the development of the HRT (Harm Reduction Team) have all improved the ability of addiction services to coordinate care and respond more quickly to the needs of patients.

(iii) Following his disengagement from addiction services in June 2019, Mr Hand could have been reviewed to further discuss his disengagement

from addiction services and offer him the opportunity to re-engage with addiction services. If Mr Hand still refused to engage in addiction services following that further review, he could have been asked to sign the treatment refusal form and thereafter sent a follow-up letter reminding him that he could re-engage with addiction services at any time through the self-referral process.

(iv) The failure to carry out an evening welfare check on prisoners within Kelvin Hall, HMP Low Moss on 26 October 2019 was a breach of the SPS revised requirements during Locking and Unlocking Periods document dated 28 March 2016.

(v) The failure to carry out an evening welfare check on prisoners at weekends was a defect in the system of working at HMP Low Moss at the time of Mr Hand's death.

(vi) On 3 October 2019, following his episode of intoxication at work, Mr Hand could have been referred to addiction services for review to discuss his illicit drug use, provide harm reduction education and encourage engagement with addiction services.

Recommendations

And, further, in terms of section 26(1)(b) of the 2016 Act, the sheriff makes the following recommendation:

(i) An evening welfare check on prisoners should be carried out at HMP Low Moss at weekends at the same time as the evening welfare check is carried out on weekdays, ie between 8.15pm and 8.30pm.

The inquiry (procedure and evidence)

[1] This determination is made following the Fatal Accident Inquiry held under the Act into the circumstances of the death of Neil Hand, born 17 April 1989, who died while a prisoner in HM Prison Low Moss, 190 Crosshill Road, Glasgow.

[2] The first notice in the inquiry was issued on 31 December 2024. A preliminary hearing took place on 14 February 2025. It was apparent at the preliminary hearing that, notwithstanding the length of time which had passed since Mr Hand's death, parties required further time to consider a number of issues, including in particular the instruction of expert witnesses. Accordingly, a continued preliminary hearing was fixed to take place on 6 May 2025.

[3] At the continued preliminary hearing on 6 May 2025 a revised draft joint minute of agreement was produced, an order was made for the proceedings to be intimated to Mr Kallen Stuart and dates to hear the evidence in the inquiry were fixed for 6 to 9 October 2025. Thereafter a number of further preliminary hearings took place. The preliminary hearings were of assistance in determining the parties' state of preparedness for the inquiry and in considering other issues including the way in which the evidence was to be presented at the inquiry and the extent to which expert evidence would require to be led.

[4] At the preliminary hearing on 12 September it was noted that an objection was to be taken by Mr Stuart and Greater Glasgow and Clyde Health Board to any evidence to be taken from the Crown expert Mr Philip Wheatley, particularly in relation to the matters referred to in paragraph 74 of Mr Wheatley's report dated 21 May 2023 and in relation to any response by Mr Wheatley to question 4 as contained within the Opinion section of his report.

[5] Evidence was led at the inquiry on 6, 7 and 8 October 2025. At the conclusion of the evidence on the joint motion of all of the parties I fixed a further date to hear submissions. In the event, for several reasons, the hearing on submissions did not take place until 24 February 2026. Prior to the hearing on submissions, I received written submissions. I am grateful to the parties for the time and trouble which they took to prepare written submissions which assisted me in focusing upon the issues which the inquiry required to address. At the conclusion of the hearing on submissions, I made avizandum.

[6] Six parties were represented at the inquiry: Ms Sweeney, procurator fiscal depute, appeared for the Crown; Ms Turner solicitor, appeared on behalf of the Scottish Ministers for the Scottish Prison Service; Mr Dundas, advocate appeared on behalf of Greater Glasgow and Clyde Health Board; Ms McIlwham solicitor appeared on behalf of The Prison Officers Association Scotland; Mr Muir solicitor appeared on behalf of the next of kin of the deceased and Mr Gillies solicitor appeared on behalf of Mr Stuart.

[7] For the purposes of the inquiry parties tendered a joint minute of agreement which covered a significant amount of the evidence which required to be placed before the court.

[8] A substantial number of productions were lodged in the course of the inquiry. The Crown lodged productions 1 to 20. Greater Glasgow and Clyde Health Board lodged productions 1 to 8. The Scottish Ministers for the Scottish Prison Service lodged productions 1 to 19. In terms of the joint minute of agreement, it was agreed that all of these productions were true and accurate copies of the documents that they bore to be and that they could be admitted into evidence without the need to be spoken to by a witness. Where referring to parties and productions in this determination I shall use the abbreviation CP for Crown productions, GGHB for Greater Glasgow and Clyde Health Board and its productions and SPS for the Scottish Prison Service and its productions.

[9] In terms of the joint minute of agreement Crown label no 1 was agreed to be a true and accurate copy of CCTV footage within Kelvin 2, Section A, HMP Low Moss, between the hours of 16:30:00 and 21:06:53 on 26 October 2019.

[10] Affidavits were produced from Angus Yuile, Alan Haswell Hardy Henderson and Barry Hay. In terms of the joint minute of agreement the affidavits were taken to be the evidence-in-chief of these witnesses subject to any further examination in chief as the court might allow.

[11] Parole evidence was led from the following witnesses:

- Ronald Gibson, a prison officer at HMP Low Moss at the time of Mr Hand's death.

- Lisa Leneghan, a prison officer at HMP Low Moss at the time of Mr Hand's death.
- Keith Johnston, an offender outcome officer at HMP Low Moss at the time of Mr Hand's death, based in the timber machine workshop.
- Barry Hay, the current head of operations at HMP Low Moss.
- Gordon Kidd, a residential unit manager at HMP Low Moss.
- Kallen Stuart, an addictions nurse at HMP Low Moss at the time of Mr Hand's death.
- Shona Malone, the interim operational manager for prison healthcare at HMP Low Moss.
- Dr Gary Dyson, an expert instructed by GGHB to comment on Mr Hand's medical treatment, particularly in relation to addictions, while in prison.
- Dr Marjorie Turner, the principal forensic pathologist who carried out the post-mortem examination on Mr Hand.
- Mr Philip Wheatley, a prison expert instructed by the Crown.

The legal framework

[12] This inquiry was held in terms of section 1 of the Act. It was a mandatory inquiry in terms of section 2(4)(a) of the Act as Mr Hand was in legal custody at the time of his death.

[13] 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

any other deaths occurring in similar circumstances. Section 26 requires the sheriff to make a determination which in terms of section 26(2), is to set out the factors relevant to the circumstances of the death, in so far as they have been established to his satisfaction. These are:

(a) when and where the death occurred;

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

(c) the cause or causes of death;

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

(e) any precautions which could reasonably have been taken and if they had been taken might realistically have resulted in the death being avoided;

(f) any defect in any system of working which contributed to the death or to the accident; and

(g) any other facts which are relevant to the circumstances of the death.

[14] In terms of sections 26(1)(b) and 26(4) of the Act, the inquiry is to make such recommendations (if any) as the sheriff considers appropriate as to:

(a) the taking of reasonable precautions;

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

(c) the introduction of a system of working; and

(d) the taking of any steps which might realistically prevent other deaths in similar circumstances.

[15] 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

determination must be based on the evidence presented at the inquiry. It is not the purpose of an inquiry to establish criminal or civil liability (section 1(4) of the Act).

Findings in fact

[16] Having regard to the evidence presented to the inquiry, I found the following facts admitted or proved. I have taken the findings from the parole evidence led in the course of the inquiry and also from the terms of the joint minute of agreement. However, I have not included all of the findings in the joint minute as I do not consider that all of the findings are relevant to the circumstances of Mr Hand's death. In some cases, I have summarised findings made in the joint minute. As Sheriff Reid observed in his determination in the *Inquiry into the death of Shea John Ryan* [2025] FAI 31 the court is not bound to accept any or all of the facts contained within a joint minute without qualification.

Background

(1) Neil Hand (hereinafter referred to as "Mr Hand") was born on 17 April 1989 and was 30 years old at the date of his death. On 5 November 2018, Mr Hand was sentenced to 3 months' imprisonment in HMP Perth for a domestically aggravated contravention of section 39(1) of the Criminal Justice and Licensing (Scotland) Act 2010. On 18 December 2018, Mr Hand was convicted of assault and robbery at Dundee Sheriff Court and was given a custodial sentence of 40 months backdated to 27 August 2018.

HMP Perth

(2) On initial assessment at HMP Perth, Mr Hand was classified as requiring a "low level" of supervision. Within the risk assessment, the question of "means and willingness to organise serious indiscipline, (including drug dealing)", was answered in the negative. Current substance abuse was answered in the negative. The assessment form was completed by Prison Officer D Jackson on 5 November 2018, Hall Manager S Aston on 7 November 2018 and Unit Manager, G Stewart, on 8 November 2018.

(3) On 8 February 2019 at HMP Perth, Mr Hand was removed from association under Rule 95, which allows the governor to order in writing that a prisoner must be removed from association with other prisoners, either generally or to prevent participation in a prescribed activity or activities. The paperwork documenting his removal from association notes that the purpose of the general removal from association was to "maintain good order or discipline"'

(4) The reason given for the Rule 95(1) order imposed on 8 February 2019 was as follows:

> "There has been an increase in the incidents of prisoners being placed on MORS [Management of an Offender at Risk due to Any Substance] within the establishment and it is believed that Mr Hand is a significant part of the organised prisoner network (OPN) responsible for the introduction and distribution of PS (psychoactive substances) within the establishment. Mr Hand is to be managed under Rule 95 conditions to facilitate time for further investigation while maintaining the good order of the establishment"

The Rule 95 order was to run from 8 February 2019 until 1 February 2019, as authorised by D Reid, duty governor on 8 February 2019.

(5) An application to extend the Rule 95 order was then made on 11 February 2019. The reason for the application was given as follows:

> "There has been an increase in the incidents of prisoners being placed on MORS within the establishment and it is believed that Mr Hand is a significant part of the organised prisoner network (OPN) responsible for the introduction and distribution of NPS within the establishment. Mr Hand has accumulated eighteen intelligence reports since the beginning of December 2018 relating to his subversive behaviours including the bullying and threatening of other prisoners and his involvement in the drug scene within HMP Perth. The intention of the original R95 (1) was to disrupt the activities of Mr Hand and its detrimental effect on the establishment and our prisoners. HMP Perth senior management and the IMU deem it necessary and justified to apply for an extension in order to continue to disrupt Mr Hand's criminal activities and facilitate time to develop a future management plan while maintaining the good order of the establishment."

(6) A Rule 95 case conference was held on 11 February 2019 which was attended by Mr Hand, two Separation and Reintegration Unit (SRU) officers, one SRU manager and chaired by the unit manager D Reid. The MHT were unable to attend the case conference. In providing the reason for Mr Hand's removal from circulation, Mr Reid referred to Mr Hand's perceived involvement in the supply and distribution of drugs within the establishment. Mr Hand denied this. The chair said that the information they had was credible. The chair stated that there was further information which indicated that Mr Hand was also involved in bullying other prisoners and threatening violence to get what he wanted. Mr Hand denied this.

