SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY AT HAMILTON

[2026] FAI 6

HAM-B167-25

DETERMINATION

BY

SHERIFF DAVID YOUNG KC

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

into the death of

JAMES STEVENSON

Hamilton 23 January 2025

The Sheriff, having considered the information presented at an inquiry on 8 December 2025, under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act") determines:

When and where the deaths occurred

1. In terms of section 26(2)(a) of the Act, that James Stevenson's life was pronounced extinct at 19.13 on 11 October 2021 at HMP Shotts.

When and where any accidents resulting in the deaths occurred

2. In terms of section 26(2)(b) of the Act, that there was no accident that resulted in the death.

The cause or causes of the deaths

3. In terms of section 26(2)(c) of the Act, that the cause of James Stevenson's death was:

1a: Buprenorphine, gabapentin, pregabalin, etizolam and flubromazepam intoxication.

The cause or causes of any accidents resulting in the deaths

4. In terms of section 26(2)(d) of the Act, that there was no accident that resulted in the death.

Precautions

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

System of working

6. In terms of section 26(2)(f), there were no defects identified in any system of working which contributed to the death.

Other facts relevant to the circumstances of the deaths

7. In terms of section 26(2)(g), there are no other facts which are relevant to the circumstances of the death.

NOTE

Introduction

[1] A fatal accident inquiry was held at Hamilton Sheriff Court on 8 December 2025 into the death of James Stevenson.

[2] The following parties were represented at the inquiry. Ms O'Hara, procurator fiscal depute, appeared for the Crown; Ms Doyle, solicitor, appeared for the next of kin; Ms Thornton, solicitor appeared for the Scottish Ministers on behalf of the Scottish Prison Service; Ms Ritchie, solicitor, appeared for Lanarkshire Health Board, and Mr Rodgers, solicitor, for the Prison Officers Association, Scotland. The next of kin, who were represented and kept informed throughout proceedings, ultimately chose not to attend the hearing in person.

[3] Five preliminary hearings were held before the final hearing. During this process a draft joint minute of agreement was considered and revised. At the preliminary hearings, both I and parties' representatives raised queries about several matters that were felt not to be adequately addressed in the various drafts of the joint minute, or were not clearly addressed in the statements and productions which had been lodged at the respective hearings. Each matter raised at a preliminary hearing was

later investigated, supplementary statements or other documents were produced, and the draft joint minute was revised to incorporate the new information before the next hearing.

[4] Ultimately, all the queries raised were investigated and a final revised draft minute was circulated. The final draft covered all the necessary chapters of evidence which required to be placed before the court. All parties were content to agree the final draft minute and considered that it addressed all matters that required investigation. Being cognisant of the principles that an inquiry is to be progressed expeditiously and efficiently, and that the manner in which information is presented is to be as efficient as possible, it was decided that the hearing should proceed on the basis of the evidence contained in the joint minute and that there was no requirement to lead, or merit in leading, additional parole evidence.

[5] Accordingly, at the final hearing, parties tendered a joint minute of agreement which covered all the necessary chapters of evidence that required to be placed before the court, and no parole evidence was presented.

[6] With one exception, there was no submission that the substantive determinations should be other than as set out above.

[7] The exception to the above was as follows. On behalf of the next of kin, Ms Doyle submitted that I should make a finding in terms of section 26(2)(f) that there had been a defect in a system of working which contributed to the death. Ms Thornton for the Scottish Prison Service made submissions to the contrary. This matter is discussed below.

The Legal Framework

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

[9] In terms of section 1(3) of the Act, the purpose of an inquiry is to establish the circumstances of the death and to consider what steps, if any, may be taken to prevent other deaths in similar circumstances. Section 26 requires the sheriff to make a determination which, in terms of section 26(2), is to set out 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 the 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. In terms of section 26(1)(b) and 26(4), 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 other steps, which might realistically prevent other deaths in similar circumstances. The procurator fiscal depute 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.

Findings

[10] The following findings were set out in the Joint Minute of Agreement.

