SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2026] FAI 7

GLW-B1575-24

DETERMINATION

BY

SUMMARY SHERIFF SIMONE SWEENEY

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

into the death of

JOHN MCINTYRE

Glasgow, 30 January 2026

DETERMINATION

The summary sheriff, having considered the evidence and information presented at a Fatal Accident Inquiry on 17 June 2025; and written and oral submissions made on 19 August 2025; determines under section 26 of the Inquires into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (hereinafter referred to as "the Act") that:

Findings

F1 In terms of section 26(2)(a) of the Act, John McIntyre, born 9 September 1963, then a prisoner within His Majesty's Prison, Low Moss, 190 Crosshill Road, Glasgow, G64 2QB (hereinafter referred to as "HMP Low Moss") died between 1701 hours on

1 August 2022 and 0723 hours on 2 August 2022 and his life was pronounced extinct at 0802 hours on 2 August 2022 at cell B17 (K1) a single occupancy cell at HMP Low Moss.

F2 In terms of section 26(2)(b) of the Act, no accident took place and therefore no finding requires to be made.

F3 In terms of section 23(2)(c) of the Act, the cause of death was:

1a. heroin and tramadol intoxication.

F4 In terms of section 23(2)(d) of the Act, there was no accident and therefore no finding requires to be made.

F5 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 John McIntyre's death being avoided.

F6 In terms of section 26(2)(f) of the Act, there were no defects in any system of working which contributed to the death.

F7 In terms section 26(2)(g) of the Act, there are no facts which are relevant to the circumstances of John McIntyre's death.

RECOMMENDATIONS

The sheriff having considered the information presented at the Inquiry, makes no recommendation in terms of section 26(1)(b) of the Act.

NOTE:

Introduction

[1] This was a Fatal Accident Inquiry ("FAI") into the death of John McIntyre. Preliminary hearings took place on 10 December 2024, 5 February 2025 and 24 February 2025. At the hearing of 10 December 2024 dates were assigned for an FAI on 4 and 5 March 2025 with a preliminary hearing on 5 February 2025. At the hearing on 5 February 2025 CCTV footage was played to the court. Footage from two separate camera angles was shown to the court. This captured the area of Kelvin Hall at HMP Low Moss between the hours of around 1700 hours on 1 August 2022 and around 0800 hours on 2 August 2022. Relevant sections included prison officer Laura McKinlay locking the doors of cells at 1702 hours and conducting an evening check of cells at around 2000 hours; prison officer Paul Moscrop opening the door to the cell of Mr McIntyre at around 0700 hours on 2 August 2022; NB, a former inmate of HMP Low Moss moving in and around Mr McIntyre's cell area and thereafter various prison personnel and finally NHS paramedics coming and going from Mr McIntyre's cell. Parties sought a further preliminary hearing on 24 February 2025 to confirm to the court the availability of witnesses for the FAI on 4 and 5 March 2025. At the hearing of 24 February 2025 parties moved to adjourn the FAI to 17 June 2025 due to a witness being unavailable on 4 and 5 March and to allow time for parties' further preparations in recovering affidavit evidence. The FAI was adjourned to 17 June 2025. Evidence was heard on 17 June 2025 from Peter Russell, National Operations and Protection Manager

for the Scottish Prison Service ("SPS"). A hearing on parties' submissions took place on 19 August 2025.

[2] The Crown was represented by Ms Lan, procurator fiscal depute, Mr Richmond, solicitor, appeared on behalf of the Scottish Ministers for SPS, Ms McIlwham, solicitor, appeared on behalf of the Prison Officers Association. I am grateful to those appearing for their assistance. Intimation of the Inquiry was made to John McIntyre's daughter, Claire McIntyre, who elected not to participate in the Inquiry.

[3] On 17 June 2025 parties tendered a joint minute of agreement ("the joint minute"). This helpfully agreed certain necessary evidence to be placed before the court. It did not include the issue of drug prevention measures within HMP Low Moss and whether there was any defect in any system in place which allowed drugs to get into the prison and may have contributed to the death of John McIntyre. In respect of these matters the court heard parole evidence from Peter Russell, former Head of Operations at HMP Low Moss and now National Operations and Protection Manager for SPS. In addition, the court was provided with affidavit evidence from Barry Hay, current Head of Operations at HMP Low Moss and Frank Slokan, Theme Lead for Criminal Justice within SPS.