(7) At the conclusion of the Rule 95 case conference on 11 February, a decision was made to apply to the Scottish Ministers for an extended month's rule to ensure that Mr Hand was legally located within SRU while maintaining the good order of the establishment, facilitating time to consider options for future management. The extension was granted and was to continue to run until 11 March 2019. A future case conference was scheduled for 10 March 2019 in HMP Perth.

HMP Low Moss

(8) Neil Hand was admitted to HMP Low Moss on 13 February 2019 as a transfer from HMP Perth. He was admitted to Lomond Separation and Reintegration Unit (SRU) in HMP Low Moss. Mr Hand's removal from association under Rule 95 came to an end and he was relocated onto one of the main halls, Kelvin 2, on 17 February 2019.

(9) An intelligence and incident summary in respect of Mr Hand's period of incarceration in HMP Low Moss was provided by the Scottish Prison Service.

(10) In March 2019, intelligence suggested that Mr Hand was expecting to receive mail sprayed with psychoactive substances.

(11) In May 2019, intelligence suggested that Mr Hand was dealing in psychoactive substances and was trying to employ a prisoner to assault another who had failed to pay for drugs supplied.

(12) In May 2019, intelligence suggested that another individual and Mr Hand were enemies due to a drug debt being owed by the individual.

(13) In June 2019, intelligence suggested Mr Hand's drug trading had caused another prisoner and Mr Hand to be enemies because of a drug deal gone wrong. It was noted that Mr Hand and the other prisoner were already linked as enemies.

(14) In September 2019, intelligence suggested that another prisoner owed money to Mr Hand and that Mr Hand was taking goods the prisoner had purchased in the prison canteen to meet the debt. This intelligence was corroborated by CCTV showing Mr Hand taking the prisoner's purchases from his cell.

(15) In October 2019, intelligence indicated that Mr Hand had paid a prisoner to assault another who owed him money and further that Mr Hand had taken Xanax on an unspecified date and time.

(16) On 30 April 2019, Mr Hand was allocated cell 2C23 on Kelvin Hall, Section C-L2. On 8 October 2019, Mr Hand was reallocated to cell 2A26 on Kelvin Hall, Section A-L2.

(17) On 30 April 2019 Mr Hand's cell was searched. On 2 August 2019 Mr Hand's cell was searched. On 2 September 2019 Mr Hand's cell was searched. On 8 October 2019 Mr Hand's cell was searched.

Events prior to 26 October 2019

(18) On 4 June 2019, nursing staff from HMP Perth were called via radio to a GeoAmey van as Mr Hand was unresponsive while being transferred to another establishment. Upon examination, Mr Hand was conscious. Officers informed nursing staff that Mr Hand admitted to having taken four tablets containing 300 milligrams of Pregabalin while at court. It was noted that Mr Hand was quite drowsy, his pupils were dilated and his speech was slurred. Nursing staff advised GeoAmey staff to take Mr Hand to A & E, however Mr Hand refused to go.

(19) On or around 16 August 2019 Mr Hand completed the Challenging Unhelpful Thinking module of the Short-Term Intervention Programme (STIP). A post-programme report was prepared on 4 October 2019.

(20) On 3 October 2019 at or about 1.30pm Mr Hand attended for work at the timber machine workshop under the influence of an unknown substance. He was seen by a nurse following this incident and placed under 30-minute observations. He was also charged with a disciplinary offence. On 4 October 2019 he attended a disciplinary hearing where he pled guilty to the charge. He told the adjudicating governor that he had taken sleeping tablets and Amitriptyline before attending work on 3 October 2019.

Provision of healthcare in Scottish prisons

(21) On 1 November 2011, the responsibility for the provision of healthcare to prisoners transferred from the SPS to the NHS. Since then, individual regional health boards have been responsible for the delivery of healthcare services within prisons in Scotland which fall within their geographical ambit for the provision of medical care.

Medical history

(22) Prior to being imprisoned at HMP Low Moss Mr Hand had a lengthy history of mental health problems and substance misuse.

(23) He had interaction with drug misuse services in various prisons, including HMP Perth and HMP Castle Huntly, during previous periods of incarceration. In the course of these interactions, he had been provided with information about the risks of taking illicit substances. He had also been made aware of the support services available to him both within the prison environment and in the community.

(24) On 14 February 2018 Mr Hand attended his GP for review. He advised his GP that he was using Valium, crack cocaine and cocaine. He was depressed with suicidal thoughts. He advised his GP that he had previously tried to hang himself when he was 21 years of age. He was given advice by his GP about NHS and mental health support services.

(25) On subsequent GP visits on 29 June 2018 and 27 August 2018 Mr Hand denied any suicidal ideation.

(26) On 15 April 2019 Mr Hand underwent a mental health assessment in HMP Low Moss. It is documented within Mr Hand's medical records that during the course of the assessment, Mr Hand said he had been struggling while in HMP Perth and had been using a lot of drugs. He advised that, since being transferred to HMP Low Moss, he felt more settled, was not using illicit drugs and was getting back to the gym. Mr Hand was on a regular prescription for Mirtazapine which had been prescribed for depression. It was noted that, whilst Mr Hand considered that Mirtazapine was effective, at times he still felt low and struggled with sleep. It was noted that Mr Hand had no thoughts of self-harm or suicide at that time. It was noted that nursing staff would contact medical staff about increasing the dose of Mirtazapine and review Mr Hand 6 weeks later.

(27) On 29 May 2019 Mr Hand was reviewed by a mental health nurse. It was noted that, since the previous review, Mr Hand's mood had improved with an increase in medication. It was noted that he still struggled with anxiety issues. It was noted that all was okay in the halls and that all was okay with addictions. On review no signs of psychosis were identified. His mood appeared good. Mr Hand was communicating freely and made good eye contact. It was noted that nursing staff would approach a GP about Propranolol and that Mr Hand would be reviewed 6 weeks later. Following discussions with medical staff, Mr Hand was prescribed Propranolol 20mg twice daily.

(28) On 6 June 2019, in the course of a consultation after he had experienced chest pains, Mr Hand admitted to nursing staff that he had taken seven Propranolol tablets, as well as taking diverted medication intended for other prisoners, including Pregabalin, Suboxone, Valium and Diazepam. Nursing staff informed medical staff of what had been reported by Mr Hand. Dr Van Den Meersschaut changed Mr Hand's essential medication (Mirtazapine and Propranolol) to supervised consumption. Co-codamol was stopped for safety reasons. It was noted that Mr Hand would be reviewed later that day. At the time of further review Mr Hand was not complaining of chest pain or discomfort. It was noted that prison officers had removed medications from his cell and that he was now on a supervised medication regime.

(29) On 6 June 2019 Mr Hand submitted a NHS Prison Healthcare Self-Referral Form 69 Mr Hand's stated reason for the self-referral was:

> "Been taking insulin for gym reasons not supposed to be on it also a few other substances not ment to take been feeling dizzy as if im away to faint all day need blood tests done also heart rate + blood pressure really high as I think I have damaged some organs due to long term abuse."

(30) On 8 June 2019 it was noted that Mr Hand had failed to attend for his medication that morning.

(31) On 10 June 2019 it was noted that Mr Hand had failed to attend for his medication that morning.

(32) On 10 June 2019, Mr Hand was reviewed by nursing staff to discuss his refusal to take his Propranolol for the previous few mornings as well as in

relation to concerns regarding dizzy spells which Mr Hand had submitted a self-referral form for. During the examination, Mr Hand admitted to snorting 2mg of Buprenorphine daily as well as other occasional drug use such as MST if available to him. It was noted that he reported that he had been injecting insulin to promote results at the gym up until a few weeks previously. At this time, he had also self-referred to the NHS Addiction Services (on 6 June 2019) and it was noted within his medical records that he would benefit from an addictions assessment.

(33) On 14 June 2019 it was noted that Mr Hand was not in the hall at the morning medication administration.

(34) On 14 June 2019, Mr Hand underwent an initial substance misuse assessment with NHS Addiction Services within the prison. The assessment was undertaken by Mr Kallen Stuart. The following was noted:

(i) Mr Hand was well kempt and maintained good eye contact and conversation throughout the assessment;

(ii) That Mr Hand reported that his use of illicit substances had increased since 2017 following his brother being sentenced which tied in with the loss of business and property;

(iii) That he reported that when outside prison he took 20 Valium tablets per day and that he had been taking increasing quantities of cocaine;

(iv) That Mr Hand had a history of overdose – recently on return from court;

(v) That he reported having attended "addaction" (addiction services) with little help;

(vi) That he said he was seeking "bup" (Buprenorphine) in the hall in Low Moss (1 - 2 ml daily);

(vii) That Mr Hand reported not drinking, however it was noted that he had a history of drinking in the past which Mr Hand would not discuss further;

(viii) That Mr Hand reported no history of self-harm or suicidal ideation;

(ix) That Mr Hand reported having been stabbed on four separate occasions which increased his use of illicit substances and

(x) That Mr Hand was concerned about his physical health due to injecting insulin to improve his performance in the prison gym.

At the conclusion of the meeting, Mr Hand was provided with a 2 week drug diary to assess his usage and it was noted that a Methadone script was to be discussed at the next meeting.

(35) Mr Stuart completed an Addiction Assessment form on 14 June 2019 which documented the following:

> "Drug use History (injecting/BBV/overdose/recovery work etc): Neil reports that he started using illicit substances when he was 16 due to his peer group and interest. Reports starting to take cocaine, ecstasy and M-kat. When he was 22 reports using valium and continuing using cocaine and ecstasy. Reports that in 2017 when his brother got a sentence

(5.5yrs) that his use of illicit substances increased, this tied in with the loss of property and business. Using up to 20tabs daily, which he reports increased his use of cocaine.

Reported that he was using valium to get through the day.

Has a history of overdose - recently when returning from court GeoAmey couldn't rouse him after using pregabalin and zanex he got when he was at court.

Has previously checked for BBV – Negative.

Reported going to addaction with little benefit. X

Currently using Buprenorphine 1-2ml daily in the halls.

Alcohol Use History (Use/seizures/withdrawal/recovery etc): Reports not drinking, however previous history highlights drinking. However would not discuss this with self.

Mental Health History (Trauma etc): Anxiety – prescribed medication for this (propanaol). Stabbed/slashed 4 separate occasions due to rival gang (increased use around these times).

No history of self-harm or suicidal ideation.

Physical Health History: Concerned about health due to previously injecting insulin for gym, ECG and bloods carried out (14/06/3029).

Social History: Owns house (however this may be seized).

Daughter 10 – stays with mum only had contact in the last couple of months.

No history of social work involvement and mum does not use illicit substances.

Additional Information:

- Provided with drug diary to fill in for 2 weeks
- To discuss methadone further as detox not an option
- To be discussed at next allocation meeting."

(36) On 17 June 2019 it was noted that Mr Hand had refused to take his morning supervised medication.