Introduction

[11] James Stevenson (hereinafter referred to as "Mr Stevenson") was born on 03 July 1985 and died at 1913 hours on 11 October 2021, aged 36.

[12] Mr Stevenson died within His Majesty's Prison Shotts, Newmill and Canthill Road, Shotts (HMP Shotts).

[13] At the time of his death, Mr Stevenson was in legal custody of HMP Shotts;

History of Prison Drug Use

[14] On 3 April 2018, Mr Stevenson was placed on MORS (Management of an Offender at Risk due to any Substance) with 30 minute observations from 1640 hours until 2000 hours then reduced to hourly observations. The last observation was taken at 7am on 5 April 2018.

[15] On 23 May 2021 Mr Stevenson was placed on MORS when he appeared under the influence. Mr Stevenson was removed from MORS on 24 May 2021 at 3.30pm.

[16] On 8 June 2021 Mr Stevenson was seen by Dr Hannah McKinlay. Mr Stevenson told Dr McKinlay that his medications had been stopped at a previous prison due to being intoxicated/under the influence.

[17] On 27 July 2021 Mr Stevenson made a previous self-referral to the addiction team, however declined to attend the appointment with an addiction support worker, stating he had changed his mind.

Background

[18] Mr James Stevenson was in legal custody at the time of his death. Mr Stevenson was convicted at Glasgow Sheriff Court on 5 January 2017 of offences under the Road Traffic Act which included driving whilst unfit, driving whilst disqualified and without insurance. He was sentenced to 7 months imprisonment.

[19] He was then convicted at Paisley High Court on 22 February 2017 of an offence of Assault to severe injury, permanent disfigurement, danger to life and attempted murder. He was given a sentence of 9 years' imprisonment. His earliest date of liberation was 21 August 2025.

[20] Following his conviction at court on 5 January 2017 he was initially remanded to HMP Barlinnie and thereafter transferred to HMP Shotts on 28 March 2018.

[21] On 10 February 2021 Mr Stevenson was transferred to HMP Edinburgh in order to complete an offence focussed programme. He was transferred back to HMP Shotts on 6 May 2021.

[22] Within HMP Shotts he was housed within Lamont Level 4, cell 67 on a single occupancy basis.

Circumstances of the death

[23] On 11 October 2021 at 1710 hours Mr Stevenson was locked within his cell by prison officers Elizabeth Wells and Laura Ferguson. He was noted to be well at this time and officers had no concerns about him.

[24] At 1840 hours the same officers carried out a welfare check on the prisoners on the wing. Mr Stevenson's cell was checked and officers found Mr Stevenson lying face down under the desk within the cell. Several witnesses noted white powder was present on Mr Stevenson's nose and/or nostril.

[25] Officers attempted to obtain a response from him and raised a code blue alarm 6 to seek assistance in relation to an unresponsive prisoner. A blue light emergency ambulance was also called.

[26] Mr Stevenson was moved onto his back and CPR was commenced by prison officers who attached a defibrillator and followed its instructions.

[27] There was no nursing cover at this time as the operational hours of NHS staff were reduced due to COVID.

[28] Paramedics James Carroll and Nicole Provan attended at 1850 hours and took over resuscitation attempts. They attached their own defibrillator which advised that the patient was asystole. Life was pronounced extinct at 1913 hours.

[29] Another prisoner, Ian Brown, was also lying face down on the floor of his own cell and was coming in and out of consciousness and at times was unresponsive. Another emergency ambulance was called for him and he was placed in the recovery position until paramedics arrived. Mr Brown was later transferred to Wishaw General Hospital. On his return to the prison the following day, Mr Brown was shocked to find out about the death of his friend Mr Stevenson and intimated that they had both taken the same illicit uncut etizolam.

[30] Police attended HMP Shotts and carried out a search of Mr Stevenson and his cell. They thereafter escorted Mr Stevenson to the mortuary at the Queen Elizabeth University Hospital, Glasgow. Medical History and Treatment

[31] Mr Stevenson's previous Medical History is as follows: • Back pain, sciatica • Epidural abscess secondary to a stab wound • Shoulder Injury • Testicular lump • Erectile dysfunction

[32] Mr Stevenson was prescribed the following: Medication – weekly from 07/05/20218 • Sertraline 150mg daily • Amitriptyline 100mg daily • Codeine Phosphate 60mg QID • Bisacodyl 5mg daily.