[4] On 19 August 2025, a hearing was assigned for parties' submissions. At conclusion of the Inquiry, parties invited me to make formal findings under sections 26(2)(a) and (c) of the Act, only. A notional hearing was assigned for 11 September 2025 but discharged as not required. Avizandum was made administratively on 11 September 2025.

Information made available to the inquiry

[5] In terms of the joint minute of agreement which was lodged with the court, the following documents and material were admitted in evidence, comprising volumes 1 - 4 of the Crown's productions and productions produced on behalf of the Scottish Prisons Service:

i. Postmortem report

ii. GP records for Mr McIntyre from Ardgowan Medical Practice

iii. SPS medical records for Mr McIntyre

iv. SPS death in custody documentation

v. Death in Prison Learning, Audit and Review ("DIPLAR")

vi. Photographs of the inside of the cell

vii. Scene examination report

viii. Toxicology report

ix. Email exchange between Procurator Fiscal Depute Liza Lann and Consultant Forensic Pathologist, Dr Gemma Kemp

SPS revised requirements for locking and unlocking periods, 28 March 2016.

x. Witness statement – prison officer Paul Moscrop

xi. Witness statement – prison officer Richard Hogg

xii. Witness statement – former prisoner of HMP Low Moss Neil Burke

xiii Witness statement – Registered nurse Heather Johnstone

xiv. Witness statement – Paramedic Michelle Durham

xv. Witness statement – Paramedic Sam Godson

xvi. Witness statement – Police Constable David McFarlane

xvii. Witness statement – Detective Constable Paul Hendry

xviii. Witness statement – Health Improvement lead SPS Doris Williamson

xix. Witness statement - Former Head Operations HMP Low Moss Peter Russell

xx. Affidavit of Barry Hay, Head of Operations HMP Low Moss

xxi. Affidavit of Frank Peter Slokan, Theme Lead, Criminal Justice, SPS

xxii. Prison Resource Library – Population counts/Number check 1.3.33 b

xxiii. Session plan relating to locking/unlocking from Residential Officers Foundation Programme.

xxiv. SPS response to Gary Ross FAI Determination

xxv. Mylo training package locking/unlocking April 2024

xxvi. Rule 92, Prisoners and Young Offenders Institutions (Scotland) Rules 2011.

xxvii. HMP Low Moss Standard Operating Procedure for Outside Patrol and Report Completion SO68

xxiii. HMP Low Moss Standard Operating Procedure for routine cell searches INTEL 02

xxix. HMP Low Moss Standard Operating Procedure for external area searches work sheds/activity areas INTEL 05

xxx. HMP Low Moss Standard Operating Procedure for visits- Visitor search policy S177

xxxi. HMP Low Moss Standard Operating Procedure for Rapiscan Operation INTEL 14

xxxii. HMP Low Moss Standard Operating Procedure for numbers checks SO05

xxxiii. Rule 95, Prisoners and Young Offenders Institutions (Scotland) Rules 2011.

Relevant statutory scheme

[6] 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 McIntyre was in custody at the time of his death.

[7] In terms of section 1(3) of the Act, the purpose of the Inquiry is to establish the circumstances of 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 death, in so far as they have been established to her satisfaction. These are found at section 26 of the Act and reads as follows:

> "(1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out—
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> (a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and

(b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.

(2) The circumstances referred to in subsection (1)(a) 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—

(i) could reasonably have been taken, and

(ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided,

(f) any defects in any system of working which contributed to the death or any accident resulting in the death,
(g) any other facts which are relevant to the circumstances of the death.

(3) For the purposes of subsection (2)(e) and (f), it does not matter whether it was foreseeable before the death or accident that the death or accident might occur—

(a) if the precautions were not taken, or
(b) as the case may be, as a result of the defects.

(4) The matters referred to in subsection (1)(b) are—

(a) the taking of reasonable precautions,
(b) the making of improvements to any system of working,
(c) the introduction of a system of working,
(d) the taking of any other steps,

which might realistically prevent other deaths in similar circumstances.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to—

(a) a participant in the inquiry,
(b) a body or officeholder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature."

