SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2025] FAI 44

EDI-B72-25

DETERMINATION

BY

SUMMARY SHERIFF FRANCIS GILL

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

into the death of

CONNOR MORRISON

EDINBURGH, 17 October 2025

The summary sheriff, having considered the evidence and 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 "the Act"), that:

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

Connor Morrison, date of birth 2 October 1997, died in cell 2/22, Ingliston Hall, HMP Edinburgh sometime between 2030 hours on 19 April 2022 and 0730 hours on 20 April 2022. His life was pronounced extinct at 0733 hours on 20 April 2022.

2 In terms of section 26(2)(b), of the Act (when and where any accident resulting in death occurred).

Mr Morrison's death was self-inflicted and was not the result of an accident.

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

The cause of Mr Morrison's death was hanging.

4 In terms of section 26(2)(d), of the Act (the cause of any accident resulting in the death).

Mr Morrison's death was self-inflicted and was not the result of an accident.

5 In terms of section 26(2)(e), of the Act (the taking of precautions).

There were no precautions which could reasonably have been taken which might realistically have resulted in Mr Morrison's death being avoided.

6 In terms of section 26(2)(f) of the Act (defects in any system of working).

There were no defects in any system of working which contributed to Mr Morrison's death.

7 In terms of section 26(2)(g) of the Act (any other facts relevant to the circumstances of the death).

There are no other facts which are relevant to the circumstances of Mr Morrison's death.

Recommendations

The summary sheriff having considered the evidence and information presented to the inquiry, makes no recommendations in terms of section 26(1)(b) of the Act.

NOTE

Introduction

[1] This inquiry was held into the death of Connor Morrison ("Mr Morrison") who was found dead within HMP Edinburgh on 20 April 2022. Preliminary hearings were held by way of WebEx on 3 March 2025, 28 April 2025 and 14 May 2025.

[2] The inquiry itself took place on 28 and 29 May 2025 followed by a hearing on submissions on 18 July 2025.

[3] The parties' representatives were as follows:

i. Mr Simon Gregor, procurator fiscal depute, represented the Crown;

ii. Ms Lesley Turner, solicitor, represented the Scottish Ministers for the Scottish Prison Service ("the SPS");

iii. Ms Morag McLelland, solicitor, represented Lothian Health Board ("the Health Board"); and

iv. Ms Christie Wishart, solicitor, represented the Prison Officers Association Scotland ("POAS").

[4] A joint minute of agreement was lodged and read into evidence by the procurator fiscal depute at the start of the inquiry.

[5] The inquiry heard oral evidence from the following witnesses:

i. Dr Gordon Skilling, consultant forensic psychiatrist.

ii. Danielle Pagliarulo, paramedic.

iii. ME, former prison officer.

iv. CP, prison officer.

v. JM, prison officer.

vi. SM, head of operations at HMP Edinburgh.

[6] The statements of a number of witnesses were lodged by the Crown and referred to in the joint minute. The contents of those statements from the following individuals were not disputed.

i. AF, prison officer, HMP Edinburgh

ii. GH, first line manager, HMP Edinburgh

iii. BB, prison officer, HMP Edinburgh

iv. CP, prison officer, HMP Edinburgh

v. ME, former prison officer, HMP Edinburgh

vi. HF, prison officer, HMP Edinburgh

vii. JM, prison officer, HMP Edinburgh

viii. KB, prison officer, HMP Edinburgh

ix. LB, prison officer, HMP Edinburgh

x. PB, unit manager, SPS

xi. JB, intelligence management unit manager, HMP Edinburgh

xii. JD, night shift operations manager, HMP Edinburgh

xiii. Alana Kelly, deputy charge nurse, NHS Lothian

xiv. Elaine McAdam, advanced nurse practitioner, NHS Lothian

xv. Amy Dunn, advanced nurse practitioner, NHS Lothian

xvi. Shelley Jones, advanced nurse practitioner, NHS Lothian

xvii. Allen Beatson, registered nurse, HMP Edinburgh

xviii. Danielle Pagliarulo, paramedic, NHS Lothian

xix. Alan Jackson, solicitor

xx. JH, prisoner, HMP Edinburgh

xxi. Gordon McKean, head of projects, estates and technical services, SPS

[7] An affidavit dated 14 May 2025 of Linda Pollock, the deputy chief executive of the Scottish Prison Service, was also lodged.

[8] A number of productions were lodged including some which were not referred to in the joint minute or at the inquiry hearings.

[9] The productions lodged by the Crown were as follows:

i. The death certificate of Connor Morrison dated 29 April 2022.

ii. Intimation of Death form dated 9 May 2022.

iii. The final post-mortem report.

iv. Mr Morrison's prison records.

v. Mr Morrison's GP and medical records.

vi. SPS Death in Custody folder in relation to Mr Morrison.

vii. HMP Edinburgh Reception Risk Assessment for Mr Morrison dated 21 February 2022.

viii. HMP Edinburgh Reception Risk Assessment for Mr Morrison dated 23 February 2022.

ix. HMP Edinburgh Reception Risk Assessment for Mr Morrison dated 30 March 2022.

x. SPS Talk to Me paperwork dated 8 April 2021.

xi. Expert report by consultant forensic psychiatrist, Dr Gordon Skilling, consultant forensic psychiatrist.

xii. Death in Prison Learning Audit Review ("DIPLAR") report carried out at HMP Edinburgh following Mr Morrison's death.

xiii. Summary complaint against Mr Morrison – ED21015784.

xiv. Summary complaint against Mr Morrison – LI22000621.

xv. Sample Review of Ligature Anchor Points at HMPYOI Polmont (November 2018).

xvi. Ligature Free Accommodation Costings report (February 2019).

xvii. Written submission made to the cabinet secretary for justice and home affairs by the SPS CEO dated 15 February 2019 re ligature anchor points at HMPYOI Polmont.

xviii. Transcript of statement made by the cabinet secretary for justice and home affairs to the Scottish Parliament dated 23 January 2025 re the determination into the deaths of Katie Allan and William Brown.

xix. Transcript of the statement made cabinet secretary for justice and home affairs to the Scottish Parliament dated 27 March 2025 re the determination into the deaths of Katie Allan and William Brown.