[33] Mr Stevenson had intermittent contact with mental health services since his admission to HMP Shotts in March 2017, however, these were mostly related to his removal from association to the SRU and / or review under the MORS policy.

[34] His mental health difficulties (depression & anxiety) were managed and monitored by GP services. Mr Stevenson did not require intensive input from either the visiting psychiatrist or mental health nursing team. There was no contact with mental

health services in the 6 months prior to his death and no contact with mental health services throughout 2020.

[35] It is recorded that a mental health assessment was completed on 21/02/2019 however, we have been unable to access this.

[36] Mr Stevenson experienced a number of physical ailments (as documented above) and received input from primary care services as and when required. He was noted to have high blood pressure on 24 May 2021 following a clinical review where it was believed he was under the influence of illicit substances. This was reviewed by the Primary care nursing team again on 25 May and he was seen by the GP on 8 June 2021 who noted that this had resolved.

Post Mortem

[37] A post mortem examination was carried out by forensic pathologists at the Queen Elizabeth University Hospital, Glasgow on 19 October 2021. They determined the cause of death to be: 1a: Buprenorphine, gabapentin, pregabalin, etizolam and flubromazepam intoxication. The report noted that opioids, benzodiazepines and gabapentinoids when taken in excess and/or in combination can cause respiratory depression, coma and death. Whilst some contribution towards this effect from codeine and dihydrocodeine cannot be entirely excluded, it is considered that they did not play a significant role given the levels of the other drugs involved in this case. In the absence of any other explanation the death is therefore attributed to this combined drug intoxication. There were no other significant findings.

Death in Prison Learning, Audit & Review

[38] Crown production number 2, A Death in Prison Learning, Audit & Review report was conducted on 6 December 2021.

[39] The report noted that Mr Stevenson was sentenced 2 February 2017 and came to Shotts on 28 March 2017. There was a period when he was displaying disruptive behaviours and therefore transferred to HM Prison Edinburgh before later returning to Shotts. Mr Stevenson was sentenced to 9 years' imprisonment and commenced the sentence in February 2017. He has never been supported on 'Talk to Me'. He had previously been on Management of Offender at Risk due to a Substance (MORS) on 23 May 2021 as he was considered to be under the influence and before that only other period was in April 2018 where there was some suspicion that he was involved in drug use.

[40] Mr Stevenson had a GP review because of back issues and that was the point where a National Early Warning Score (NEWS) was done which alerted that he was under the influence of some sort of substance. Mr Stevenson advised at that time he had taken a double dose of Amitriptyline which was his prescribed medication but denied taking any other substance and was placed on MORS for that reason. Observations from 24 May 2021 were still showing as under the influence.

[41] Mr Stevenson had been on MORS and was seen by nursing staff on a number of occasions. After coming off from MORS he was suffering from hypertension and he also had a letter sent to him on 27 May 2021 from the Addiction Services advising of the

services available. Again, hypertension was being reviewed in Shotts, blood pressure, and observations. He was complaining of back pain and was given the relevant advice. No additional medication was given other than already prescribed. He had a consultation with Addictions Case Worker on 2 September 2021 and was offered psycho-social support. He was provided with advice on harm reduction, intolerance levels in regards to overdose. The conversation included current drug trends in prison and associated consequences to both health and sentence progression. Psycho-social support was declined. He was aware to refer to services if required.

[42] A few times Mr Stevenson did not engage with health services and that was his last interaction with the health service. 27 July 2021 he was due to meet addictions services after a self-referral, but declined to attend informing that he had changed his mind. 2 September 2021 he met with addictions services to discuss how he was currently managing and to offer additional psycho-social support. Mr Stevenson declined this additional psycho-social support but was made aware he could self-refer on to services if he required it.