[8] 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).

Facts

[9] That Mr McIntyre previously received a custodial sentence for assault to severe injury, danger of life and attempted murder in 2014, receiving two sentences of 5 years and 4 months which ran concurrently.

[10] That Mr McIntyre was released from prison on 23 March 2018 from the Open Estate.

[11] That Mr McIntyre was recalled to custody on 15 August 2018 having been convicted on 30 July 2018 for an offence under Criminal Law (Consolidation) (Scotland) Act 1995, S52(1) & (3) (vandalising property with a hammer).

[12] That Mr McIntyre appeared at Greenock Sheriff Court on 22 August 2018 and received a custodial sentence of 4 months imprisonment.

[13] That Mr McIntyre was liberated on 31 December 2019.

[14] That Mr McIntyre was admitted to HMP Low Moss on 4 April 2022 on an untried warrant for an allegation of an assault to severe injury, danger of life and attempted murder.

[15] That there are historical testing records from his previous periods in custody, with one instance of being placed on the Management of Offender at Risk from any Substance programme ("MORS") on 15 December 2017.

[16] That between February 2017 and January 2018 Mr McIntyre was drug tested whist in prison on ten different occasions, each resulting in negative results for illicit drugs.

[17] That on admission to HMP Low Moss on 4 April 2022, a urine screen was carried out by medical staff, testing positive for opiates and benzodiazepine.

[18] That Mr McIntyre was not placed on the MORS programme on admission to HMP Low Moss on 4 April 2022.

[19] That, at the date of his death, Mr McIntyre was not noted as suffering from a current drug dependency and his recent drug use was not known by the National Health Service ("NHS") or SPS.

[20] That Mr McIntyre was a trusted inmate who performed the role of a "passman" entrusted with food and cleaning duties and was well liked by inmates and prison officers.

[21] That there was no trace of Mr McIntyre being involved in any suspicious activities or involved in any feuds with other inmates.

[22] That on 1 November 2011, the responsibility for the provision of healthcare to prisoners transferred from SPS to NHS. Since then, individual regional NHS 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.

Mr McIntyre's health and medical circumstances

[23] Mr McIntyre had a medical history of alcoholism, gastric issues, being overweight and mental health issues including self-harm and, on admission to HMP Low Moss on 4 April 2022, he reported a history of cocaine usage.

[24] On admission to HMP Low Moss on 4 April 2022, Mr McIntyre was referred to the Mental Health Team due to his ongoing engagement with the community psychiatric services and the range of medication, including anti-depressant and anti-psychotic medication.

[25] Mr McIntyre was seen by the Mental Health Team at HMP Low Moss and was last reviewed on 20 July 2022, where it was noted by that team that he was coping well with his mental health.

[26] That on admission to HMP Low Moss on 4 April 2022, Mr McIntyre had previously been a patient at The Queen Elizabeth Hospital in Glasgow where surgery had been undertaken to have a vertical laceration to his face repaired, whilst under the care of Police Scotland.

[27] That on admission to HMP Low Moss on 4 April 2022, an appointment to review Mr McIntyre's facial wounds was arranged.

[28] That on 5 April 2022 Mr McIntyre had 28 stiches removed from his face and nose and 7 stiches from his arm, his pain was managed through medication.

[29] That on 28 May 2022 Mr McIntyre was referred to Colorectal Services, requiring an urgent colonoscopy due to ongoing gastric issues.

[30] That Mr McIntyre attended hospital on 13 July 2022 for said colonoscopy.

[31] That said colonoscopy was not carried out on 13 July 2022 due to medical reasons and a further appointment was arranged for 10 August 2022, 9 days after his death.

[32] That Mr McIntyre, at time of death, was prescribed the following medications: amitriptyline, co-codamol, mirtazapine, venlafaxine, olanzapine, lansoprazole, ferrous fumarate, epimax cream and scarsil silicone gel for facial scarring.