[10] The productions lodged by the SPS were as follows:

i. SPS Talk to Me, Reception Risk Assessment form dated 18 March 2022.

ii. SPS Talk to Me, Reception Risk Assessment form dated 22 March 2022.

iii. SPS Standard Operating Procedure re Ambulance Service Access & Egress dated March 2019.

iv. SPS Talk to Me Guidance Part 1, revised June 2021.

v. SPS Talk to Me Guidance Part 2, revised June 2021.

vi. SPS cell allocation history for Mr Morrison.

The legal framework

[11] The inquiry was held in terms of section 1 of the Act and the procedure was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. It was a mandatory inquiry held in terms of sections 2(4)(a) and 2(5)(a) of the Act because Mr Morrison died while he was a prisoner in HMP Edinburgh.

[12] Section 1(3) of the Act sets out that the purpose of a Fatal Accident Inquiry is to establish the circumstances of the death and consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

[13] The inquiry is an inquisitorial process and its purpose is not to establish civil or criminal liability. The manner in which information may be presented to the inquiry is not restricted and the court is entitled to reach conclusions based on that information.

Background facts and circumstances

[14] Mr Morrison was born on 2 October 1997. He died sometime between 2030 hours on 19 April 2022 and 0730 hours on 20 April 2022. At the time of his death, he was 24 years of age and was being held in legal custody at His Majesty's Prison Edinburgh where he was serving a sentence of imprisonment of 441 days.

[15] Mr Morrison's medical records disclose that between June 2020 and July 2021, he received a variety of treatment for his mental and physical health. Notably, he had been detained under an Emergency Detention Certificate ("EDC") at St John's Hospital, Livingston on 7 June 2020. He was diagnosed with acute substance intoxication and discharged on 9 June 2020. He was subject to an urgent referral to the psychiatric outpatient department on 29 June 2020 and was prescribed antipsychotic medication. He was again made subject to an EDC during an admission to St John's Hospital between 4 and 6 July 2020 and was discharged on 8 July 2020. Concerns were expressed about his mental health at an outpatient review with a consultant psychiatrist on 21 July 2020.

[16] On 25 March 2021, Mr Morrison was taken by police to the emergency department at St John's Hospital as a result of concerns about his behaviour. He was

reviewed by psychiatry specialists while in the emergency department before being discharged without further input.

[17] During a period of imprisonment within HMP Edinburgh in April 2021, Mr Morrison was placed on the Talk to Me programme ("TTM") for a short period because of concerns about his volatile behaviour and comments he had made to prison staff. He was placed on TTM on 8 April 2021 and removed from it the next day after a TTM Case Conference concluded that there was no apparent risk of suicide.

[18] Whilst at liberty, Mr Morrison was reviewed by a community GP on 6 July 2021 and noted to be paranoid. From 19 to 22 July 2021, Mr Morrison was again admitted to St John's Hospital where he had self-presented seeking help with his mental health. He was diagnosed with alcohol dependence and commenced an alcohol detox regime and thereafter discharged with a plan for community addictions input. Throughout this period, the medical professionals treating Mr Morrison noted concerns with his drug and alcohol misuse.

[19] On 21 February 2022, Mr Morrison appeared from custody at Livingston Sheriff Court where he pled not guilty to a summary complaint. He was remanded in custody to HMP Edinburgh, bail having been refused. Thereafter, on 18 March 2022, Mr Morrison appeared at Livingston Sheriff Court in relation to a number of matters all of which were continued by the sheriff until 22 March 2022 for consideration of sentence. When he appeared on that date, Mr Morrison was sentenced in total to 441 days imprisonment.

[20] In the weeks immediately before his death, Mr Morrison had been subject to five Reception Risk Assessments ("RRA") at HMP Edinburgh. These were carried out on 21 February 2022, 23 February 2022, 18 March 2022, 22 March 2022 and 30 March 2022. A RRA must be completed on a prisoner's first admission to a prison, transfer from another prison, return from court, return from external escort, after video conference court appearances and tribunal hearings. A risk assessment must also be completed after a parole hearing and following receipt of the parole decision. Parts 1 – 5 of the Reception Risk Assessments are always carried out in the above circumstances. Part 6, which is the Healthcare Assessment, should be carried out if the individual is an admission, transfer or has returned from court (including a virtual court), convicted while on remand or where there is a change in their liberation date. None of the parties were able to confirm the reason why a RRA was completed on 30 March 2022. However, there was no evidence before the inquiry that this was a factor which in any way related to Mr Morrison's death.

[21] On 30 March 2022, after the evening lock up of cells, Mr Morrison advised prison staff that he needed to change his cell because he was going to harm his cellmate. Prison staff refused this request, but around 5 minutes later, Mr Morrison repeated his request. Although his cell mate told prison staff that he was not particularly concerned for his safety and that Mr Morrison had not made any threats towards him, the decision was taken to remove Mr Morrison to the Segregation and Reintegration Unit (SRU). On the way to the SRU and without warning, Mr Morrison started performing press-ups. He complied with the instruction from the officer escorting him to stop and then continued

on to the SRU. He denied feeling suicidal and the officer did not have any concerns for his welfare at that time.

[22] On 1 April 2022, Mr Morrison returned to the general prison population from the SRU to cell 2/22 within Ingliston Hall. From that date, apart from the period between 7 and 14 April 2022, Mr Morrison was the only occupant of his cell.

[23] On 19 April 2022 at around 1600 hours, Mr Morrison was observed eating his meal in the communal area with other prisoners and appeared to staff to be jovial. He was telling jokes and laughing together with other prisoners.

[24] During the lock up and numbers check later that evening at around 2030 hours, a prison officer observed Mr Morrison sitting at the desk in his cell, looking out of the window. The officer spoke to Mr Morrison who indicated that he was feeling okay and there were no concerns for his welfare.

[25] The next morning (20 April) when two prison officers were conducting the morning prisoner numbers check, they discovered Mr Morrison hanging from a ligature connected to a bar of the top bunk of the bed within the cell. Prison officers successfully removed Mr Morrison from the bunk bed and untied the ligature from his neck. He was described as being cold and hard to the touch.