[43] Mr Stevenson had white powder around his nose when found. During the cell search, a tube was also found which appeared to have been used and when tested, it tested positive for Heroin.

Police Service of Scotland Investigation

[44] Detective Constable Scott Johnston carried out investigation into where the deceased had sourced drugs, however no associates of the deceased within HMP Shotts

were willing to engage with police. Intelligence systems were also checked with a negative result.

[45] In May 2023, Detective Constable Scott Johnston became aware that prison staff had seized a number of items from the deceased cell, namely a Broken Pen and two Mirrors which had tested positive for controlled substances, namely Diamorphine and Spice.

SPS Drug Prevention Policies

[46] Mitchell Baillie, Head of Operations at HMP Shotts provided a statement to inform of the possible routes of entry and measures taken within HMP Shotts to prevent illicit commodities from entering the prison. Crown Production Number 9 at Page 33 is the witness statement of the said Crown Witness Mitchell Baillie. This statement is to be taken as the evidence of the witness.

NHS Learning

[47] Lorraine Smith, Interim General Manager of Adult Health Services at NHS Lanarkshire, provided an emailed response in relation to the question of what learning was undertaken in light of the incident. She advised that all prisoners now have baseline observations taken and recorded on the Vision electronic clinical system, which is embedded in practice.

Statement of Crown Witness SPS Officer Mitchell Baillie

[48] The above passages, as set out in the joint minute of agreement, include reference to the statement of Crown Witness SPS Officer Mitchell Baillie. His statement described the systems intended to prevent illicit commodities from entering the prison. As Mr Stevenson's death occurred due to the presence of illicit drugs in the prison, I now set out the full relevant content of Witness Mitchell Baillie's statement. This information is germane to the submissions relating to my findings, discussed below.

> "The information below is provided to inform a Fatal Accident Enquiry of the possible routes of entry and measures taken within HMP Shotts to prevent illicit commodities from entering the prison.
>
> Throw overs
> 1. Illicit substances can be thrown over the walls or fences of prisons, into areas of the establishment for collection and distribution by prisoners within. Packages can be thrown over manually or carried over the walls and into the establishment using drones.
>
> 2. HM Prison Shotts has very little intelligence on the use of drones and it doesn't appear to be an issue at this establishment. I am aware that at other prisons drones have been used to carry the packages over the walls, prisoners then open their windows and use something to hook onto the wire attached to the drone to pull the package towards their cell window. This isn't an issue at HMP Shotts as the windows of the cells don't open, but instead are fitted with ventilation slots.
>
> 3. To combat illicit substances being thrown over the walls, we have several measures in place: we have regular internal and external patrols by staff. Staff carry out the patrols during the day and night; staff are trained to be constantly observant; CCTV cameras are used to monitor inside and outside the establishment. If any suspicious behaviours are noticed outside the establishment, then staff will report this to Police Scotland. HMP Shotts is quite remote, so people hanging around outside the prison or suspicious cars parked nearby are quite easily spotted and immediately reported to Police Scotland, who do come to the establishment and investigate. SPS Staff liaise with Police Scotland and our Intelligence team to intercept or stop throw overs when possible; staff search areas prior to use, whether that is exercise areas or football

pitches. Prisoners using the external areas for exercise are searched on route and supervised by staff during use. If there is any suspicion after using an external area that a Prisoner may have collected a throw over, then staff intervene and they are searched before returning to their cell.

Mail

4. Illicit substances can enter the prison by post. Letters are known to have entered the prison soaked in liquid drugs or containing secreted illicit substances. We became aware that the prisoners were then extracting the substances for use. Similarly, goods entering the prison for prisoners use such as clothing can be soaked in a drug or have illicit substances secreted within them.

5. To combat this, the SPS introduced a process by which all post coming into establishments are photocopied. The prisoners do not get to touch the original letters. In the presence of the prisoner, SPS staff open the post and allow the prisoner to see it. The post is then photocopied in front of the prisoner, and they are issued with the photocopy. The Prisoner is then asked if they want the original shredded or kept until their release. If shredded, then the post will be shredded in front of them and passed to recycling.