(37) A medical record dated 19 June 2019 notes:

> "Neil has been listed for follow up assessment for drug diary to be reviewed and establish what Neil is looking to achieve by engaging with addictions. Not currently allocated worker until this review is carried out then to be passed back to senior addiction nurse for allocation if required".

(38) On 1 July 2019 Mr Hand attended a dental appointment. It was noted that he was not in pain but was aware of a broken filling. It was noted that Mr Hand was a smoker who vaped. It was noted that his alcohol intake was nil units per week and that illegal drug intake was not an issue. Following examination Mr Hand was diagnosed with caries and chipped fillings with smoking tar evident.

(39) On 2 July 2019 it was noted that Mr Hand had refused his morning medication.

(40) On 10 July 2019 it was noted that Mr Hand had refused to attend the hatch for his morning medication.

(41) On 1 August 2019 it was noted that Mr Hand had refused his morning medication.

(42) On 14 August 2019 Mr Hand submitted an NHS prison self-referral form in which he requested that his medications were reviewed by a GP as he wished to take them in possession instead of supervised.

(43) On 19 August 2019 Mr Hand was reviewed by Dr Daly. It was noted that Mr Hand reported that his mental health was much improved. He requested C + P ("course in packet") medication to help him with the timing of medication. On examination Mr Hand was euthymic and reactive. He had no thoughts of self-harm or suicide. Following review Dr Daly switched Mr Hand's medication from supervised to course in packet. Dr Daly reminded Mr Hand about the GGCHB prescribing policy.

(44) On 14 September 2019 Mr Hand was reviewed in the hall. He was complaining of lower back pain. He reported urinating little and often. He was advised to submit a urine sample and was provided a urine sample bottle for doing so.

(45) On 16 September 2019 Mr Hand submitted a self-referral asking to see a BBV nurse.

(46) On 17 September 2019 Mr Hand was seen by a BBV nurse. It was noted that he had been sharing snorting equipment with a known HCV positive prisoner. A DBS was completed and sent for testing. It was noted that he would be reviewed again 2 weeks later.

(47) On 22 September 2019 Mr Hand submitted an NHS prison self-referral form. He requested to see a nurse in respect of sore kidneys and liver and stomach pains. He also reported groin pain.

(48) On 23 September 2019 Mr Hand was reviewed by a GP. It was noted that he reported chronic lethargy. He reported occasional symptoms of GORD

(gastroesophageal reflux disease). It was noted that his bowels were moving as normal, that his appetite was fine and that he was not suffering from any weight loss. The plan was to await BBV testing. Blood tests were arranged. Omeprazole 20mg was commenced.

(49) On 27 September 2019 it was noted that Mr Hand's mother had called with concerns regarding Mr Hand's health. Mr Hand was reviewed on 1 October 2019. It was noted that he was seen in the health centre following his mother's concerns. Mr Hand stated that it was his physical health that he was concerned with. He stated that he was experiencing pain around his stomach area. He was experiencing shooting pains. It was noted that he was worried as his father suffered from bladder cancer. Mr Hand reported that he was okay mentally at that time, although he was experiencing slight anxiety. It was noted that medical staff would be asked to increase his medication dose as he was on a small dose. It was noted that Mr Hand could self-refer if he required to in the future.

(50) On 1 October 2019 Mr Hand underwent blood testing.

(51) On 17 October 2019 Mr Hand was reviewed by a GP. The following was noted:

> "bloods all fine…reassuring chronic non specific cramp abdo pains and wind ++ good appetite/no weight loss abd (abdomen) soft and non tender, no masses, no free fluid/no organomegaly bs (bowel sounds) normal mebverine prescribed states that would like to discuss talking therapies potential with NPEAR (Natalie Pearman, a staff nurse from the mental health team)…agreed I'd email her and let her know."

(52) At the time of his death, Mr Hand was prescribed the following medication on an in possession basis:

- Mirtazapine 45mg taken at night, anti-depressant
- Omeprazole 20mg take in the morning
- Propranolol 40mg twice a day
- Mebeverine 135mg, three times a day, antispasmodic to reduce stomach cramps.

Circumstances of death

(53) At the time of his death, Mr Hand was residing in Kelvin 2, Section A, Cell 26. Mr Hand was accordingly in legal custody as at the date of death. On the evening of 26 October 2019, Mr Hand was locked in his cell at approximately 5.05pm. There are no noted observations made about Mr Hand at the time of lock up. Mr Hand did not appear under the influence at the time of lock up which was approximately 5.05 pm.

(54) CCTV evidence covering Kelvin 2, Section A shows that at approximately 8.52pm an SPS officer is observed to walk through the hall, attend at each cell and touch the door handle of each cell. The officer is not observed to speak at any time and does not look into any cell at this time.

(55) At approximately 8.08am on 27 October 2019, Neil Hand was discovered in his cell by SPS Officer Gibson and SPS Officer Leneghan during morning numbers check. He was found to be lying on the floor of his cell wearing only

his underwear with his head almost under his bed. He was unresponsive, cold to the touch and did not appear to be breathing. He was the sole occupant of the cell.

(56) A code blue was called. Nurses attended but Mr Hand was beyond attempts of resuscitation. An ambulance was called. Mr Hand was pronounced dead at 8.37am by the paramedics who had responded to the request for urgent assistance from the prison. Mr Hand's cell was secured, and Police Scotland arrived at the scene at 9.16 am. Mr Hand's next of kin, his father Neil Hand, was informed by Police Scotland of his son's passing. A private ambulance attended at the prison and removed Mr Hand to the mortuary at 5.10pm

(57) There was evidence of drug misuse within Mr Hand's cell. There were no obvious signs of injury or disturbance. Drug paraphernalia was recovered: polythene bags; knotted polythene bags (one containing a trace of white powder); an item described as a "tick-list" which has details of bank accounts and telephone numbers, all of which are written on a calendar within his cell.

Post-mortem and toxicology

(58) A post-mortem examination was carried out on Mr Hand on 8 November 2019 at Queen Elizabeth University Hospital, Glasgow by Dr Marjorie Turner, consultant forensic pathologist and Dr Gemma Kemp, forensic pathologist.

(59) The final cause of death was recorded as:

1a: Methadone, Flualprazolam, Etizolam, Buprenorphine, Amitriptyline and Pregabalin intoxication.

(60) The post-mortem report concluded that there was no evidence of any natural disease that would have accounted for Mr Hand's death.

(61) Three samples of blood and one of urine were retained for toxicological examination. A toxicological report was prepared by Dr Hazel Torrance and Dr Denise McKeown, both forensic toxicologists, dated 6 March 2020.

(62) Toxicological analysis identified several drugs in his blood only one of which was indicated as prescribed, namely, Mirtazapine, and which was within the therapeutic range. Methadone was detected at a concentration within the range associated with fatalities. Also detected were the illicit benzodiazepine drugs, Alprazolam and Etizolam, together with Buprenorphine and "therapeutic" concentrations of Amitriptyline and Pregabalin. The final drug detected was a cannabinoid "4F-MDMB-BINACA".

(63) There was evidence of aspirated gastric contents within the airways, but no evidence of any associated inflammatory response to this so it could be contributory to his death with vomiting a consequence of drug intoxication or reflect a peri-mortem event. There was bruising over the right side of the scalp which would be in keeping with a terminal collapse but no evidence of significant injuries.

The parties' submissions

The Crown's submissions

[17] The Crown invited the court to make formal findings about where and when Mr Hand died. After reviewing the authorities, the Crown submitted that it could be inferred from the circumstances of his death that Mr Hand did not intend to end his own life. On that basis, for the purposes of section 26(2)(b) of the Act, his fatal overdose and therefore his death should be categorised as accidental. I was invited to accept the terms of the post-mortem report CP production no 2 and find that Mr Hand' death was caused by Methadone, Flualprazolam, Etizolam, Buprenorphine, Amitriptyline and Pregabalin intoxication. In terms of section 26(2)(e) of the Act the Crown submitted that no findings should be made. That was on the basis that the requisite causal connection could not be established to prove that there were any reasonable precautions which could have prevented Mr Hand's death. A finding in terms of section 26(2)(f) of the Act that there was a defect in the system of working which contributed to the death also required a direct causal connection. However, the standard required for a finding under section 26(2)(f) was proof on a balance of probabilities. The Crown submitted that two defects in the system of working had contributed to Mr Hand's death, firstly the inadequacy of drug prevention policies within HMP Low Moss and secondly the lack of a multi-disciplinary/multi agency approach to the prevention of drug misuse within HMP Low Moss. In relation to section 26(2)(g) the Crown submitted that, unlike the position with subsections (e) and (f) there did not require to be any causal connection between a relevant fact and the death. In this case there were three facts relevant to the

death namely (1) the lack of follow up after the first addictions assessment; (2) the lack of an evening numbers check at weekends and (3) the issue of MORS engagement after the incident in the timber machine workshop on 3 October 2019. Finally, the Crown submitted that the inquiry should make two recommendations in terms of sections 26(1)(b) and 26(4) of the Act that: (1) an evening numbers check should be carried out at HMP Low Moss at weekends at the same time as on weekdays and (2) a review should be carried out of drug prevention policies currently in place in HMP Low Moss.

The submissions of the Scottish Ministers on behalf of the Scottish Prison Service

[18] The SPS invited the court to find, in terms of section 26(2)(a) that Mr Hand died at 8.37am on 27 October 2019 at HMP Low Moss. With particular reference to the observations made in the determination by Sheriff Alison McKay in the Fatal Accident Inquiry into the death of William Gorrie, it was submitted that Mr Hand's death should not be regarded as an accident for the purposes of section 26(2)(b). Accepting the terms of Dr Turner's post-mortem examination the cause of Mr Hand's death was multi-drug intoxication. Dealing with the other parts of section 26, for a finding to be made under section 26(2)(e) the precaution identified had to be reasonable and there had to be a basis for concluding that the precaution might realistically have avoided the death. No evidence was led in the course of the inquiry to satisfy either of these requirements. On the issue of defects and section 26(2)(f) Barry Hay spoke to the various policies which were in place at HMP Low Moss at the time of Mr Hand's death. The court should

prefer his evidence over that of the Crown's expert Mr Wheatley. There was no evidence that the drug prevention policies operating in HMP Low Moss at the time of Mr Hand's death were inadequate. Neither was there any evidence that the lack of a multi-disciplinary/multi-agency approach to the prevention of drug misuse within HMP Low Moss amounted to a defect in the prison's system of working. Prisoners' medical records were confidential and as such their contents could not be shared with SPS officers without Mr Hand's consent. The part of Mr Wheatley's report referred to by the Crown at paragraph 4.51 of their written submissions was not agreed in terms of the joint minute and was not spoken to in evidence.