[26] A "code blue" call was made via radio at 0730 hours to summon medical assistance and an ambulance. This was made by a different prison officer than the two who had discovered Mr Morrison. A code blue is an emergency call used in prisons to summon medical assistance for a prisoner who is unresponsive and may or may not be breathing. Nursing staff responded to the code blue and attended at Mr Morrison's cell.

They noted observable rigor mortis and were of the opinion that Mr Morrison was deceased. A nurse pronounced Mr Morrison's life extinct at 0733 hours.

[27] A Scottish Ambulance Service paramedic attended HMP Edinburgh in response to an emergency call from the prison. The call was code purple, which is the highest priority call. Upon arrival at Mr Morrison's cell, the paramedic was not required to provide any medical care, as Mr Morrison's life had already been pronounced extinct.

[28] On 29 April 2022 a post-mortem examination of Mr Morrison's body was conducted and his cause of death was attributed to 1a) pressure on the neck and 1b) hanging.

Evidence at the inquiry

[29] The Crown led evidence in person from five witnesses at the inquiry.

Dr Gordon Skilling

[30] Dr Gordon Skilling is an experienced consultant forensic psychiatrist based at the State Hospital, Carstairs. He had prepared a report dated 3 December 2023 on the instructions of the Crown for the purpose of this inquiry. The report was lodged by the Crown as a production and Dr Skilling was prepared to adopt the contents of the report as his evidence.

[31] Dr Skilling gave evidence principally about two issues. The first was the nature and quality of the Reception Risk Assessments carried out on Mr Morrison while he was in HMP Edinburgh in 2022. The second was the overall standard of psychiatric care

offered to Mr Morrison while he was in custody at HMP Edinburgh during the same period and in particular whether the prison failed to identity and act on any factors suggesting that Mr Morrison was at risk of committing suicide.

[32] Dr Skilling explained there were a number of factors that, overall, would point to someone being at risk or an increased risk of committing suicide. The factors could be distinguished between those which were "static" and those which were "dynamic". The former includes, for example, substance misuse and mental illness while an example of the latter would be a prisoner living in a single occupancy cell. A factor which increased the risk of suicide significantly was the individual being a prisoner. A number of the risk factors applied specifically to Mr Morrison such as, that he was male, he was experiencing a stressful life event (custody), that he had a history of drug misuse and at the time of his death he was the sole occupant of his cell.

[33] However, even when the risk factors have been identified, it is not possible to predict that someone is going to take their own life.

[34] When assessing a particular individual's immediate risk of death by suicide, a prison officer would rely primarily on what the person was self-reporting and what others, for example, family members calling into the prison, were reporting. The observations of prison staff who had particular dealings with the prisoner were also important. Significant weight should be placed on any self-reporting of suicidal thoughts. Prison officers work closely with the prisoner and from their training would be aware that if any thoughts of self-harm were made expressly or by implication then

an appropriate strategy would be needed. Within prisons, that would be the Talk To Me ("TTM") strategy.

Reception Risk Assessments

[35] Dr Skilling confirmed that he had had no personal involvement in any of Mr Morrison's RRAs. His assessment of the process was based only on what he had read in the forms. Dr Skilling had never observed an actual Reception Risk Assessment taking place.

[36] Three of the RRAs completed for Mr Morrison had been considered by Dr Skilling when preparing his report. The other two were put to him when he gave his evidence. He had not been asked to compare and contrast the quality of Mr Morrison's RRA forms with a RRA that did highlight concerns for a prisoner. In his view the RRAs were clearly part of a positive attempt to "check in" with the prisoner regarding any issues on admission to the prison.

[37] From his perspective as a consultant forensic psychiatrist, the assessments could not be regarded as thorough, but that was unsurprising as these assessments were being carried out for a particular purpose and by staff with no clinical training. He would not have expected an in-depth medical analysis from someone who was not medically trained such as a prison officer. If the prisoner was presenting as fine, he agreed that it was reasonable for the assessments to be briefer in nature. The clear impression from the RRA forms was that prison staff had no concerns about Mr Morrison so far as his being at risk of suicide was concerned.

[38] Dr Skilling also did not wish to be too critical of the quality of the assessments as he assumed the staff would be under pressure from having to process a volume of prisoners when completing the forms. Dr Skilling considered that the format of the forms and the questions being asked were adequate. The forms are designed to prompt the prison officers to ask the relevant questions about a prisoner's mental health. He recognised that there was a risk they could become a tick box exercise and so he considered that there should be an audit from time to time of completed RRA forms. It would be appropriate for SPS staff to do this rather than NHS staff working in the prison.

[39] Dr Skilling's evidence was that a prisoner having a cell mate was a protective factor against the risk of suicide. This was for three reasons: (i) assuming the cell mates got on, they could provide mental health support to each other; (ii) one cell mate could raise an alarm if they had concerns about the other's mental health; and (iii) simply having another person in the room would make it less likely for someone to act on any suicidal urges because they would not want their cell mate to see the act or because their cell mate would try and stop them.

[40] Although he had not been asked to comment on ligature anchor points in his report and had not done so, Dr Skilling was asked about the issue towards the end of his oral evidence. He spoke in general terms about the mitigations used in the bedrooms within the State Hospital to limit possible ligature anchor points. However, Dr Skilling made it clear that this was not his area of expertise and also that the overall context of someone being detained in a prison than in the State Hospital was quite different.

[41] In his report, Dr Skilling's main conclusions were:

- HMP Edinburgh had not failed to correctly identify any potential factors that Mr Morrison was at risk of committing suicide.
- There was no reason to consider Mr Morrison a risk of suicide over and above the risk generally presented in the prison population. There were no indicators that his risk was acutely increased and no reason to consider changes to his risk management in the days leading up to his suicide.
- Mr Morrison had some risk factors for suicide; however, the reality is that it remains impossible to predict when individuals, who have chronic, broad statistical risks, are at acute risk of actually attempting or completing suicide.
- The RRA process is designed to be a quick assessment, mainly focused on how the prisoner is presenting at the time. It is not intended to be a detailed assessment of a prisoner's history or risks.
- There were no changes to the RRA process which, had they been made, may have prevented Mr Morrison's death.