6. If there is any suspicion that mail contains illicit substances, then that piece of mail is tested using a Rapiscan Itemiser machine and if positive, placed in an evidence bag. A report is then made to Police Scotland.

7. At the point of access, parcels and mail are signed for, x-rayed and if suspicious then staff use the Rapiscan machine to test and if positive report to Police Scotland. The mail doesn't get through to the prisoner.

8. Legal mail is privileged and SPS staff are not allowed to open that unless we have reasonable suspicion. We must have reasonable cause before legal correspondence can be opened. If we have reasonable cause, then the prisoner will be present when the mail is opened. The letter is not read by staff, but the mail is swabbed and tested on the Rapiscan machine in the presence of the prisoner. If negative on testing, the prisoner can take the correspondence with them. If positive on testing, then the correspondence is kept as a production, placed in an evidence bag and Police Scotland are notified.

9. If suspicious or testing positive we check whether privileged mail is counterfeit. We have a list of recognised sources treated as privileged correspondence and this can include letters from solicitor firms or the Children's Reporter for example. If we have concerns that the correspondence is counterfeit, then we make enquiries to check whether it is genuine. If it is

counterfeit the correspondence is placed in an evidence bag and Police Scotland are notified.

Deliveries:
10. Illicit substances can enter the prison environment through deliveries coming into the prison. HMP Shotts receives many deliveries from contractor vehicles whether they are coming to the establishment for repair and maintenance which has been facilitated via our estates team or whether they are delivering goods into the prison's stores and kitchens. Anything can be delivered, from stationary to food or new office equipment.

11. To combat this, all deliveries being made to the prison must pass through the main vehicle lock. Searches take place at the vehicle lock and SPS staff have equipment such as extended mirrors, torches and handheld metal detectors to carry out the checks. Each driver attending the prison to make a delivery is subject to a Disclosure check, goes through a security process on entry and if there are any suspicions subject to a rub down check by a trained member of SPS staff. Any passengers are required to leave the delivery vehicle and go through Front of House security processes before entering.

12. SPS staff remain with the vehicle for the entirety it is on site and continuously monitor the driver. CCTV cameras, monitored by SPS staff, are also used throughout.

13. The parcels and deliveries then go through the same screening process and checks as incoming mail; they are searched by trained SPS staff, scanned, if suspicious swapped and checked using the Rapiscan machines.

14.The SPS provide updated awareness in addition to training for staff working in the point of entry areas to ensure they are up to date with the latest techniques being used to try and get illicit substances into the prison population. An example I have seen recently was a new bathrobe being delivered to a prisoner. The robe tie had been secreted with a row of small tablets. The SPS seek to educate and improve the knowledge of staff so the drugs can be found.

15.The SPS share security bulletins with staff to raise their awareness.

Rapiscan machines
16. Rapiscan machines are used within SPS prisons as a drug detection tool… Any suspicious items coming into the prison will be tested on the Rapiscan machine.

Collaborative working

17. We continuously work collaboratively with Police Scotland and gather Intelligence to be well-informed of new methods of illicit substances coming into prisons. We work together to try and be proactive and intercept illicit substances coming into the prison.

18. This is an ever-changing environment and prisoners have 24 hours a day, 7 days a week to think about how to get illicit substances into the establishment. Some prisoners have links to serious and organised crime groups in the community. They have the finance and capacity to explore a range of ways of introducing drugs into the prison. Money and technology are available to such serious crime organisations.

National Tactical Search Unit

19. There is a National Tactical Search Unit (NTSU) who are not based on site at HMP Shotts but are in attendance frequently. The Unit has trained dogs which are used to check staff, visitors, areas, mail and parcels in the prison.

20. The dogs are also used to check deliveries being made into the prison. The Unit can attend the establishment to carry out random checks or can come based on intelligence to search specific areas or individuals. If there is suspicion, we may liaise with Police Scotland and the NTSU, to monitor that situation and that risk.

21.The Unit carry out random visits to screen for illicit substances utilising the dogs.