Circumstances and cause of death

[33] Mr McIntyre entered his cell from the communal area of Kelvin 1 hall at 1701 hours on 1 August 2022. Prison officer Laura McKinley opened and then locked Mr McIntyre's cell door at 1703 hours on 1 August 2022. She repeated this at 2023 hours on 1 August 2022. Throughout the night of 1 August 2022 to the morning of 2 August 2022 no other persons entered Mr McIntyre's cell.

[34] Nightly observations following lock up are only undertaken on prisoners who have been placed on the, "Talk to Me" or the MORS programmes which SPS have in place. Mr McIntyre was not subject to either of these programmes at the time of his death.

[35] The following morning, 2 August 2022 at 0714 hours, prison officer Dominic Markey opened Mr McIntyre's cell door and then locked it. Prison officer Markey failed to get the required verbal response from Mr McIntyre as it appeared to him that Mr McIntyre was sleeping at 0714 hours. Thereafter, at 0723 hours on 2 August 2022, prison officer Paul Moscrop unlocked the doors to the cell of Mr McIntyre. Former prisoner, NB, entered Mr McIntyre's cell at 0723 hours and exited Mr McIntyre's cell at 0724 hours. He alerted prison staff that Mr McIntyre was not waking. At 0725 hours, prison officers Paul Moscrop and Richard Hogg entered Mr McIntyre's cell. They discovered Mr McIntyre lying on his back in bed, eyes and mouth open, his right arm hanging from the bed and his left hand clenched in a fist against his chest. He did not appear to be breathing. Prison officer Moscrop radioed a "Code Blue" to summon assistance at 0725 hours. A "Code Blue" is an emergency call used in prisons to convey quick and specific information and to initiate a timely and effective response. A "Code Blue" signified an individual who is experiencing severe breathing difficulties and may or may not be responsive. In response to the "Code Blue" call, a nurse attended immediately, confirmed that Mr McIntyre was cold to touch. Other medical staff attended soon thereafter. Another prison officer brought the emergency bag located on Kelvin 1 hall to Mr McIntyre's cell at 0726 hours, a defibrillator was brought at 0727 hours.

[36] Prison officers Moscrop and Hogg lifted Mr McIntyre on his mattress down to the floor of his cell at the request of medical staff. Medical staff with the assistance of prison officers commenced cardiopulmonary resuscitation (CPR) on Mr McIntyre, an

ambulance was summoned at 0733 hours, arriving at 0751 hours. Privacy screens were placed around Mr McIntyre's cell door at 0755 hours and ambulance personnel took over CPR from prison staff. The prison defibrillator was removed from Mr McIntyre's body and the ambulance defibrillator was applied as this was able to provide a heart reading. The ambulance defibrillator provided a reading to paramedics advising that Mr McIntyre's heart had ceased all electrical activity and there was no heartbeat.

[37] Paramedic Sam Godson assessed Mr McIntyre's veins for an intravenous access. This was assessed as futile as Mr McIntyre's body was cold to touch and postmortem staining was observed on his body. The paramedics carried out CPR for approximately 15 minutes with no response or signs of life from Mr McIntyre. At 0802 hours on 2 August 2022, Mr McIntyre's life was pronounced extinct, by paramedics Sam Godson and Michelle Durham.

[38] Mr McIntyre's body mass index of 34kg/m^2 is classified as clinically obese. The larger a person, the longer their body takes to cool after death, as a larger body can retain more heat. Therefore, it is highly unlikely that Mr McIntyre was still alive at 0714 hours on 2 August 2022 as Mr McIntyre's temperature would take several hours to drop after death.

[39] Police Scotland was notified of the circumstances of the death. A search of Mr McIntyre's cell at time of death revealed no signs of any disturbance and no suspicious items were found within.

[40] On 9 August 2022 a postmortem examination was undertaken on the body of Mr McIntyre at the Queen Elizabeth Hospital, Glasgow by Consultant Forensic

Pathologist Doctor Gemma Kemp. The toxicological examination showed a low level of alcohol and the presence of mirtazapine, amitriptyline, olanzapine, morphine and tramadol in Mr McIntyre's blood. It showed the presence of morphine, codeine and monoacetylmorphine in Mr McIntyre's urine. A final postmortem report was issued by said pathologist on 20 September 2022. It certified Mr McIntyre's cause of death as: 1a heroin and tramadol intoxication.