Danielle Pagliarulo

[42] Danielle Pagliarulo is a paramedic and has been employed by NHS Lothian for around 12 years. Ms Pagliarulo estimated that over her career, she had been tasked to respond to around 25 emergency calls following incidents within HMP Edinburgh. On 20 April 2022, she had been on shift in the role of first responder and was working on

her own in a paramedic car rather than in an ambulance. Ms Pagliarulo recalled receiving a high priority call to attend HMP Edinburgh regarding Mr Morrison. After she received the call, it took her around 8 minutes to arrive at the gates of HMP Edinburgh.

[43] Ms Pagliarulo was familiar with the process for paramedics arriving to deal with an emergency at HMP Edinburgh. On entering the prison grounds, there are a number of secure gates that vehicles need to drive through before getting to the area where the emergency vehicle is then parked. Thereafter, the paramedic makes the rest of the journey on foot. After she had parked her vehicle, Ms Pagliarulo was met by a prison officer who escorted her to Mr Morrison's cell. On the way to Mr Morrison's cell, there were a number of security doors to pass through but as she was being escorted by a prison officer this did not cause any delay. From arriving at the prison gates until reaching Mr Morrison's cell, Ms Pagliarulo estimated that in total it took her around 12 to 13 minutes. From entering the prison building itself until reaching Mr Morrison's cell, she estimated that it took her less than 1 minute.

[44] Ms Pagliarulo did not have an opinion on whether a period of 12 to 13 minutes was acceptable. She felt that the size of the prison and grounds and the necessary security measures in place made it inevitable that access – even in an emergency situation – would always take some time. It was a factor which she was cognisant of when receiving a call to attend an incident within the prison. In her experience, prison staff always did their best to get paramedics to the situation as quickly as possible.

[45] Almost at the same time as she entered Mr Morrison's cell, she received a call from her controller advising her that she had been stood down and was not required to assist. She had not carried out her own assessment of Mr Morrison although she had seen him on the floor of his cell. The charge nurse present had already pronounced life extinct and therefore Ms Pagliarulo was surprised that the paramedic response had not been stood down when that happened.

ME, CP and JM

[46] These three witnesses were all prison officers who had been on duty on the day of Mr Morrison's death. ME left his employment as a residential prison officer with the SPS in January 2023 at which point he had just over 2 years' service. CP has been employed as a first line manager at HMP Edinburgh for about the last 18 months. He has about 8 years' service with the SPS. His previous roles included those of residential officer and operations officer. JM has been a prison officer for 30 years. He worked initially in HMP Perth for around 17 years and the remainder of his service has been in HMP Edinburgh.

[47] Mr Morrison was housed in cell 2/22 in Ingliston Hall of the prison. It was a double cell with a bunk bed. There were around 64 double cells in Ingliston Hall, each of which had bunk beds. Overall, there were around 349 prisoners in Ingliston Hall and it usually operated at capacity.

[48] JM remembered Mr Morrison from a previous sentence which he had served in HMP Edinburgh. JM had noted that in the days before his death Mr Morrison appeared

to be much happier than he had been during the previous period in custody. He had settled down and was interacting well with fellow prisoners and prison staff. Mr Morrison was taking part in recreation and exercising. There had been no further issues after had returned from segregation.

[49] On 20 April 2022, ME and CP had carried out the morning count of the prisoners in the west wing of Ingliston Hall. When they arrived at Mr Morrison's cell, they unlocked the door but found it difficult to push open. When they accessed the cell, they found Mr Morrison hanging from the back of his bed. The ligature used has been some of his bedding. ME ran to alert his colleague JM, who was the desk officer that day, so that he could call a code blue over the prison radio system. CP remained with Mr Morrison and tried to support his body which he described as already feeling very stiff. Neither ME nor CP were carrying a radio and so could not make the code blue call themselves. A code blue is well understood throughout the prison as being a call about a medical emergency in which the casualty is not breathing. A code red on the other hand indicates a medical emergency when the casualty is bleeding. In Mr Morrison's situation it was vital to get a message to the prison nursing staff immediately via a code blue call. On hearing a code blue for a medical emergency, the nurses would more or less drop everything and rush to the scene. JM placed the code blue call via his personal radio and then ran to Mr Morrison's cell to assist. He confirmed that he was the officer who had to raise the code blue because he had a personal radio.

[50] The distance which ME had to run to reach JM was not far. It took ME around 10 seconds to reach JM but as he ran towards him, he was already shouting at him to

raise a code blue. JM raised the code blue and at the same time made his way with ME back to Mr Morrison's cell. The officers had found it difficult to untie the knot on the ligature because Mr Morrison's body was so stiff. At that time, prison officers did not carry ligature cutters although a set was part of the crash pack which was kept at the desk on each landing. No CPR was carried out on Mr Morrison as it was clear to the prison officers that he was already dead. An advanced nurse practitioner had already arrived on the scene at this point and pronounced life extinct.

[51] All prison officers are issued with a personal alarm which is akin to a pager and can be used in the event of the need for urgent help. The personal alarm would be used to call for help in violent incidents or if an officer was in danger rather than in the case of medical emergencies. Not every prison officer would respond to the activation of a personal alarm. For example, they might not be able to leave the area where they were deployed depending on the nature of their role. In addition, sections or wings of the prison would be left vulnerable if too many staff responded to the same incident. Accordingly, officers would have to weigh up whether they could respond to a personal alarm without compromising the security of the area they were working in. When officers are summoned to an incident via an alert on their personal alarm, they do not know the nature of the incident to which they are responding, only that additional officers are required to provide urgent assistance. On discovering Mr Morrison's body, there would have been limited use in summoning help via the personal alarm because nurses do not respond to calls made via the personal alarm system. What was needed was urgent medical assistance. Any prison officers summoned to help in response to an

alert on their personal alarm may not have had a personal radio in which case they too would not have been able to raise a code blue.