Prison Visits

22. Individuals coming in to visit prisoners is another avenue for introduction of illicit substances into the system. Not every prisoner is on closed visits, it is dependent on risk.

23. At visits, most prisoners are allowed some level of physical contact to allow for family life and maintain bonds. Generally, this would be a hug, kiss or handshake at the beginning of the visit and again at the end. Illicit substances can be passed from the visitor to the prisoner.

24. To combat this risk, visitors coming into the prison require to walk through a scanner and their outer garments and personal belongings are put through a security scanner machine. Lockers are provided for the visitors to store any unnecessary items which cannot be taken into the visit, such as their coats, mobile phones, food, and bags. Visitors are allowed to take in cash if they are using the vending machines in the visit room.

25.Under Rule 106 of The Prisons and Young Offenders Institutions (Scotland) Rules 2011, the SPS are allowed to request a visitor consents to a search. If we have reasonable suspicion, we can terminate a visit and remove a visitor or contact Police Scotland to come to the prison and deal with any incident relating to a visitor.

26.Prisoners receive a rub down search for every person leaving the visiting room and a number of prisoners are selected for a body search after the visiting session.

27. The SPS can conduct targeted body search of prisoners if staff have observed something suspicious during the visit either in person or on our CCTV cameras and have reason to believe they have received an unauthorised or prohibited article.

28.CCTV monitoring is in place throughout the visiting session and staff within the visiting centre are contactable by those observing the cameras, by radio and phone. Staff within the visiting centre, who are physically observing the session, can react as necessary to prevent the introduction of illicit substances or prohibited articles.

29. Visitors' hands and open mouths can be checked before entering the visiting room.

Transfer of Prisoners

30.Illicit substances can enter the establishment due to prisoner movement. For example, there are occasions where prisoners leave the prison for funerals, hospital appointments, court appearances or transferring to and from another establishment.

31.To combat this, before a prisoner leaves the prison, they are subject to a full body search and are fully searched again when they return.

32.We have equipment to assist searches to include a Boss Chair, which is mostly used for metal detection and a Cell Sense metal detector

33.The SPS liaise with Police Scotland and use our own intelligence units to assess individual prisoner risk and arrange for the dogs from the NTSU to be there on their return to the establishment, if deemed necessary.

34.If we have good intelligence information or, on some occasions, evidence, we can isolate a prisoner on their return to the establishment. The prisoner is

searched and removed from association which reduces the risk of the drugs getting into prison population and afford us the opportunity to recover those drugs. Sometimes the prisoner will pass them and flush them away or use them until they are depleted.

35. We conduct interviews of prisoners, arrange counselling during the monitoring period and offer help via our addiction services.

Staff corruption
36.Unfortunately, there is a risk that illicit substances can enter the prison system due to staff corruption.

37.Intelligence is used to identify corruption within SPS staff, partner agencies and contractors and we have an Anti-Corruption Policy which is used to raise awareness amongst staff, identify corruption and support those potentially at risk of corruption.

38.Disclosure background checks are conducted on staff, including SPS employees, partners and contractors.

39.All staff possessions are x-rayed at the point of entry into the prison, and they are subject to random searches. The searches take place randomly but regularly and the NTSU can assist with the use of screening dogs.

40. The SPS have support in place for those staff members who may be directly or indirectly targeted. This is an avenue for those feeling vulnerable to corruption.

41. The SPS gather intelligence and if strong enough will work with Police Scotland to take action on anyone who is involved in corruption.

42. Staff medication requires authorisation, through the Head of Operations. Staff who are prescribed medication that is required to be taken during their working hours require to apply for authorisation and checks with the NHS may take place.

Prisoner medication
43. Medication prescribed to prisoners can be subject to abuse.

44. The NHS are responsible for the provision of healthcare to prisoners within Scottish Prisons. Some prisoner medication, which is assessed as suitable by NHS, can be issued by the NHS on a weekly basis with doses to last the week. This is subject to regular checks by NHS staff to ensure prisoners have the

appropriate amount left at the point of checking. For example, medication will be checked to ensure the correct amount remains within the package if on day 5 of a 7-day allowance.