[41] On 12 October 2022, following the final postmortem report being received, an instruction was sent to Greater Glasgow CID by the Custody Death Unit at the Crown Office and Procurator Fiscal Service to investigate who supplied the deceased with said heroin and tramadol. A full investigation was conducted to ascertain who supplied Mr McIntyre with the said drugs that led to his death. All available lines of enquiry were exhausted, and no further lines of enquiry were identified.

[42] There are measures in place within HMP Low Moss to prevent drugs coming onto the prison estate. These include an x-ray scanner (which has identified many items being brought into the prison) searches of cells and inmates, searches of those coming into the prison, drug testing, intelligence analysis.

[43] Moreover, SPS has in place a procedure for the locking and unlocking of cells. This is contained within the Governor and Managers Actions and sets out the standard across the prison estate and compulsory for all staff.

Evidence

Witness evidence of Peter Russell, National Operations and Protection manager, SPS

[44] At the hearing of the Inquiry on 17 June 2025, the court heard evidence from Peter Russell, National Operations and Protection manager for SPS since October 2024. Mr Russell had been provided with the affidavit produced by the current Head of Operations, Barry Hay, prior to giving evidence.

[45] In his evidence, Mr Russell confirmed that he had 29 years' service with SPS. He began as a prison officer in 1996 and had worked in a number of prisons throughout Scotland including HMPs Aberdeen, Polmont, Edinburgh and Barlinnie. In August 2022, around the time of Mr McIntyre's death, Mr Russell was appointed Head of Operations at HMP Low Moss. Mr Russell remained in this role at HMP Low Moss until his appointment to his current role in October 2024. The role gave him responsibility for overall security at HMP Low Moss, including monitoring patrols, locking, permitting people in and out of the prison, undertaking searches for amongst other things, drugs, weapons and alcohol and dealing with security breaches.

[46] Mr Russell submitted that the existence of illegal drugs within the SPS estate is a constant issue. With regards to processes for preventing drugs entering HMP Low Moss during the period August 2022 to October 2024 when he was in the role of Head of Operations, Mr Russell submitted that there was a range of activities undertaken on a daily basis. Mr Russell spoke of searches of visitors, mail, deliveries and those coming onto the prison estate. Reliance is made of intelligence management whereby any concerns are assessed and graded by experts. A national unit exists for support and

advice. This is relied upon when there is information of drug smuggling from the intelligence unit. Mr Russell had reason to rely upon the expertise of this national unit for assistance during his time at HMP Low Moss where concerns about drugs arose.

[47] Asked by the Crown about anti-drug measures in HMP Low Moss at present, Mr Russell referred to the affidavit of Barry Hay, currently Head of Operations at the prison. He confirmed that the affidavit provided by Mr Hay outlines comprehensively the current measures in place. Reference was made to x-ray body scanners in place. These were described as similar to the scanners which exist for passengers in an airport where an x-ray is taken of a person and shows up anything secreted on their person. Since installation of this machinery, it has become very clear that drugs are being brought into the prison at highly regular intervals.

[48] The Crown put to Mr Russell that it was a matter of agreement that Mr McIntyre had died from taking tramadol and heroin. It was enquired of Mr Russell how Mr McIntyre might have got hold of these drugs within the prison. In his opinion, Mr Russell considered it a possibility that the drugs were secreted on Mr McIntyre during a prison visit or they had come from another person within the prison. He submitted that drugs are commonplace within HMP Low Moss. The prison has a capacity of 784 prisoners but currently holds 880. Whilst he could not put an exact figure on the number of those prisoners using drugs, Mr Russell considered it to be very high. A programme is in place to address those with known drug dependencies. Prisoners are placed on MORS. The number of prisoners on MORS fluctuates from time to time. In his experience, prisoners tend to use drugs at night when not under

observation. This makes it difficult to know who is using drugs. It did not cause Mr Russell any surprise, generally, to learn that a prisoner had used drugs during the night. Not knowing Mr McIntyre personally, Mr Russell could not comment on whether or not it was a surprise to learn that Mr McIntyre had been using drugs during the night. What did cause surprise for Mr Russell was that Mr McIntyre had no history of drug use and had taken drugs during the night. If the prison authorities had known that Mr McIntyre was under the influence, measures would have been taken in line with relevant procedures.