[52] A personal radio is different from a personal alarm. Not every prison officer on shift carries a personal radio. As well as calling a code red or code blue, the radios were generally used to assist with coordinating prisoner movements throughout the prison (for example to and from court visits) or the whereabouts of a member of staff could be established quickly via a radio message if necessary. The radios also assisted with the secure movement of any contractors working in the prison. Two such radios were assigned to each landing in the prison. There were five officers assigned to each landing. The officer manning the landing desk always had a radio. The desk was close to the back office and had a computer for staff use and relevant prison paperwork was stored there. It was not clear who had the responsibility of assigning the radios at the start of each shift although it was "set in stone" that the desk officer would have one. Another officer in the section would be given the second radio. The second radio could change hands throughout a shift for operational reasons. On the day in question, the second radio had not been picked up and was still at the desk. The radios used an electronic wave. There are a number of different channels on the radio, eg channel 1 is the main channel and is used for messages about prisoner movements or emergency calls whereas there is a separate channel for estates issues. JM did not consider that it was any particular colleague's role to decide who was given the second radio.

[53] ME had not personally raised a concern with management that he was not equipped with a personal radio, but he was aware that some colleagues had done so in

the past. As he understood matters, the response from management had been to the effect that there was not the budget to do so.

[54] CP had experience of using a personal radio within other halls in the prison and had received training on how to use the radio as part of his induction training. He explained that as well as using the radio to raise a code red or a code blue, the radios can be used to communicate with a manager and to assist with prisoner movements throughout the day. He was not sure why each prison officer was not issued with a personal radio and had not asked his managers about that. On balance he thought it would be useful for each prison officer to have their own personal radio.

[55] JM on the other hand was not concerned that in a code blue or code red situation, the officer finding the casualty might not be carrying a personal radio. He did not consider there would be any material distance to be covered to reach a colleague with a radio. The first reaction of a prison officer without a radio in an emergency situation would be to shout to the desk officer to raise the emergency and then run towards them to make sure they had made the code blue call. He was confident the desk officer would always hear the shout straightway. JM considered that if every prison officer carried a personal radio this would increase the overall communication traffic over the airwaves, possibly about non-work matters. This could lead to important information such as an emergency call being missed or lead to delays in day-to-day tasks such as the co-ordination of prisoner movements within the prison. He had personally never asked management to provide each officer with a personal radio and he was not aware if such a request had been made by any colleagues. In his view it was not necessary.

Other witnesses

[56] The SPS led evidence from one witness in person at the inquiry.

SM

[57] SM is employed as the head of operations at HMP Edinburgh and has been in that role for around the last 18 months. He had joined the SPS in 2013 on its graduate scheme. He had experience of working in prison officer roles in HMP Shotts and HMP Cortonvale as well as HMP Edinburgh. In his current role he is responsible for the security and safe operation of the prison. He gave evidence about three main issues: (i) the arrangements for emergency vehicles entering HMP Edinburgh; (ii) the availability of personal radios for prison officers; and (iii) the RRA process generally and specifically relating to Mr Morrison.

[58] SM was familiar with the SPS Standard Operating Procedure ("SOP") for emergency vehicles arriving at HMP Edinburgh. This version of the SOP was in place at the time of Mr Morrison's death. SM explained the process that is followed when a 999 call is made requesting that an ambulance or paramedic attend at HMP Edinburgh. He described the journey which the emergency vehicle has to make from arriving at the gates of the prison to being parked up as close to the site of the emergency as possible. A number of security gates must be passed through, some of which are operated manually and some of which are automatic. The vehicle is subject to security checks. In SM's view there was not a significant delay in an emergency vehicle making its way

to the site of an incident when account is taken of the need to maintain security and the size of the prison grounds. In his view all staff were aware of the need to get an ambulance and paramedics to the casualty as quickly as possible. Staff would do what they could to move emergency personnel within the prison as fast as possible. He estimated that it would take a paramedic around 10 minutes to get from the perimeter gate of the prison to Ingliston Hall. Once in Ingliston Hall it would depend precisely where the injured person was located but it would only take about a further 90 seconds at most to reach them.

[59] If there were any concerns about the length of time that a paramedic had taken to arrive at an incident, SM would have expected those to be raised by NHS colleagues or the staff involved. Prison staff work closely with their NHS colleagues and senior managers in both organisations speak regularly. He considered there was a good line of communication between prison management and NHS staff and that NHS staff could easily raise any concerns about paramedic access times if indeed there were any. He was not aware of any occasions when prison staff had caused delay to the arrival of a paramedic or ambulance at HMP Edinburgh.

[60] Prison management work to certain formal Key Performance Indicators ("KPI"), for example, relating to violence reduction within the prison. There is no KPI in relation to how quickly a paramedic arriving in an emergency vehicle should be able to get from the prison gates to someone in the prison who required medical assistance.

[61] At present there are not enough personal radios available to be allocated to each member of staff on each shift. It is not just residential staff who need and use radios

within the prison. Prison radios are be shared among staff across a number of functions including prisoner work parties, gym staff and nurses. Some roles do not require the member of staff to ever carry a personal radio, eg mental health nurses.

[62] In HMP Edinburgh and other Scottish prisons, it is common to have the role of a desk officer on each landing. That individual will always be allocated a radio. If a prison officer who discovers a medical emergency is not carrying a personal radio, they would shout to the desk officer to radio a code blue. The desk officer would then immediately place that call via their personal radio.

[63] SM considered that the desk officer nearest to Mr Morrison's cell would have easily heard his colleague shouting for the code blue to be raised. In any event it was a short distance to run from the cell to the desk officer. A code blue can also be raised by telephone and there is a telephone on the desk on each landing. SM has never been made aware of any delays being caused in an emergency situation because of a lack of personal radios. SM was not aware of the historical reasons why personal radios were not allocated to every prison officer. In relation to whether that could be achieved, he explained that the prison lacked the electronic infrastructure at present to do so. In particular there was insufficient space within the control room to secure and charge additional radios. The availability of more radios in relation to a code blue emergency situation would provide additional peace of mind, but the lack of radios would cause a delay of only a matter of seconds.