[19] In relation to section 26(2)(g) any facts established under this subsection had to be relevant to the circumstances of the death. Adopting that approach there should be no finding that the lack of an evening numbers check was relevant to the circumstances of Mr Hand's death. In that respect the evidence of Dr Turner and Gordon Kidd should be accepted. Again, the parts of Mr Wheatley's report which the Crown relied upon for the purposes of their submission on this issue were not part of the evidence. In his parole evidence Mr Wheatley said he was not concerned about the earlier lock up time at weekends. There was insufficient information and documentation to determine what took place when Mr Hand was assessed by the NHS nurse on 3 October 2019. From the information available Mr Hand was placed on regular observations until he stopped presenting as intoxicated. Finally on the issue of recommendations the recommendation regarding a weekend evening numbers check was neither reasonable nor a recommendation that was capable of practical implementation. The recommendation

that a review of drug prevention policies within HMP Low Moss be carried out was not reasonable and, in any event, was not supported by the evidence.

The submissions of Greater Glasgow and Clyde Health Board

[20] GGHB focused its submissions on its responsibility for the medical treatment of Mr Hand when he was at HMP Low Moss. It summarised the evidence given by Shona Malone, Mr Stuart and Dr Dyson about

(i) The provision of addiction services at HMP Low Moss in 2019;

(ii) Mr Hand's referral to addiction services in 2019;

(iii) Mr Stuart's addictions assessment;

(iv) Mr Hand's disengagement from addiction services;

(v) The addiction services system in place now including the use of allocation and MDT (Multi-Disciplinary Team) meetings;

(vi) The MAT standards;

(vii) The Health Improvement Team ("HIT");

(viii) How patient disengagement is handled now;

(ix) The use of drug diaries;

(x) The general chronology of treatment now;

(xi) Patient motivation to engage in addiction services;

(xii) The operation of the MORS policy at HMP Low Moss;

(xiii) Medication management; and

(xiv) The incident on 3 October 2019 when Mr Hand was reported as being intoxicated.

[21] In light of the evidence of Ronald Gibson, Lisa Leneghan and Dr Marjorie Turner a finding should be made in terms of section 26(2)(a) that Mr Hand died in cell 26, Section A, Kelvin Hall 2, HMP Low Moss, at sometime between 5.05pm on 26 October 2019 and 5.08am on 27 October 2019, his life being pronounced extinct at 8.37am on 27 October 2019.

[22] With reference to the authorities a distinction should be drawn between a death caused by an accident and an unintended death for the purposes of section 26(2)(b) of the 2016 Act. The evidence suggests that Mr Hand did not intend to take his own life. His death arose from his deliberate consumption of a mixture of drugs. That should not be categorised as an accident. Accordingly, no finding was sought in terms of section 26(2)(b) nor in terms of section 26(2)(d).

[23] For the purposes of section 26(2)(c) Mr Hand's death was caused by the consumption of Methadone and other drugs.

[24] On section 26(2) GGHB summarised the evidence led about the history of Mr Hand's substance misuse, the SPS intelligence about Mr Hand, his engagement with healthcare services and the importance of patient motivation. It concurred in the Crown's submission that there was insufficient evidence to conclude that there were any reasonable precautions which, if taken, might realistically have resulted in Mr Hand's death being avoided. Any further steps which could reasonably have been taken to try and engage Mr Hand in addiction services should be referred to under section 26(2)(g)

where no causal connection requires to be established. Similar to the position in terms of reasonable precautions there was insufficient evidence to conclude that any defects in the system of work contributed to Mr Hand's death. No findings should be made in terms of section 26(2)(f).

[25] Subsection 26(2)(g) allows for the recording of matters which are relevant to the death both in terms of reasonable precautions or defective systems of work where the necessary causal connection for a finding in terms of either section 26(2)(e) or (f) has not been established. GGHB accepted that the approach which would be taken to Mr Hand's disengagement from addiction services now would have been a reasonable approach to take in 2019. It sought a finding in fact in terms of section 26(2)(g) on that basis.

[26] A further finding in fact was sought that following the incident on 3 October 2019 Mr Hand should have been referred to addiction services for review.

[27] In response to the Crown submission on section 26(2)(g) if the court was satisfied that a member of the nursing staff reviewed Mr Hand and placed him on 30 minute observations then there ought to have been a record made in the medical records to that effect and a care plan ought to have been completed. GGHB also accepted that a finding about the improvements in addictions services at HMP Low Moss since 2019 could be made as proposed by the Crown at paragraph 4.66 of their written submissions.

[28] Given the improvements made in the system for addiction services which operates within HMP Low Moss GGHB did not seek any recommendations in terms of section 26(1)(b) and (4).

The submissions of Mr Stuart

[29] Mr Stuart's submissions focused on his role as an addictions nurse at HMP Low Moss. He adopted the Crown submissions made in respect of section 26(2)(a), (c), (d) and (e). No submission was made in relation to section 26(2)(b). In relation to section 26(2)(f) no submission was made on the basis that any suggested defects in the system of working did not relate to anything done or not done by Mr Stuart. The court was reminded of the objection taken to the admissibility of certain parts of Mr Wheatley's evidence. No submission was made in terms of section 26(2)(g) nor in relation to any of the proposed recommendations on the basis that these matters did not involve Mr Stuart.

The submissions of the Prison Officers Association Scotland

[30] The Prison Officers Association Scotland proposed that only mandatory formal findings should be made.

The submissions of Mr Hand's next of kin

[31] Mr Hand's next of kin adopted the submissions made by the Crown in full.

Discussion and determination

Issues arising in the course of the inquiry

[32] A number of issues arose from the evidence led at the inquiry and from the submissions made by the parties. I shall consider the issues in the context of the requirements of section 26 of the Act. Inevitably there will be some overlap between the discussion of the statutory provisions as, at times, the parties discussed the issues under different headings.

[33] Before I deal with the issues, it is appropriate to comment on the objection to Mr Wheatley's evidence which was taken by GGHB and Mr Stuart. The basis of the objection is set out at paragraphs 16 and 89 of GGHB's written submissions. In short, the submission is that Mr Wheatley does not have the necessary qualifications or experience to express an opinion on the actions of healthcare professionals. Reference is made to *Griffiths* v *TUI (UK) Ltd* [2025] AC 374 and *Kennedy* v *Cordia Services LLP* 2016 SC (UKSC) 59 in that respect. I do not propose to go into any detail on what is said in these cases. That is because Mr Wheatley did not adopt his report certain parts of which gave rise to the objection. In submissions I was advised that the Crown took a deliberate decision to refrain from asking Mr Wheatley to adopt his report so that the objectionable parts of his report would not form part of the evidence. In the circumstances I need not rule on the objection.

Section 26(2)(a) – where and when Mr Hand died

[34] It is clear from the evidence that Mr Hand died within cell 26, Section A, Kelvin Hall 2, HMP Low Moss.

[35] Determining precisely when he died is more difficult.

[36] Both the Crown and SPS submitted that I should make a finding that death occurred on 27 October 2019 at 8.37am. That is the date and time when Mr Hand was discovered within his cell.

[37] Prison Officers Leneghan and Shires carried out the lock up procedure within Kelvin Hall on 26 October 2019. In the course of the lock up a verbal response from each prisoner was obtained. Ms Leneghan stated that she did not notice anything untoward about Mr Hand during lock up. With reference to Crown label no 1, Ms Leneghan testified that she and Prison Officer Shires completed lock up at around 5.05pm.

[38] No further check on prisoners was carried out that evening. It follows that the last time that Mr Hand was known to be alive was during the lock up procedure at about 5.05pm on 26 October 2019.

[39] Dr Marjorie Turner gave evidence about the likely time of Mr Hand's death. She spoke to her post-mortem report, CP no 2 and to her supplementary report, CP no 19. She explained that it is very difficult to establish an exact cause of death given the lack of evidence of an internal temperature at the time of death. Based primarily on the post-mortem findings in relation to rigor mortis and hypostasis, Dr Turner concluded that it was unlikely that death occurred within 2 to 3 hours of the discovery of Mr Hand's body. He had probably been dead longer than that and possibly from the

evening/later hours of the previous day. I accept Dr Turner's evidence on the likely time of Mr Hand's death. Accordingly, I have made a finding that Mr Hand died at some point between 5.05pm on 26 October 2019 and 5.08am on 27 October 2019.

Section 26(2)(b) - when and where any accident resulting in Mr Hand's death occurred

[40] The Crown submitted that there was no evidence that Mr Hand intended to take the combination of drugs which caused him to become intoxicated. On that basis Mr Hand's fatal overdose should be treated as accidental and a finding to that effect should be made in terms of section 26(2)(b).

[41] It cited the determinations by Sheriff MacRitchie in the *Inquiry into the death of Steven Gunn* [2022] FAI 28 and in the *Inquiry into the death of Gary Ross* [2023] FAI 35 in support of its submission. In both of these cases Sheriff MacRitchie made a finding that fatal overdoses in similar circumstances to the present should be treated as accidents for the purposes of section 26(2)(b).

[42] Quite properly the Crown cited a number of other recent determinations in which the court had taken a different view to that of Sheriff MacRitchie, namely the *Inquiry into the death of Deyan Nokolov* [2021] FAI 59 per Sheriff Bowie, the *Inquiry into the death of Mark Robertson Stephen* [2021] FAI 7 per Sheriff Principal Wade and the *Inquiry into the death of James Russell Gorrie* per Sheriff McKay [2025] FAI 9. In all of these cases the view had been taken that while a fatal overdose may not have been intentional it was not appropriate to characterise it as an accident in terms of the Act. It was more

appropriate to regard the death as the unintended consequence of the deliberate act of consuming a substantial amount of drugs.

[43] In its submissions GGHB referred to a number of further authorities on this issue:

- *Fenton* v *J Thornley & Co* [1903] AC 443
- *Clover, Clayton & Co Limited* v *Hughes* [1910] AC 242
- *Dhak* v *Insurance Co of North America (UK) Ltd* [1996] 1 WLR 936
- *Chief Adjudication Officer* v *Faulds* 2000 SC (HL) 116
- *MacLeod* v *New Hampshire Insurance Co Ltd* 1998 SLT 1191
- *Ward* v *Norwich Insurance Ltd* [2009] CSOH 27
- *Paul* v *Royal Wolverhampton NHS Trust* [2025] AC 459

[44] GGHB submitted that a distinction should be drawn between a death caused by an accident and an unintended death for the purposes of the Act. I accept that submission.

[45] I also accept that no evidence was led in the course of the inquiry that Mr Hand intended to take his own life. It is true that Mr Hand had complained of suicidal thoughts in February 2018 (finding in fact 24). However, in August 2019 he told Dr Daly that he had no thoughts of self-harm or suicide (finding in fact 43), on 27 September 2019 he reported that he was "okay mentally" (finding in fact 49) and on 4 October 2019 he was reported as having no thoughts of self-harm or suicide (CP 10 at page 1315).

[46] Against that background the likelihood is that Mr Hand's death was an unintended consequence of his deliberate consumption of drugs.

[47] I accept GGHB's submission that the deliberate act of taking drugs and dying of an unintended overdose does not fit with the definition of an accident as suggested in *Paul*, *supra.* The ingestion of drugs was a deliberate act and the overdose which followed was a consequence of the ingestion. As GGHB submitted that analysis is consistent with the decision in *Dhak supra.* It is also consistent with the determinations of Sheriff Bowie, Sheriff Principal Wade and Sheriff McKay referred to above.

[48] For these reasons I make no finding in terms of section 26(2)(b).