[49] With regards to processes for locking and unlocking cell doors, Mr Russell explained that visual and verbal checks ought to be undertaken and a response should be obtained. It was clear to Mr Russell that this did not appear to happen here. Prison officer Dominic Markey had opened the door to Mr McIntyre's cell on 2 August 2022 but had not undertaken these checks. Prison officer Markey had been spoken to about his involvement in the presence of his trade union representative. Prison officer Markey had confirmed that he did not receive any response from Mr McIntyre. This information was passed onto the prison governor. Mr Russell explained that a Code of Conduct exists for prison staff. This sets out the ways in which staff ought to conduct themselves within their roles. Given his failure to get a response from Mr McIntyre, Prison officer Markey was the subject of a Code of Conduct investigation. Whether this investigation brought about any disciplinary action against the prison officer, Mr Russell could not say.

[50] On behalf of SPS, Mr Richmond asked Mr Russell to consider the Governor and Managers' revised requirements during locking and unlocking periods from 28 March

2016, the document having been lodged in process. Mr Russell confirmed that this document set out the requirements in place at the time of Mr McIntyre's death. Subsequent to Mr McIntyre's death and following on from another FAI, prison officers had received refresher training on locking and unlocking procedures.

[51] Mr Russell confirmed that SPS implements a significant resource into its efforts to eradicate drugs from within its prisons on a daily basis. He described what had occurred to Mr McIntyre as, "tragic."

[52] On behalf of the Prison Officers' Association, Ms McIlwham enquired about the role of passman within the prison system. Mr Russell was aware that Mr McIntyre had held this position within HMP Low Moss and described it as a role of trust. Mr Russell agreed it was odd that someone in such a role would be under the influence of drugs. He, himself, could not imagine appointing a prisoner to the role of passman if they were a drug user. Mr Russell accepted it possible that prison officers might not know that Mr McIntyre was under the influence of drugs and it likely that officers would have revoked Mr McIntyre's passman status had they been aware of this information.

[53] Having been shown an excerpt of the CCTV footage, Mr Russell confirmed this showed Mr McIntyre going into his cell between 1659 and 1701 hours on 1 August 2022. Footage from 1702 hours shows prison officer Laura McKinley pulling cell doors towards her and locking them. Footage from 2022 hours shows prison officer McKinley pulling cell doors towards her. It appears from Mr Russell's view of the screen that prison officer McKinley looks inside the cells positioned on the left-hand side of the footage.

Submissions

[54] All parties provided written submissions which were amplified or adopted in court. These have been of assistance. I mean no disrespect by not setting these out at length. All represented parties sought formal findings.

[55] There was no natural contradictor in this Inquiry.

My views and analysis of the evidence

[56] I found witness, Peter Russell, credible and reliable. I accept his evidence that the existence of illegal drugs within the SPS estate is a major issue on a daily basis. SPS is alive to this and has measures and procedures in place to detect and combat drugs coming onto its estate. These measures and procedures are kept under review and changes are implemented whenever necessary. Notwithstanding these efforts, illegal drugs find their way into prisons and in this case, into HMP Low Moss.

[57] Mr McIntyre was known to medical staff within HMP Low Moss from his admission on 4 April 2022. He was found to be coping well with his mental health on 20 July 2022. He was known to prison staff and trusted in his role as passman. There was no indication that Mr McIntyre was using illegal drugs or had any history of using illegal drugs since his admission to HMP Low Moss. There was no reason to place him under observation.

[58] A full investigation was undertaken by police and prison staff to establish where and how Mr McIntyre had acquired drugs. The investigation was concluded, without success.

[59] Processes in place for locking and unlocking doors were followed by prison staff on 1 August 2022. Whilst there was a failure on the part of prison office Dominic Markey to get a response from Mr McIntyre on 2 August 2022 at 0714 hours, the evidence indicates that this would have made no difference to the outcome.