[64] SM's evidence was that there were 166 personal radios available for use at any one time within HMP Edinburgh. Of the number available he estimated that they were

allocated equally between SPS and non-SPS staff. When a prison officer radioed a code blue that would be heard by nurses in the nurses' station. It would in any event be repeated by staff in the control room. He could not express a view on whether an increase in the number of personal radios would lead to an increase in airwave traffic and if that would cause problems. It would not necessarily follow that more radios would lead to more radio traffic. However, he did confirm that even with the current number of available radios, there was already a lot of traffic over the airwaves. SM was asked whether he would welcome having 100 more radios to issue to prison staff and replied he would.

[65] SM was familiar with the RRA process. He had also witnessed it at first hand recently in HMP Edinburgh. He estimated that about 30 prisoners would go through the RRA process each day but sometimes that figure could be much less.

[66] The RRA forms are audited every week by unit managers who check a percentage of completed forms. The TTM programme is taken extremely seriously within the prison. The RRAs are also further checked by the SPS auditors who periodically go to all prison establishments in Scotland carry out an audit of various aspects of the TTM records and the RRAs. He thought that in one way or another, there was an audit of the TTM process each day.

[67] If a clear trend or problem emerged following any audit, that would be raised by management at staff meetings or by an email to the relevant staff. If the issue was specific to a member of staff, it would be raised with them directly. His evidence was that the audits identified more errors in the TTM paperwork than in the RRA process.

[68] The RRA forms for Mr Morrison were shown to SM while he gave his evidence. Overall, he considered that certain sections of the forms were incomplete and generally he would like to have seen more detail recorded by the officers who had completed the forms. If the RRA forms for Mr Morrison had been looked at during an audit, these points would have been picked up and feedback given to staff. He advised that after an audit of RRA forms, a general reminder is sent to relevant staff alerting them to the issues raised. The information is also shared with NHS staff working within the prison. He explained that there is good communication between the SPS staff and NHS staff working within the prison. He thought the system for auditing RRA forms had been in place since around 2022.

[69] After every emergency situation within the prison there is always a debrief. In his view, had the length of time it took the paramedic to arrive on scene been an issue, that would have been raised as part of any such review. SM also explained that from 0600 hours to 2100 hours each day, there are NHS staff on duty within the prison who would respond immediately to any code blue call.

[70] SM agreed that it was likely that the reason that parts of Mr Morrison's RRAs were not completed by NHS staff was because the forms had not been passed to the healthcare team by prison staff as should have happened. The forms should have been sent back to reception with Mr Morrison when he returned there after his virtual court appearances.

[71] SM estimated that the whole reception risk assessment process took around 30 to 40 minutes. The part of the process involving prison officers would take around

20 minutes and the same again would be spent with nursing staff. In terms of the forms, he estimated that the prison officer would spend 2 to 3 minutes with the prisoner completing them. The audit process involves a specific form being used to assess the quality of the assessments. A lack of information in the forms would be a concern for those carrying out the audit. The reception area for prisoners is different from the reception to the prison. It is quite a distance between the two areas.

Other evidence

[72] I do not intend to analyse all of the productions lodged by the parties or referred to in the joint minute. The same applies to the statements lodged. A large number of the statements and productions were not referred to in the joint minute or at the inquiry itself. However, in light of the submissions made by the Crown, it is important that I highlight parts of the evidence of Linda Pollock which is contained in her signed affidavit and also the productions which relate to the use of bunk beds as ligature anchor points.

Affidavit evidence of Linda Pollock

[73] Ms Pollock is the deputy chief executive of the SPS. Her affidavit dated 14 May 2025 was agreed as her evidence in the joint minute. Her evidence was not challenged or referred to at the inquiry. The affidavit provided an update on the response by the SPS to certain of the recommendations made in the determination following the

conjoined FAI into the deaths of *Katie Allan and William Brown,*[1] ("the Polmont FAI"). The determination in that FAI was published on 17 January 2025 ("the Polmont Determination").

[74] The affidavit explains that the SPS is reviewing the design of prison bunk beds. Once a prototype is available, it will be tested in line with British Standards and then assessed using the pilot Ligature Toolkit. Consideration will then be given to how and when the introduction of these bunk beds could occur across the remainder of the SPS estate. The design may need to change depending on cell size and available space. Each prison has a different cell accommodation so the design may need to be updated to work in other prisons.

[75] Due to current overcrowding, SPS establishments need to have bunk beds in adult cells to maximise the number of prisoners they can hold in establishments.

[76] The Polmont FAI recommended that Scottish Ministers put in place a system to ensure that information from court is sent to the SPS so it can be considered by prison officers conducting RRAs. A working group led by Scottish Government has been set up and the SPS is fully supportive of and engaged in this work. The SPS has also sent reminders to partners about how a third party can report a concern about a prisoner, including the use of a special telephone line and via online reporting. The SPS has also issued guidance to governors and staff highlighting how to raise a concern about an individual and the process to be followed.

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[1] [2025] FAI 6

[77] The Polmont FAI also recommended that the TTM guidance should be amended. A formal and independent review of the TTM Suicide Prevention policy has commenced. As part of the review process, a public "Call for Views" has been launched by the review team and is currently live and accessible via the SPS website and communication channels. This call seeks contributions from a wide range of stakeholders, including SPS staff and relevant external partners. The review is scheduled to complete by the end of summer 2025. In parallel, the SPS is developing plans to support a comprehensive overhaul of the TTM policy, with the intention of publishing an updated version by the end of 2025.

Bunk beds as ligature anchor points

[78] The issue of bunk beds being used as a ligature anchor point within prisons has been a concern for some time. The Crown lodged a document titled "Sample Review of Ligature Anchor Points, HMYOI Polmont." This was completed in November 2018 by a team led by Gordon McKean who at the time was the head of professional and technical services at the SPS. It identified a number of potential ligature anchor points within HMPYOI Polmont. It followed on from earlier research and a report which Mr McKean had prepared in relation to ligature points across the SPS estate at the request of the chief executive of the SPS.