Section 26(2)(c) - the cause or causes of death

[49] Dr Turner's conclusion in her post-mortem report was that the primary cause of Mr Hand's death was:

> 1a: Methadone, Flualprazolam, Etizolam, Buprenorphine, Amitriptyline and Pregabalin intoxication.

[50] Her evidence on the cause of death was not challenged and was consistent with the other evidence led during the inquiry. Accordingly, I have made a finding reflecting Dr Turner's evidence about the cause of death.

Section 26(2)(d) - the cause or causes of any accident resulting in the death

[51] Given that I have not made any finding in terms of section 26(2)(b) it follows that I shall not make any finding in terms of section 26(2)(d) either.

Section 26(2)(e) - reasonable precautions which might realistically have prevented the death

[52] Section 26(2)(e) refers to any reasonable precautions which might realistically have prevented the death. As explained by the Inner House in *Duncan* v *Lord Advocate* 2025 SLT 1199 at paragraph 51:

> "For present purposes the key word in this provision is 'could'. If the evidence presented at the FAI shows that a precaution could reasonably have been taken and that had it been taken it might realistically have resulted in the death or any accident resulting in the death being avoided then the sheriff must set out such a precaution in his or her determination."

The Inner House went on to explain that the word "precaution" should be given its ordinary and natural meaning: a measure, action or step taken beforehand against a possible danger, risk or inconvenience. The court can consider the issue of reasonable precautions with the benefit of hindsight.

[53] The Crown submitted that the requisite causal connection was not established for the purposes of stating any reasonable precautions which could have been taken in terms of this section. It made that submission for two reasons. Firstly, on the evidence led at the inquiry it was unknown whether Mr Hand would have actively engaged with addiction services or accepted any treatment for his substance misuse. Secondly it was unknown whether any medical intervention would have made any difference to the eventual outcome.

[54] None of the other parties disagreed with the Crown's submission on this matter. I accept that the Crown's submission on causation was appropriate given the evidence led at the inquiry. It follows that I make no findings in terms of section 26(2)(e) that

there were any reasonable precautions that may realistically have prevented Mr Hand's death.

[55] As far as sections 26(2)(f) and 26(2)(g) are concerned five main issues emerged from the evidence led at the inquiry and from the parties' submissions. Those issues are as follows:

(i) The inadequacy of drug prevention policies within HMP Low Moss.

(ii) The lack of a multi-disciplinary/multi-agency approach to the prevention of drug misuse within HMP Low Moss.

(iii) The lack of follow up after the first addictions assessment.

(iv) The lack of an evening numbers check at weekends.

(v) MORS engagement following the incident in the workshop on 3 October 2019.

[56] The Crown submitted that the first two of these issues were defects in the system of working at HMP Low Moss which contributed to Mr Hand's death. Accordingly, I shall consider these issues in the context of section 26(2)(f).

[57] For reasons which I shall explain later in this determination I shall consider the remaining three issues (iii) to (v) above under the heading of any other facts which are relevant to the circumstances of Mr Hand's death.

Section 26(2)(f) - any defects in the system of working which contributed to the death or the accident resulting in death

[58] I accept the Board's submission that to make a finding under section 26(2)(f) the court must be satisfied that any defect contributed to the death. The defect must be a significant or material cause in the death, whether alone or in combination with other factors, but not so remote as to have played no real part in it (see *Inquiry into the deaths of Katie Allan and William Brown* [2025] FAI 6 per Sheriff Collins at paragraphs 30 to 31 of his determination).

(i) The inadequacy of drug prevention policies within HMP Low Moss

[59] The Crown submitted, that given the cocktail of drugs that Mr Hand was found to have ingested at the time of his death, none of which he was prescribed, it was not difficult to infer that HMP Low Moss had ineffective drug prevention polices in place at the time of his death. In response the SPS submitted that no evidence had been led before the inquiry as to how the drugs taken by Mr Hand entered HMP Low Moss and came to be in his possession. I accept that submission. I also accept the force of the observations made by Sheriff Young in the *Inquiry into the death of James Stevenson* [2026] FAI 6. In that inquiry the next of kin sought a finding under section 26(2)(f) that there was a defect in the system which contributed to Mr Stevenson's death, on the basis that whilst accepting that the SPS had taken a great number of precautions to prevent drugs from entering prisons, drugs were available in the establishment and

Mr Stevenson had access to those drugs. Sheriff Young stated at paragraph 54 of his determination that:

> "The inquiry also considered the evidence of the official police investigation into the circumstances of the death, and in particular how the drugs in question were introduced. This investigation has not identified the source"

At paragraph 55 Sheriff Young stated:

> "Accordingly, while it is possible to say that there must be a defect of some kind within the system it was not possible for the inquiry to identify any particular defect. I do not consider that it would be beneficial, or in keeping with the purposes of the Act, simply to record that an unidentified defect must exist somewhere, without the ability to provide further specification. For that reason, I have not made a finding in terms of section 26(2)(f)".

To the comments made by Sheriff Young I would add, as is obvious, that the findings in fact in any determination must be made on the basis of the evidence led at the inquiry. Given the lack of evidence about how Mr Hand came to be in possession of the drugs he ingested, I do not consider that it is appropriate to state on the basis of that fact alone (ie the fact that he was in possession of the drugs in question) that there was some unidentified defect in the system which contributed to his death.

[60] I turn to the evidence which was led about the drug prevention policies operating within HMP Low Moss at the time of Mr Hand's death.

[61] Mr Barry Hay is the current Head of Operations at HMP Low Moss. He gave oral evidence to the inquiry in the course of which he adopted his affidavit dated 17 July 2025. Although Mr Hay has been employed by SPS since August 1992 he has only been based at HMP Low Moss since September 2022. It follows that he was not based at HMP Low Moss at the time of Mr Hand's death.

[62] Mr Hay referred to a number of SPS Standard Operating Procedures or policies. These policies are lodged as items 1 to 14 of the SPS's productions. I summarise them as follows:

1. Standard Operating Procedure SI 40, Visitors and Staff Search Policy, dated November 2015.
2. Standard Operating Procedure SI 43, Visits, Recovery of Unauthorised Article during Visitor Search dated 7 July 2022.
3. Standard Operating Procedure SI 45, Refusing Entry to Visitors.
4. Standard Operating Procedure SI 65, Visitors Handing in Mail, dated 29 June 2015.
5. Standard Operating Procedure SI 77, Visits - Visitor Search Policy, dated 4 May 2022.
6. Standard Operating Procedure SI 15, Procedure for all Unmanned Aerial Vehicle (UAV's) Sightings and Incidents, dated 19 January 2024.
7. Standard Operating Procedure SO68, Outside Patrol and Report Completion, dated 22 January 2024.
8. Standard Operating Procedure, Intel 02, Routine Cell Searches, dated 19 January 2024.
9. Standard Operating Procedure, Intel 04, BOSS Chair, dated 19 January 2024.
10. Standard Operating Procedure, Intel 05, Routine External Area Searches, Worksheds/Activity Areas, dated 19 January 2024.

11. Standard Operating Procedure, Intel 06, Archway Metal Detector Operation dated 19 January 2024.
12. Standard Operating Procedure 13, The Management of Contamination of Mail, Legal Mail, Property and Money, dated 22 January 2024
13. Standard Operating Procedure, SO79, Using X-ray Body Scanner to Search Prisoners.
14. Standard Operating Procedure 70, Rapiscan Operation, dated 22 January 2024.

[63] All the policies bar four have acceptance dates which post-date Mr Hand's death. The visitors and staff search and the visitors handing in mail policies have acceptance dates of November 2015 and 29 June 2015 respectively; in the Visitors – Refusing Entry to Visitors and Using X-ray Body Scanner policies the acceptance date has been left blank.

[64] Although most of the policies lodged by SPS bear acceptance dates which post-date Mr Hand's death Mr Hay was "pretty sure" that the policies have been in existence for years. He explained that policies should be reviewed annually and that it is just the current live policies which exist on the SPS system. Mr Hay's evidence on this matter was not challenged. His evidence is consistent with Mrs Malone's testimony who also stated that policies are generally reviewed annually. Accordingly, I accept that the policies spoken to by Mr Hay were in existence at HMP Low Moss at the time of Mr Hand's death.

[65] Mr Hay explained that all the policies which were in place at the time of Mr Hand's death were national policies; there were no local policies specific to HMP Low Moss.

[66] The Crown relied primarily on Mr Philip Wheatley's evidence for its submission that there was an inadequacy of drug prevention policies within HMP Low Moss at the time of Mr Hand's death. Mr Wheatley is a retired former director general of the prison service in England and Wales. In addition to that role, he has significant other experience of managerial roles within the prison service and of policies for the prevention of drug misuse within prisons. Although now retired he stated that he had kept up to date with policies and strategies for the prevention of drug misuse in prisons.

[67] Mr Wheatley testified that any prison should have a policy in place to address drug use dealing with inter alia what level of searching should be carried out, the use of CCTV to detect drugs, how intelligence should be used and the use of trained dogs.

[68] During cross-examination SPS asked Mr Wheatley questions about the various Standard Operating Procedures numbered 1 to 14. Mr Wheatley had not seen these policies before. To ensure that the inquiry obtained the best possible evidence and in the interests of fairness the court allowed a short adjournment to give Mr Wheatley time to consider the Standard Operating Procedures. When the inquiry resumed Mr Wheatley indicated that he had considered the Standard Operating Procedures. He did not indicate that he required any further time to consider the documentation.

[69] In general, when he was referred to the Standard Operating Procedures, Mr Wheatley accepted that HMP Low Moss probably did have some drug prevention measures in place in 2019. However, he disputed the effectiveness of those measures.

[70] In fact, the only Standard Operating Procedure which Mr Wheatley commented on in any detail was number 5, Standard Operating Procedure SI 77, Visits - Visitor Search Policy, dated 4 May 2022.

[71] In relation to this policy Mr Wheatley observed that most drugs are carried into prison internally. None are brought in metallically. Therefore, it is essential to use CCTV to detect drugs when they are being passed from visitor to prisoner. Properly trained spotters can intercept 20 to 30% of drugs at the point of passing. Mr Wheatley considered that HMP Low Moss should have had CCTV in operation in 2019 at the time of Mr Hand's death.

[72] Mr Wheatley also stated that there was no evidence that the prison used any specially trained dogs to search prisoners and detect drugs. He was surprised that trained dogs were not used at the time of Mr Hand's death.

[73] In their submissions SPS challenged the value of Mr Wheatley's expert evidence given that he had no experience of working within the Scottish Prison Service and had not seen any drug prevention measures in operation at HMP Low Moss at the time of Mr Hand's death.

[74] Although it is true that Mr Wheatley did not see any drug prevention measures in place at HMP Low Moss in October 2019 he does have significant experience of drug prevention measures within the prison service as a whole. I consider that his evidence is

of value in considering the drug prevention measures which were in place at the time of Mr Hand's death; I do not accept the submission made by SPS that no weight should be attached to his evidence.