45. SPS staff observe within the Residential Halls to prevent the movement of prescription medication between prisoners.

46. Prisoners who are on supervised medications, such as methadone, are subject to tight and restricted movement on taking those medications. The NHS staff supervise the prisoner taking the medication, they are not left alone during this process. Security protocols are in place for the dispensing of supervised medication in line with NHS policies

47. Intelligence has found that supervised medication can be regurgitated and then distributed. Some prisoners can half swallow the medication, regurgitate, and distribute it. If we have any evidence that the prisoner is doing this, we can remove them from that medication. We obviously wouldn't put their life at risk and would work collaboratively with the NHS, but if the medication is being abused, then we can take steps to take the prisoner off of it.

48. We offer prisoners support through our addiction teams.

49. Bullying and intimation can be used by prisoners to take other prison's medication. If we have intelligence or suspicion that this is happening, we would challenge those individuals and offer them help and support from our addiction recovery team."

Submissions re defect in the system of working

[49] As outlined above, Ms Doyle on behalf of the next of kin submitted that I should make a finding that there had been a defect in a system of working which contributed to the death. Ms Doyle accepted that the prison service has taken a great number of precautions to prevent drugs entering prisons. However, as a matter of fact the system is not completely successful. If Mr Stevenson had not had access to drugs within prison, he would not have died from a drug overdose. Accordingly, there is clearly a defect in the system because that drugs were available in a prison, which was supposed to be a

highly secure environment. Ms Doyle submitted that deaths similar to Mr Stevenson's continue to happen too often, and that this suggests that the current system needs further reviewed and improved. Ms Doyle advised that there was no submission as to what any such improvement would look like in practical terms, and did not develop her submission beyond the above.

[50] Ms Doyle emphasised, on behalf of the next of kin, that it was appreciated that the SPS were making significant efforts to prevent drugs entering the prison estate, and that there had been an investigation into Mr Stevenson's death that had attempted to identify the source of the drugs concerned. However, the mere fact that drugs had entered on this occasion showed that there must necessarily be a defect in the system, although that defect had not been identified. Accordingly, a finding to this effect should be made.

[51] Ms Thornton, for the Scottish Prison Service, submitted that no such finding should be made. Evidence of the investigation into the death had been agreed. In addition, a detailed statement had been obtained, lodged and agreed setting out the prison policies and procedures to address illicit substance introduction and abuse. None of this had been challenged. Any finding must be based on evidence led at the inquiry, and must be based on a conclusion that any defect that was identified either caused or contributed to the death. There had been no evidence to suggest that there was any systemic failure or defect in the system. In response to a question, she submitted that the SPS drug prevention policy was intended for the prevention, not the elimination, of illicit drugs from prisons. It was not possible to conclude that there was a systemic

defect due simply to the fact that drugs had been introduced to the prison, resulting in Mr Stevenson's death.

Decision re defect in the system of working

[52] Having considered the competing submissions, my decision on this point is that I should not make a finding of a defect in terms of section 26(2)(f).

[53] I accept that the circumstances of Mr Stevenson's death demonstrate that the system intended to prevent illicit substances from entering the prison was necessarily imperfect. It is a small step to conclude that there must therefore be a defect.

[54] The inquiry considered the evidence about the steps taken by the prison service to prevent drugs from entering. Plainly, the SPS face constant challenge from those who seek to overcome the system and to introduce drugs into prison, and the system must continuously react and adapt. It is not surprising in these circumstances that the system is not perfect. 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 had not identified the source. There was no suggestion by any party that seeking further evidence at the inquiry would succeed in identifying the source of the drug, or the means of its introduction. I was of the same view.

[55] 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).

[56] I would add that I indicated at the hearing that, if I did not make such a finding, I would record the submissions and the above reasoning in the determination. All parties were content with this approach.

Conclusion

[57] I end this note as the hearing began, with my own condolences, added to those of the representatives at the hearing, to the family, friends and others who have been and continue to be affected by Mr Stevenson's death.