[79] Once the sample review had been completed, Mr McKean was involved in various other meetings about the issue and in February 2019, he produced a document titled "Ligature Free Accommodation Costings report." This was requested by the SPS

chief executive and its purpose was to calculate the cost of making all accommodation across the SPS estate ligature free. The Crown also lodged a memorandum from the chief executive of the SPS to the cabinet secretary for justice dated 15 February 2019. The stated purpose of that memorandum was to update the cabinet secretary on the work undertaken by the SPS to identify ligature points at HMPYOI Polmont together with the associated implications and costs in creating a ligature free environment. The memorandum concluded (among other things) that it would be possible to create ligature free environments in prison establishments. However, that would require considerable expenditure and may create a different set of problems affecting the health and wellbeing of prisoners. It noted that suicide prevention and positive mental wellbeing among prisoners is about more than just their physical environment.

Submissions for the parties

[80] In terms of sections 26(2), (a) and (c), the parties invited the court to make formal findings.

[81] In terms of sections 26(2), (b) and (d), the Crown and the POAS made no submissions and the SPS and the Health Board invited the court to make formal findings.

[82] In terms of section 26(2)(f), the POAS made no submissions and the other parties invited the court to make no finding.

[83] The submissions on the matters about which there was no agreement were as follows.

Section 26(2)(e) – the taking of precautions

The Crown

[84] The Crown submitted that a reasonable precaution and one which if taken, may have realistically prevented Mr Morrison's death would have been the removal of the bunk beds within Mr Morrison's cell. This was reasonable because the SPS was well aware of the risk posed by bunk beds within single occupancy cells and had known about the risk since at least 2018, if not before. The risk posed by bunk beds had been explicitly identified in the Sample Review of Ligature Anchor Points at HMPYOI Polmont (November 2018).

[85] The Crown also highlighted that in the Polmont FAI, the SPS accepted, at paragraph 623:

> "that bunk beds were and are a known ligature anchor point risk … SPS, as a direct response to this evidence led in this inquiry, had now removed all 74 bunk beds from accommodation within Polmont used by children and young persons."

[86] The Crown also pointed to paragraph 804 of the Polmont Determination in which the sheriff stated, that:

> "it would have been a reasonable precaution to have removed double bunk beds from use in relation to all single occupancy cells for young prisoners in Polmont prior to 2018. This could have been done relatively cheaply and easily and did not require substantial capital expenditure."

[87] The Crown submitted therefore that it would have been reasonable for HMP Edinburgh to have removed the bunk beds from Mr Morrison's cell. While accepting that the particular facts and circumstances of the Polmont FAI meant that the

precaution was limited to "children and young persons", the Crown submitted that if bunk beds pose a ligature anchor point risk for children and young persons, they must also be a risk for the adult population.

[88] If the precaution had been taken, Mr Morrison would not have been accommodated in a cell with a double bunk in the days leading up to his death and would have been unable to die by suicide in the manner which he did. The removal of the bunk beds would realistically have prevented Mr Morrison's death.

The SPS

[89] The SPS referred to Ms Pollock's affidavit evidence. This noted that due to overcrowding at SPS establishments, bunk beds are required in standard adult cells to maximise the number of prisoners that can be held in each establishment. As Mr Morrison's cell was not a single occupancy cell, and the bunk bed required to be available for additional prisoners in the establishment, it would not have been a reasonable precaution to have removed the bunk bed from Mr Morrison's cell.

[90] Mr Morrison's cell was not a single occupancy cell and for a time he had shared it with another prisoner. In addition, during his time in HMP Edinburgh, Mr Morrison showed no warning signs that indicated he was at risk of suicide or self-harm. In the circumstances, it would not have been reasonable for the SPS to have altered their management of Mr Morrison or to have taken any additional precautions, including the removal of the bunk beds from Mr Morrison's cell. The SPS submitted that no findings under this section were necessary.

The Health Board and the POAS

[91] The Health Board and the POAS had nothing material to say in their submissions on this issue.

Section 26(2)(g): Any other facts which are relevant to the circumstances of the death.

The Crown

[92] The Crown invited the court to find that the following two facts were relevant to the circumstances of Mr Morrison's death:

i) The healthcare sections of two RRAs conducted on 18 March 2022 and 22 March 2022 were not fully completed; and

ii) There are not enough radios available at HMP Edinburgh for each prison officer who needs one to use during their shift. Lack of access to a radio increased the length of time taken to raise a code blue on 20 April 2022, albeit a short increase.

The SPS

[93] The SPS accepted that there was evidence at the inquiry about these two matters. However, they are not facts that relate to the circumstances of Mr Morrison's death and therefore no findings are necessary in respect of this section.

The Health Board

[94] The Health Board accepted that the healthcare sections of the RRAs conducted on 18 and 22 March 2022 were not completed when they ought to have been. However, this was because SPS staff did not provide RRAs to the healthcare team. In any event, the fact they were not completed is not relevant to the specific circumstances of Mr Morrison's death. Accordingly, no finding under this section falls to be made against the board.

POAS

[95] There were no submissions from the POAS on this issue.

Section 26(4): Recommendations

The Crown

[96] In the event that the court was to make any findings under sections 26(2)(e), (f) or (g), the Crown also invited the court to "crystalise" those findings into recommendations.

[97] Even if the court did not make any findings under any section of the Act, the Crown proposed a number of recommendations that the court should make which are as follows.

[98] Firstly, that the SPS remove double bunk beds from cells within HMP Edinburgh. The Crown submitted that the SPS have accepted the risk of suicide that is posed by these beds and have taken no action to address it, other than that in

relation to HMPYOI Polmont. The SPS and the Scottish Ministers have been aware of this issue since at least 2018. Based on the productions lodged, it is clearly a significant undertaking to adapt the prison estate to make it safer for prisoners. However, the SPS and the Scottish Ministers have had almost 7 years to take action, or to implement a programme of work to address this issue, or to begin a process of reducing ligature anchor points in prisons. So far, action has only been taken at HMPYOI Polmont and only in response to the Polmont Determination.

[99] In the event the court was not persuaded to recommend removal of bunk beds from HMP Edinburgh, the Crown proposed that the court recommended that SPS implement a requirement that no prisoner should be accommodated within a cell with a bunk bed on a single occupancy basis. In other words that cells with bunk beds should only be used to accommodate two prisoners. This submission focussed on the part of the evidence of Dr Skilling which spoke of the protective factor that a cell mate can provide against the risk of suicide. The Crown accepted that there will naturally still be times when a prisoner is alone in the double cell.