[75] SPS also submitted that no weight should be attached to Mr Wheatley's evidence as he had not seen the Standard Operating Procedures before giving evidence and had limited time to consider them in the course of the inquiry. No submission was made to this effect by SPS in the course of the inquiry or in the course of the cross-examination of Mr Wheatley. More importantly Mr Wheatley did not suggest that he needed more time to consider the Standard Operating Procedures as I am sure he would have done if that was the case. The documentation in question was not extensive or complex. On Mr Wheatley's evidence he had considerable experience of considering Standard Operating Procedures of the type lodged by SPS and would be very familiar with what these documents should contain. In the circumstances I reject SPS's submission on this matter.

[76] I accept Mr Wheatley's submission that HMP Low Moss should have had CCTV in operation at the time of Mr Hand's death. The use of CCTV and properly trained operators would appear to be a reasonable and potentially effective means of detecting the passing of drugs from visitors to prisoners.

[77] Mr Hay states at paragraph 19 of his affidavit that visits are monitored by both staff and CCTV. However, it is not clear whether he is referring to the position now or at the time of Mr Hand's death. In so far as Mr Hay only started working at HMP Low

Moss in September 2022, I am not prepared to regard the comments about the use of CCTV made in his affidavit as applying at the time of Mr Hand's death.

[78] I cannot see any reference to members of SPS staff viewing interactions between prisoners and visitors in any of the Standard Operating Procedure documents lodged by the SPS. No other evidence was led to indicate that CCTV was used in the way envisaged by Mr Wheatley at the time of Mr Hand's death.

[79] In the circumstances I am not prepared to find that there was a system of using CCTV to monitor visits in operation at HMP Low Moss at the time of Mr Hand's death.

[80] I have already commented that it is not clear how Mr Hand came to be in possession of the drugs which he took at the time of his death. He had previously taken diverted drugs, ie drugs intended for other prisoners. It is stated in his intelligence and incident summary that he was expecting to receive mail sprayed with psychoactive substances in March 2019 (see finding in fact 10). For these reasons the failure to monitor visits by the use of CCTV cannot be regarded as causative of his death for the purposes of section 26(2)(f). I do though regard the failure to monitor visits by the use of CCTV evidence as a fact relevant to the circumstances of his death and have therefore made an appropriate finding in terms of section 26(2)(g).

[81] Mr Wheatley also stated that there was no evidence that trained dogs were in use at Low Moss in October 2019.

[82] Mr Hay refers to the use of search dogs at paragraph 21 of his affidavit. I have the same reservations about accepting Mr Hay's evidence on the use of dogs as I do

about accepting his evidence about the monitoring of visits by CCTV, ie he was not at HMP Low Moss in October 2019.

[83] However, there are a number of references to the use of dogs or trained sniffer dogs in the Standard Operating Procedure documents which have been lodged. In particular reference is made to the use of trained sniffer dogs and to searches by the SPS Drug Dog Detection Unit at pages 3 and 4 of the Visitors and Staff Search Policy SPS production no 1. Given the references in the documentation, I am not prepared to find that there was a failure to use trained search dogs at HMP Low Moss at the time of Mr Hand's death.

[84] The other issue which Mr Wheatley raised in the course of his evidence about drug prevention policies was intelligence. He stated that intelligence ingathered by SPS about a prisoner's drug use is of no value unless it is shared with the prison staff. The sharing of intelligence would inform, eg when to search a prisoner's cell and what to look for.

[85] Mr Hay spoke to the intelligence and incident summary produced in relation to Mr Hand (CP 7). The nature of the intelligence would determine who would have access to the intelligence. In cross-examination he stated that it was extremely unlikely that intelligence would be passed on to SPS staff. That would not ordinarily be done to protect the source. It is understandable why that would be the case in a prison environment.

[86] Although Mr Wheatley queried whether the intelligence collated in respect of Mr Hand was shared appropriately it should be borne in mind that Mr Hand's cell was

searched on 30 April 2019, 2 August 2019, 2 September 2019 and 8 October 2019 (see finding in fact 17). The dates of these searches were put to Mr Wheatley in the course of his parole evidence. He stated that the frequency of the searches was a good indicator that SPS staff were carrying out targeted searches of Mr Hand's cell based on intelligence reports about his suspected drug use. That suggests that intelligence about Mr Hand's suspected drug use **was** (my emphasis) being shared with those members of the SPS staff responsible for coordinating and arranging searches of Mr Hand's cell. For that reason, I do not consider that I can conclude that there was a failure to share intelligence about Mr Hand's drug use in an appropriate way.

(ii) The lack of a multi-disciplinary/multi-agency approach to the prevention of drug misuse within HMP Low Moss

[87] In the course of the inquiry multi-disciplinary or multi-agency issues were discussed in a number of contexts.

[88] Firstly, the issue arose in relation to the prescription of drugs within HMP Low Moss.

[89] Mrs Malone explained the system for the prescription of medication at HMP Low Moss. If a patient can manage medication on their own, they will be given the medication. This is referred to as "in possession". The alternative is that the taking of medication is supervised by SPS staff.

[90] On 19 August 2019 at a review by Dr Daly Mr Hand's prescription was changed from supervised to course in packet.

[91] At the time of his death, Mr Hand was prescribed, on an in-possession basis: (1) Mirtazapine (2) Omeprazole (3) Propranolol and (4) Mebeverine.

[92] Dr Dyson referred to the change in Mr Hand's medication from supervised to in-possession in his parole evidence. He criticised the failure of those treating Mr Hand to ascertain the drugs that he was using before prescribing his drugs on an in-possession basis. He suggested that the review of Mr Hand's medication would have benefitted from a multi-disciplinary approach.

[93] Dr Dyson's evidence about the failure to ascertain the drugs that Mr Hand was taking before changing his prescription to in possession was not challenged and I accept it. There is no evidence that the change in Mr Hand's prescription from supervised to in possession contributed to his death. Accordingly, the causal connection for the purposes of section 26(2)(f) is absent.

[94] I have considered whether I should make a finding in terms of section 26(2)(g) that there was a failure on the part of those treating Mr Hand to ascertain the drugs that he was using before changing his prescription from supervised to in possession. I do not consider that such a finding would be appropriate. Mr Hand did not die from taking drugs that were prescribed for him. None of the drugs which caused his death were prescribed for him. Accordingly, I do not consider that the failure to ascertain the drugs that he was taking when changing his prescription to in possession can be regarded as a fact relevant to the circumstances of his death.

[95] In relation to the other point made by Dr Dyson it is not clear to me how a more multi-disciplinary approach to the review of Mr Hand's medication could have occurred

nor how that would have made any difference to the eventual outcome. Therefore, I have not made any findings in respect of that aspect of Dr Dyson's evidence either.

[96] The second matter that the Crown raised in relation to multi-disciplinary or agency issues was whether information about Mr Hand's drug use ought to have been shared with SPS staff.

[97] This matter arose particularly in the context of "diverted" medication. Medication is diverted where a prisoner gives medication they have received to another prisoner.

[98] At paragraphs 31 to 35 of her written statement Mrs Malone states that:

> "31. There are systems in place to manage the risk of diversion of prescribed medication, including spot checks, medication contracts, and supervised administration. If diversion is suspected, the GP may change the prescription to supervised administration or discontinue it.
>
> 32. SPS officers are responsible for checking that medication is swallowed, but nurses also routinely check at the point of administration. If a patient is caught diverting medication, SPS will put them on report, and the GP will review the prescription.
>
> 33. Patients are required to sign a contract agreeing to take their medication properly and store it safely. If they are found to be diverting medication, the GP may change the prescription to supervised administration or discontinue it.
>
> 34. Spot checks are carried out if diversion is suspected, and patients may be asked to produce their medication for inspection.
>
> 35. The process for managing medication diversion is a combination of SPS security procedures and NHS clinical procedures. SPS officers are responsible for security checks, while NHS staff are responsible for clinical management and documentation."

[99] Mrs Malone accepted that the operation of the risk management measures referred to at paragraphs 31 to 35 of her statement depended on the sharing of appropriate information between NHS and SPS staff.

[100] Mr Hand had taken diverted medication in the past (see finding in fact 28). However, that information was not, it appears, shared with SPS staff. Neither Mr Gibson nor Ms Leneghan were aware that Mr Hand had taken diverted drugs in the past. Neither were they aware that Mr Hand had a drug problem.

[101] The question arises as to whether Mr Gibson, Ms Leneghan and other prison officers should have been advised that Mr Hand had a drug problem and had taken diverted drugs in the past. Mrs Malone stated that healthcare professionals must maintain the confidentiality of a patient's medical records. Why a patient is taking drugs and what they are taking is confidential. She was referred to the Information Sharing and Consent form which Mr Hand signed on 14 June 2019 contained within Mr Hand's medical records at page 1303 of CP 8. That form states that confidentiality will be maintained at all times subject to limited exceptions. That is the position now and was the position in 2019.

[102] Considering Mrs Malone's evidence about the systems in place to prevent the diversion of medication alongside her evidence about the confidentiality of a patient's records it seems clear that limited information about a patient's drug use could be disclosed by healthcare professionals for the purpose of, for example, carrying out a spot check of a patient's medication. As Mr Hay explained at paragraph 29 of his affidavit NHS nurses and SPS work together when carrying out a spot check. NHS nurses go into

a cell to do a spot check of the medication and SPS officers supervise the process. In Mr Hand's case there is only one reference in his medical records to him taking diverted medication. There is no evidence to suggest that the one incident of him taking diverted medication should have resulted in further spot checks of his medication being carried out or to information about his drug use being shared with SPS staff. Accordingly, I do not consider that it is appropriate to make a finding that Mr Gibson and Ms Leneghan's lack of knowledge of Mr Hand's drug problem is indicative of a lack of a multi-agency approach such as to constitute a defect in the system of working.

[103] In their written submissions the Crown stated that the lack of follow up after the incidents of intoxication on 4 June 2019 and 3 October 2019 was further evidence of the lack of a multi-agency under the heading of any facts relevant to the circumstances of Mr Hand's death and accordingly, I shall deal with them later in this determination.

[104] Finally, under the heading of multi-disciplinary/multi-agency issues Mrs Shona Malone gave evidence in her statement (GGHB production no 7) and in her oral evidence about the Multi-Disciplinary Team at HMP Low Moss. Mrs Malone is the interim operational manager for prison healthcare at HMP Low Moss. She started at HMP Low Moss in June 2022.

[105] The Multi-Disciplinary Team was established in 2022. It follows that there was no Multi-Disciplinary Team at the time of Mr Hand's death. The team might include psychiatrists, mental health nurses, primary care nurses and addiction nurses - basically anyone who may be involved in the care of a patient.

[106] The benefit of the team is that it can offer co-ordinated treatment to patients across a range of disciplines. Allocation meetings are held once a week; Multi-Disciplinary or MDT meetings are also held once a week. Ten to twelve cases are discussed at an MDT meeting. A plan of action will be prepared for each case after the MDT has taken place.