[60] On the information and evidence before me, Mr McIntyre chose to acquire and consume illegal drugs, at night, undetected. Sadly, for those who make this choice and are determined enough to acquire illegal drugs, they are available throughout the prison estate. The evidence before me does not indicate that there is anything which could have been done by prison staff to have prevented Mr McIntyre from making this choice and the tragic consequences which followed.

Conclusions

[61] At the conclusion of the Inquiry, in terms of section 26(1) of the 2016 Act, I require to determine, setting out my findings, as to the circumstances arising from section 26(2) and which recommendations (if any) should be made in terms of section 26(4) of the 2016 Act.

[62] The evidence before the Inquiry does not disclose any substantive issues for me to consider in terms of sections 26(2)(b) and (d). I am obliged to make findings in terms of sections 26(2)(a) and (c). I address each of these in the following way:

Section 26(2)(a) Where and when the death occurred

[63] In terms of section 26(2)(a) based on the evidence before me, Mr McIntyre died within HMP Low Moss between 1701 hours on 1 August 2022 and 0723 hours on 2 August 2022. Life was formally pronounced extinct at 0802 hours on 2 August 2022 by paramedics Michelle Durham and Sam Godson. This is all contained within the joint minute of agreement lodged with the court.

Section 26(2)(c) The cause or causes of death

[64] Based on the evidence presented it has been established that Mr McIntyre died from intoxication of, 1a heroin and tramadol. This was the finding of the final postmortem report of 20 September 2022 and contained within the joint minute of agreement.

Section 26(4) Recommendations, if any

[65] With regards to section 26(4) of the 2016 Act, any recommendations which should be made must take account of (a) any reasonable precautions which may, realistically, have prevented the death; (b) the making of improvements to any system of working; (c) the introduction of a system of working; (d) the taking of other steps which might realistically have prevented other deaths in similar circumstances.

[66] In its written submissions, the Crown highlights that, in the explanatory notes to the 2016 Act the word, "reasonably" relates to the reasonableness of taking precautions

rather than the foreseeability of a death or accident. Based on the evidence before me there are no precautions which could reasonably have been taken and had they been taken here, might realistically have avoided the death of Mr McIntyre.

[67] With regards to sections (b) and (c) in deciding whether to make any determination as to defects in any system of work which contributed to the death, I must be satisfied that there was a defect which existed which caused or contributed to the death. It remains unclear how Mr McIntyre came to be in possession of drugs prior to his death. Systems were in place at HMP Low Moss to combat drugs coming onto the prison estate. Based on the evidence I heard, at HMP Low Moss, SPS was doing all that could reasonably have been done or was expected to have been done to prevent such illegal drugs entering the prison. However, no system can ever be entirely foolproof. There was no evidence of illegal drug taking by Mr McIntyre prior to his death. The evidence before me does not point to any knowledge on the part of SPS that Mr McIntyre was using illegal drugs prior to his death or that SPS ought to have put measures in place. There was no evidence before me that there was any defect in any system of work which caused or contributed to Mr McIntyre's death.

[68] For all these reasons I make no recommendation in respect of section 26(4).

Learning and action points

[69] There were two issues arising at points 93 and 94 of the joint minute of agreement under the heading above. I address these individually, as follows:

[70] At point 93 of the joint minute reference is made to NHS staff requesting that Mr McIntyre be brought out of his cell. Prison officers refused the request and Mr McIntyre was moved onto the floor of his cell where CPR was administered. SPS has addressed this with the issue of a communication to staff in September 2022 that such requests should be followed.

[71] Point 94 of the joint minute refers to NHS staff highlighting that radio traffic was busy at the time of the "Code Blue" on 2 August 2022 which prevented contact with a manager at the health centre. A communication was issued to all staff that during such incidents, radio traffic should be kept to a minimum and for emergency use only.

[72] Both of these issues arose after Mr McIntyre was found unresponsive and cold to touch at 0725 hours. In her email exchange with Procurator Fiscal depute Liza Lan of 12 and 13 February 2025, the evidence of Consultant Pathologist Doctor Gemma Kemp was, that it was highly unlikely that Mr McIntyre was alive at 0714 hours on 2 August 2022.

[73] For these reasons I do not consider that had these changes been in place on 2 August 2022, there would have been a different outcome.

[74] I offer my sincere condolences to the family and friends of Mr McIntyre.