

NHS Greater Glasgow and Clyde	Paper No. 26/106
Meeting:	NHSGGC Board Meeting
Meeting Date:	27 August 2026
Title:	Fatal Accident Inquiry Determination
Sponsoring Director/Manager:	Scott Davidson, Executive Medical Director
Report Author:	Iain Paterson, Corporate Services Manager (Compliance)

1. Purpose

The purpose of the paper is to provide a summary of the Determination of a recent Fatal Accident Inquiry that NHSGGC participated in at Glasgow Sheriff Court:

- Neil Hand – 23 June 2026

Our deepest condolences remain with the family of Neil Hand for their loss and the distress they have experienced.

2. Executive Summary

The paper can be summarised as follows:

- Sheriff Taylor made a single recommendation for the attention of Scottish Prison Services and none for the attention of NHSGGC: [SHERIFFDOM OF SHERIFF COURT](#)

A brief summary of the case can be found in Appendix 1.

3. Recommendations

NHSGGC is fully supportive of the purpose of FAIs and welcomes the opportunity to learn from each case.

4. Response Required

This paper is presented for awareness.

5. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:

• Better Health	<u>Positive</u> impact
• Better Care	<u>Positive</u> impact
• Better Value	<u>Positive</u> impact
• Better Workplace	<u>Positive</u> impact
• Equality & Diversity	<u>Positive</u> impact
• Environment	<u>Positive</u> impact

6. Engagement & Communications

The issues addressed in this paper were subject to the following engagement and communications activity:

- The FAI Determination was communicated to the Executive and relevant Service leads by the Corporate Services Manager. The Central Legal Office notified Board witnesses of the published findings.

7. Governance Route

- Inquiries Oversight Sub-Group and Clinical Care and Governance Committee

8. Date Prepared & Issued

Paper prepared: 30 July 2026

Paper issued: 19 August 2026

APPENDIX 1

Neil Hand FAI

Findings

- Neil Hand died in cell 26, Section A, Kelvin Hall 2, HMP Low Moss, sometime between 5.05pm on 26 October 2019 and 5.08am on 27 October 2019.
- The cause of death was multi-drug intoxication involving methadone, flualprazolam, etizolam, buprenorphine, amitriptyline and pregabalin.
- The sheriff found no accident caused or contributed to the death, and no reasonable precautions that might realistically have prevented it.
- No system defect was found to have contributed directly to the death, but several issues were identified.
- Relevant issues included lack of CCTV monitoring of visits, lack of weekend evening welfare checks, missed follow-up after disengagement from addiction services, and missed opportunity for addiction review after the 3 October 2019 intoxication incident.
- Addiction services at HMP Low Moss have since improved through MDT working, MAT (Medication Assisted Treatment) standards and harm reduction arrangements. These have all improved the ability of addiction services to coordinate care and respond more quickly to the needs of patients.

Recommendation

- The sheriff made **one formal recommendation for the attention of Scottish Prison Services** - weekend evening welfare checks at HMP Low Moss should be carried out at the same time as weekday evening checks, between 8.15pm and 8.30pm.

Observations

- The absence of a weekend evening welfare check was considered a defect in the system of working, although causation could not be established.
- The failure to carry out a welfare check on 26 October 2019 breached SPS revised requirements on locking and unlocking procedures.
- Mr Hand could have been reviewed again after disengaging from addiction services and reminded that he could re-engage at any time – *this was a suggested finding put forward by Board counsel and accepted by the Sheriff.*
- After the 3 October 2019 intoxication episode, Mr Hand could have been referred to addiction services for harm reduction advice and support – *this was also a suggested finding by Board counsel accepted by the Sheriff.*
- A wider review of drug prevention policies was not recommended, as the sheriff accepted that CCTV monitoring of visits is now in place and other policy changes had been made.