[107] Mrs Malone was asked in examination in chief if she considered that a multi-disciplinary approach would have helped Mr Hand. She stated that Mr Hand might have benefited from such an approach given that he had suffered from mental health problems in the past as well as having issues with drug misuse.

[108] In cross-examination by Mr Hand's next of kin she made it clear that she could not say for sure that Mr Hand would have been dealt with by the Multi-Disciplinary Team. He may have refused to engage with the team.

[109] Both Mrs Malone and Dr Dyson stressed the importance of patient engagement in treating drug addiction within the prison system.

[110] Given Mr Hand's disengagement from addiction services in the past I do not consider that it can be concluded that he would have engaged with the Multi-Disciplinary Team if that service had been available to him at the time of his death. What can be said is that there have been significant improvements in the way in which addiction services are provided to patients since Mr Hand's death, particularly in relation to the introduction of the Multi-Disciplinary Team. Both the Crown and GGHB accepted that it would be appropriate to make a finding in relation to the improvements

in the services offered. I agree and have accordingly made an appropriate finding in terms of section 26(2)(g).

Section 26(2)(g) - any other facts which are relevant to the circumstances of the death

[111] Section 26(2)(g) allows the court to record matters which are relevant to the death in relation to reasonable precautions or defective systems of work, but where the necessary causative connection for a finding in terms of sections 26(2)(e) and 26(2)(f) is absent (see *Inquiry into the deaths of Katie Allan and William Brown* per Sheriff Collins at paragraph 32 of his determination).

The lack of follow up after the first addictions assessment

[112] Mr Stuart testified that Mr Hand self-referred himself to addiction services on 6 June 2019 (CP no 8 medical records at page 1177).

[113] Mr Stuart completed an Addiction Assessment form in respect of Mr Hand on 14 June 2019 (CP no 8 at page 1173).

[114] The Addiction Assessment form contained details of Mr Hand's past and present alcohol and drug use. Mr Hand was provided with a drug diary to fill in for 2 weeks and was told that his case would be discussed, and treatment options decided upon, at the next allocations meeting. After completing the Addiction Assessment form Mr Stuart made an entry in Mr Hand's medical records - see CP no 8 at page 1150.

[115] In his oral evidence Dr Dyson described the addictions assessment carried out by Mr Stuart as a "reasonable review".

[116] About 2 weeks after the Addiction Assessment form was completed Mr Stuart met Mr Hand in the hall of the prison. The meeting was a chance encounter. Mr Hand advised him that he did not want to complete the drug diary as he was concerned that to do so would lead to disciplinary action. He did not wish to engage in any follow up treatment following the initial addictions assessment.

[117] As Dr Dyson observed at paragraph 5.3.2 of his report (GGHB production no 1) it would have been more appropriate for the meeting between Mr Stuart and Mr Hand to have taken place in an appropriate consulting area rather than in the hall of the prison. However, Dr Dyson also pointed out that, because of the nature of prison healthcare, opportunistic interaction with patients can sometimes be necessary because of the risk of prisoners not attending formal appointments. I do not consider that Mr Stuart can be criticised for speaking to Mr Hand in the prison hall when the opportunity arose.

[118] Mr Stuart encouraged Mr Hand to attend for follow up and told him that he could self-refer at any time. He did not complete an Appointment/Treatment Refusal form (GGHB production no 6) in respect of Mr Hand's disengagement from follow up treatment. After the chance encounter Mr Stuart cancelled Mr Hand's follow up appointment.

[119] Dr Dyson was asked about the chance encounter between Mr Stuart and Mr Hand's refusal to engage in follow up treatment. He stated that, following Mr Hand's refusal to engage, he should have been offered a follow up appointment in a

discussion or by letter. Any system should provide for self-referral but should also arrange a further review.

[120] I have already commented that there have been substantial changes to the way in which addiction services are provided at HMP Low Moss since Mr Hand's death. As Mrs Malone explained the addiction services team now strives to operate under MAT (Medication Assisted Treatment) standards. The purpose of the MAT standards is to ensure quicker assessment and access to treatment for substance misuse both in prison and the community. At Low Moss there are some areas where compliance with the MAT standards is still to be achieved eg prisoners should have access to an advocacy worker at present. However, in the future HMP Low Moss will require to report to the Scottish Government on its compliance with the MAT standards.

[121] The current system at Low Moss if a patient declines further input after initial assessment is that a face-to-face review will be conducted by a nurse. The nurse will see the patient and try and get the patient to engage so that treatment options can be provided. The result of the review should be recorded in the medical records.

[122] If the patient is not prepared to engage, they will be asked to sign a refusal of treatment form. A follow up letter will be sent to the patient encouraging further engagement and the patient will be informed that they can self-refer to addiction services at any time.

[123] If a patient changes their mind and indicates that they do wish to receive treatment the aim will be to see them again within 24 hours so that appropriate treatment can be started as quickly as possible. If a patient does not wish an

appointment within that timescale the aim will be to arrange a follow up appointment within 2 weeks.

[124] Overall Mrs Malone stressed that the current system seeks to provide a degree of flexibility, the paramount aim being to encourage patients to engage with addiction services so that they can receive the appropriate treatment.

[125] Dr Dyson described the system currently in place in relation to the review of a patient's refusal of treatment as appropriate.

[126] At paragraph 28 of her written statement Mrs Malone stated, in relation to the review of a refusal of treatment, that: "There may have been a similar process in place in 2019."

[127] No evidence was led in the course of the inquiry that there was a system for review at the time of Mr Hand's death.

[128] In the event, in her oral evidence, Mrs Malone stated that nothing like the current system for review of a refusal to engage with addiction services was in place in 2019.

[129] As mentioned earlier in this determination Dr Dyson explained that patient motivation is an important factor in the successful treatment of substance misuse. He stressed that, as is obvious, if a patient does not wish to engage you can offer them a review, but you cannot force them to accept treatment.

[130] In his evidence Mr Stuart was referred to various entries from Mr Hand's prison medical records CP no 8.

[131] The entry of 24 June 2019 records Mr Hand's refusal to attend a consultation at the health centre. An entry of the same date refers to Mr Hand's refusal to attend for dental treatment.

[132] The entry of 2 July 2019 records what is referred to as a "failed encounter" and Mr Hand's refusal to accept AM medication.

[133] The entry of 10 July 2019 records Mr Hand's refusal to attend the hatch that morning for supervised medication.

[134] The entry of 1 August 2019 refers to a further occasion on which Mr Hand refused his morning medication.

[135] Given the various entries in the medical records and Mr Hand's previous medical history, I accept that there was a pattern of him failing to accept medical treatment. Against that background it is impossible to conclude that Mr Hand would have engaged with any review or follow up treatment which addiction services had attempted to arrange.

[136] Accordingly, the causative link required to justify a finding that follow up after the initial addictions assessment would have prevented his death is absent. For that reason, it is not appropriate to make a finding regarding the lack of any follow up in terms of section 26(2)(e) or (f) of the Act.

[137] However, it is appropriate to make a finding in fact in terms of section 26(2)(g) in relation to the failure to follow up after the first addictions assessment.

[138] In its written submissions GGHB proposed the following finding:

> "Following his disengagement from addiction services in June 2019, Neil Hand could have been reviewed to further discuss his disengagement from addiction services and offer him the opportunity to re-engage with addiction services. If Neil Hand still refused to engage in addiction services following that further review, Neil Hand could have been asked to sign the treatment refusal form and thereafter sent a follow-up letter reminding Neil Hand that he could re-engage with addiction services at any time through the self-referral process".

[139] The finding proposed by GGHB reflects the evidence led at the inquiry and, in particular, the evidence which was led from Mrs Malone, Mr Stuart and Dr Dyson. Accordingly, I have made a finding in the terms suggested by GGHB in respect of the lack of follow up after the initial review.

The lack of an evening numbers check at weekends

[140] As noted above at paragraph 36 Prison Officers Leneghan and Shires completed lock up within Kelvin Hall on Saturday, 26 October 2019 at about 5.05pm. As Prison Officer Gibson explained, during lock up prison officers would make sure that they got a response from prisoners during lock up.

[141] Gordon Kidd has been the residential unit manager at HMP Low Moss since about April 2024.

[142] He adopted his statement, SPS production no 18 and gave oral evidence. He testified that after lock-up at around 5.05pm no further welfare check of prisoners was carried out unless a prisoner was on MORS or Talk to me observations.

[143] Mr Kidd referred to SPS production 17, the Standard Operating Procedure SOP06, Prisoner Management Checks, dated 17 April 2017. It is clear from this

document that the position with prisoner welfare checks between weekdays and weekends is different; during weekdays an evening welfare check of prisoners is carried out between 8.15pm and 8.30pm (see paragraph 5 of Mr Kidd's statement). Mr Kidd explained at paragraph 6 of his statement that the reason for the difference between weekdays and weekends was because there were different shift times for residential prison officers at weekends.

[144] Mr Kidd was also referred to CP no 15, the SPS revised requirements during Locking and Unlocking Periods dated 28 March 2016. This document issued amended guidance on locking and unlocking procedures within the Scottish Prison Service following a review a review of four Fatal Accident Inquiry determinations. Paragraph 2 of the document states:

> "2. PRL Standard The SPS PRL Standard 1.3.3.3 states that numbers checks should be completed, at a minimum;
>
> a. Numbers are checked, at minimum:
> - on taking up duty in the morning;
> - at lunchtime;
> - at teatime; and
> - at night.
>
> b. When conducting checks staff ensure that they physically account for each prisoner. Appropriate steps must be taken to confirm the presence and identity of each prisoner by seeing the face of and getting a response from each prisoner in their cells/dormitories."

[145] Mr Wheatley was asked about evening welfare checks on prisoners. At paragraph 65 of their written submissions the SPS submitted that the inquiry was not entitled to consider certain parts of Mr Wheatley's report, CP no 11 as his report was not agreed and he did not adopt the report as part of his evidence.

[146] While it is true that Mr Wheatley did not adopt his report, in the course of his evidence he referred to paragraph 71 of his report. Paragraph 71 states:

> "71. The documentary evidence from the Scottish Prison Service states that he was last seen alive at about 1730 on the 26th of October. The SPS Instruction to Governors and Managers 016A/16 requires that at a minimum, roll checks be carried out on taking up duty in the morning, at lunchtime, at teatime, and at night. I have been informed that a roll check completed by 18:00 is regarded by the SPS as meeting the requirements for a night time check. In all the other UK prisons the night check is carried out much later, when the night staff take over from the evening staff (normally between 20:30 and 21:00). At roll checks staff are required to physically account for each prisoner by seeing their face and getting a response from each individual in their cell/dormitory. The comparatively early timing of the night roll check at HMP Low Moss and other Scottish prisons creates a period of at least 13 hours when most prisoners are unobserved. This is such a long period that it increases the risk that anyone requiring urgent attention will not be identified in time for that assistance to be effective."

[147] SPS submitted at paragraph 66 of their written submissions that Mr Wheatley gave oral evidence that he was not concerned about an earlier lock up time at weekends and that this was similar to the position in England and Wales. That is not my recollection of Mr Wheatley's evidence.

[148] My notes indicate that he stated that he would expect another roll check to be done at the point when the night staff came on (8.30pm to 9.00pm) to make sure that all prisoners were in the right place. That is the standard position in England and Wales. The primary purpose of the further evening check would be to guard against the possibility of prisoners escaping but there would be a check to make sure that all prisoners were present and awake. That is consistent with paragraph 71 of his report which does not differentiate between lock up times on weekdays and weekends. It is

also consistent with the terms of CP no 15, the SPS revised requirements during Locking and Unlocking Periods dated 28 March 2016.

[149] It is difficult to see why there should be any difference between lock up times on weekdays and at weekends given that as stated in CP no 15 in relation to the purpose of the revised guidance: "This is a measure to reduce the risk of suicide and also identify someone with a deteriorating health condition." Notwithstanding the comments made by Mr Kidd in his statement there is just as much of a need to carry out proper welfare checks at weekends as there is on weekdays.

[150] I have made a finding about the likely time of Mr Hand's death based primarily on Dr Turner's evidence (see paragraph 38 above). In light of this finding, it is not appropriate to make any findings in terms of section 26(2)(e) or section 26(2)(f) in relation to the failure to carry out an evening welfare check on 26 October 2019. That is because it cannot be established that there is any causal link between the failure to carry out the evening welfare check and Mr Hand's death. However, it is appropriate to make findings in terms of section 26(2)(g) that:

- The failure to carry out an evening welfare check on prisoners within Kelvin Hall, HMP Low Moss on 26 October 2019 was a breach of the SPS revised requirements during Locking and Unlocking Periods document dated 28 March 2016.
- The failure to carry out an evening welfare check on prisoners at weekends was a defect in the system of working at HMP Low Moss at the time of Mr Hand's death.

MORS engagement following the incident in the workshop on 3 October 2019

[151] The court heard evidence about this matter from Keith Johnston who adopted his statement CP no 20. Mr Johnston has worked as an offender outcome officer at HMP Low Moss since 2017.

[152] In his statement Mr Johnston refers to an incident which occurred at the timber machine workshop on 3 October 2019.

[153] Mr Hand was unsteady on his feet when he turned up for work that day. Mr Johnston suspected that he might be under the influence of an illicit substance because his eyes were glazed and his speech was slurred. Mr Johnston took him to get checked over by a health care worker who placed him on MORS. The reference to MORS is a reference to the Management of an Offender at Risk due to Any Substance Policy & Guidance (the MORS policy) which is lodged as SPS production no 16.

[154] The incident on 3 October 2019 is recorded in Mr Hand's prisoner records CP no 6 at page 1062 where an entry for 4 October 2019 reads:

> "Neil presented himself for work in an intoxicated state. He was returned to the hall and checked by a nurse who put him on 30 min obs. As this is a serious breach of health and safety Neil has been removed from the workparty."

[155] Mr Hand was charged with a breach of discipline as a result of the incident on 3 October 2019. CP no 10 is a copy of the governor's report dated 4 October 2019 relating to the disciplinary proceedings against him.

[156] During his oral evidence Mr Johnston did not remember Mr Hand being reviewed by a nurse. He said that it was possible that a nurse attended the timber

machine workshop to examine Mr Hand. He accepted that he did not complete an Observations Referral form as referred to in paragraph 6 and Appendix A of the MORS policy.

[157] In her statement at paragraph 17 Mrs Malone stated that if Mr Hand had been put on MORS she would have expected a care plan to be completed and put in his prison records (see the reference to a care plan at paragraph 6 and Appendix C of the MORS policy, SPS production no 16). There is no care plan in Mr Hand's prison records. She also commented that SPS would undertake MORS observations, not nursing staff and that observations would normally be done every 15 not 30 minutes. The results of the observations should have been recorded in Mr Hand's prison records. In Mr Hand's case there is no reference in his records to any MORS observations having been carried out.

[158] Given Mr Johnston's evidence I accept that an incident occurred in the timber machine workshop as described by him in his statement. What happened after that is less clear.

[159] Mr Johnston says in his statement that Mr Hand was placed on MORS. However, there is no documentation in the way of an Observations Referral form, care plan or records of observations to support that proposition. In addition, Mrs Malone's evidence about how MORS operated in 2019 is not consistent with Mr Johnston's evidence that Mr Hand was referred to MORS.

[160] In the circumstances I am not prepared to find that Mr Hand was placed on MORS after the incident on 3 October 2019. I do not consider that Mr Johnston's

evidence is sufficiently reliable to enable me to make such a finding. As SPS observed at paragraph 71 of their written submissions Mr Hand may have been put under some form of observations, but it cannot be concluded on the evidence that he was placed on MORS.

[161] The issue arises as to whether Mr Hand should have been referred to MORS after the timber machine incident.

[162] Alan Henderson is the head of offender outcomes for SPS. He deponed to an affidavit dated 26 May 2025. At paragraph 3 of his affidavit Mr Henderson states that the MORS policy relates to a situation where a member of staff thinks a prisoner has taken an unknown substance as the prisoner is presenting as being under the influence or has ingested an unknown substance. That is the situation which applied to Mr Hand on 3 October as spoken to by Mr Johnston. It follows that Mr Hand should have been referred to MORS after the incident on 3 October 2019.

[163] On the basis that Mr Hand should have been referred to MORS after the workshop incident there is a question of whether he would still have been on MORS at the time of his death and, if so, whether his death could have been prevented.

[164] No evidence was led in the course of the inquiry to suggest that Mr Hand would have remained on MORS at the time of his death. That seems unlikely as MORS is a short-term policy designed to deal with the immediate effects of drug intoxication. As

Sheriff Collins explained at paragraph 37 of his determination into the death of Jack McKenzie (*Inquiry into the death of Jack McKenzie* [2025] FAI 24):

> "MORS is directed, in particular, to the potentially acute adverse effects on a prisoner's physical health from ingestion of drugs, for example and most typically, resulting from an overdose. It is not expressly concerned with any acute or long-term effects on a prisoner's mental health resulting from drug use, nor with treatment and/or support to reduce ongoing drug use by the prisoner."

[165] In the circumstances I do not consider that there is any basis for making a finding that Mr Hand would still have been on MORS observations at the time of his death had he been referred after the workshop incident.

[166] Irrespective of the position with MORS the events of 3 October 2019 presented an opportunity for Mr Hand to be reviewed by the addictions team. Dr Dyson testified that it would have been reasonable to offer Mr Hand further support after the workshop incident. Mrs Malone explained that the system in place now is that all patients on MORS are automatically reviewed by the Health Improvement Team who will discuss harm reduction options.

[167] Against that background I agree that it is appropriate to make the finding suggested by GGHB that:

> "On 3 October 2019, following his episode of intoxication at work, Mr Hand could have been referred to addiction services for review to discuss his illicit drug use, provide harm reduction education and encourage engagement with addiction services."

[168] Although the primary focus of the evidence at the inquiry was on the incident which occurred at the timber machine workshop on 3 October 2019 there was also reference to an incident which occurred on 4 June 2019.

[169] This incident was recorded in an entry in Mr Hand's medical records dated 4 June 2019 (CP no 8 at page 1151) the terms of which are reflected in finding in fact 18. The circumstances are that Mr Hand was found to be unresponsive in a GeoAmey van while being transported to another establishment. Mr Hand admitted to having taken 300 milligrams of Pregabalin.

[170] The Crown submitted that this earlier incident ought also to be regarded as a missed opportunity for addiction services to review the position with Mr Hand's drug use.

[171] As noted earlier in this determination Mr Hand was seen by addiction services on 14 June 2019, some 10 days after the incident of 4 June. It was apparent from Mr Stuart's evidence and from the Addictions Assessment form which he completed that he discussed the incident of 4 June with Mr Hand.

[172] Mr Hand disengaged from addiction services after the initial addictions assessment. Against that background I agree with the submission made by GGHB that any defect in the system of working arising out of the incident on 4 June 2019 cannot be regarded as having contributed to Mr Hand's death, some 4 months later. Neither do I consider that the incident of 4 June 2019 should be regarded as a fact relevant to the circumstances of Mr Hand's death for the purposes of section 26(2)(g).

Sections 26(1)(b) and 26(4) - recommendations proposed by the Crown

[173] In terms of section 26(1)(b) and (4) of the Act the court can make recommendations as to:

(a) the taking of reasonable precautions,

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

(c) the introduction of a system of working, and

(d) the taking of any other steps.

[174] The Crown proposed two recommendations.

[175] Firstly, an evening welfare check should be carried out at weekends at the same time as on weekdays. The rationale for this recommendation was that the lack of an evening welfare check meant that there was too long a period when prisoners were unobserved. That increased the risk that prisoners who need medical treatment would not be identified in time for that treatment to be effective.

[176] SPS opposed the recommendation proposed by the Crown. It submitted that it was not possible for residential staff to work longer hours at weekends without breaching their contracted 35 hour week. The recommendation proposed was neither reasonable nor one that was capable of being implemented in a practical sense.

[177] Mr Wheatley criticised the failure to carry out an evening welfare check. The need to carry out an evening numbers or welfare check is stated expressly in CP no 15, the SPS revised requirements during Locking and Unlocking Periods dated 28 March 2016. These revised requirements were introduced after four previous fatal accident inquiries. As stated in the revised requirements the carrying out of welfare checks at

appropriate times is a measure to reduce the risk of suicide. The carrying out of welfare checks at appropriate times is not something that should be dictated by the contracted hours and shift patterns of prison officers. In my view the recommendation proposed by the Crown is a reasonable and appropriate one to make based on the evidence led at the inquiry.

[178] The second recommendation proposed by the Crown was that a review of drug prevention policies at HMP Low Moss should be carried out. The rationale for this recommendation was that Mr Wheatley had raised concerns about the inadequacy of the drug prevention policies in place at the prison. I have explained earlier the particular aspects of the drug prevention policies which I consider Mr Wheatley criticised. It is important to appreciate that Mr Wheatley accepted that there were a number of drug prevention policies in operation at HMP Low Moss at the time of Mr Hand's death. He focused on the lack of proper CCTV monitoring of prison visits, the lack of a use of trained dogs and the failure to share intelligence. Of these issues I have found that there was a failure to monitor prison visits by the use of CCTV and properly trained operators at the time of Mr Hand's death. I am satisfied on the basis of Mr Hay's evidence that visits are now monitored by CCTV. On that basis I do not consider that there is a need to make a recommendation in relation to the use of CCTV to monitor visits nor to make the general recommendation to carry out a review suggested by the Crown.

[179] No recommendations were sought by the Crown in relation to the provision of addiction services within HMP Low Moss. That was on the basis that there have been

significant changes to the way in which addiction services are provided at the prison as spoken to by Mrs Malone. I agree with the Crown's submission on that matter.

Conclusions

[180] I am grateful to parties for the efforts which they put into considering and agreeing the evidence contained within the joint minute, and in conducting the inquiry and preparing written submissions.

[181] I wish to conclude this determination by expressing my sympathies and condolences, along with the parties who appeared at the inquiry, to the family of Mr Hand and to his next of kin.