[100] The Crown invited the court to make a recommendation that all prison staff involved in interacting with prisoners should have their own personal radio at all times whilst working on a prison wing. This would improve communication between prison staff and reduce the time taken to raise emergency assistance. This might realistically prevent a death in a similar circumstance where the casualty is capable of rescue and time is of the essence.

[101] The Crown invited the court to consider a recommendation that all prison staff working on residential wings should carry ligature cutters, or at least have easy access to them, to reduce the time taken to remove an individual from a ligature. This might realistically prevent a death in a similar circumstance where the casualty is capable of rescue and time is of the essence.

[102] The Crown proposed a recommendation that the SPS and the Health Board (insofar as relevant) make improvements to the Reception Risk Assessment (RRA). The particular improvements suggested were that all parts of the RRA are completed at the appropriate trigger points and refreshers/reminders should be given to all staff involved in the RRA process (both SPS and NHS) to ensure this is complied with.

[103] Finally, the Crown proposed that the court makes a recommendation that SPS takes all steps to ensure that emergency services personnel are expedited through the establishment to the scene of the emergency. This, it was suggested, may involve a formal review of current procedures to ensure they are fit for purpose and consideration of introducing a Key Performance Indicator to monitor and improve (where possible) ambulance access times.

The SPS' submissions re the Crown's proposed recommendations

[104] Due to the current adult prison population and limited availability of cells within the establishments, it is necessary for the adult standard cells to have bunk beds. This is to accommodate the maximum number of prisoners possible and to ensure that every prisoner within HMP Edinburgh has a bed. It is not possible for the SPS to remove all of

the bunk beds within HMP Edinburgh. Due to current overcrowding, SPS establishments need to have bunk beds in adult cells to maximise the number of people they can hold.

[105] There was no evidence led at this inquiry to suggest that all prisoners, or the majority of prisoners, within HMP Edinburgh were at risk of attempting suicide by using their bunk bed as a ligature anchor point. There was no evidence that would justify the removal of all bunk beds from all cells at HMP Edinburgh. This is not a reasonable recommendation and not one that is reasonably capable of being given practical effect.

[106] The Crown's suggestion that no prisoner should be accommodated in a cell with a bunk bed on a single occupancy basis is not feasible. Such a recommendation would not be practical, given the breakdown of the prison population at any given time. The SPS have in place a cell sharing risk assessment and there are prisoners within the establishment who are deemed to be unable to share a cell with other prisoners. The proposed recommendation would create a scenario where most individuals would be sharing a cell. There was no evidence led at this inquiry to suggest that all or the majority of prisoners at HMP Edinburgh were at risk of attempting or completing suicide. There was no justification for creating a situation that would force prisoners to share cells with double bunk beds. It does not make sense to put two prisoners in one cell simply because the cell contains a bunk bed, when otherwise a number of prisoners could get their own cell and living space. A number of the cells with bunk beds across the SPS estate are needed to be used as a short-term contingency measure. Dr Skilling's

evidence was that a cell mate could be a protective factor against a prisoner attempting suicide. His evidence was not that the presence of a cell mate would completely remove that risk. The normal prison regime will also create situations whereby prisoners sharing cells have periods of time where they are alone in the cell. This is not a reasonable recommendation and not one that is reasonably capable of being given practical effect.

[107] There was no evidence to suggest any delay occurred after Mr Morrison's body was found because the officers who unlocked Mr Morrison's cell were not carrying a personal radio. There was no evidence to suggest that the officers not having a personal radio contributed in any way to Mr Morrison's death. SM's evidence was that he would welcome more radios. However, he also gave evidence that at present HMP Edinburgh did not have the necessary facilities to hold and charge a radio for every prison officer working on any given shift. This proposed recommendation would also come with significant cost to the public purse. The recommendation is not reasonably capable of being given practical effect.

[108] The prison officers' evidence in this inquiry was that they chose to untie the ligature used by Mr Morrison, rather than uplifting the ligature cutters which they knew were located in crash packs that they could easily access. There may be security and financial implications for introducing additional cutters into the prison. This line of evidence was not explored in full with any of the witnesses. There was no evidence to suggest that it would be beneficial for prison staff responding to an emergency situation to have ligature cutters on their person. There is nothing to suggest that if the prison

officers who found Mr Morrison had been carrying ligature cutters, this would have prevented Mr Morrison's death. This is not a reasonable recommendation.

[109] Dr Skilling, did not recommend making any changes made to the current RRA process. Linda Pollock's affidavit confirmed that the whole TTM process, including the RRA process, is currently under review. In addition, SM gave evidence that when mistakes or errors are noticed during the existing audit process for RRA forms, then the errors are brought up at staff meetings, communicated in emails to staff or mentioned in one-to-one meetings with the staff involved. Therefore, there is no evidence to support this recommendation. It is not necessary and is not a reasonable recommendation.

[110] There was no evidence to suggest that there was any undue delay in the paramedic reaching Mr Morrison's cell or that the response time contributed to his death. There was no evidence which criticised the current procedures in place at HMP Edinburgh for emergency vehicles arriving at the establishment or that criticised the time it takes for emergency vehicles to get through the security process. No evidence was led which indicated that the current procedures in place for emergency vehicles at HMP Edinburgh was unfit for purpose and required to be reviewed and changed. Ms Pagliarulo confirmed in her evidence that the SPS staff always get the ambulance through security as quickly as possible. SM's evidence was that SPS staff are aware that emergency vehicles must be processed and brought through the establishment as a priority and as fast as possible. No evidence was led by a witness which suggested what different procedures could be put in place to reduce the time for ambulance access without causing a detriment to the overall security of the prison.

There is no available evidence to support this recommendation. This is not a reasonable recommendation and not one that is reasonably capable of being given practical effect.

The Health Board

[111] The Health Board's submissions were that in light of the evidence before the inquiry, there are no matters that would usefully be addressed by any recommendation directed to the board. Any recommendations made by the court can only be those which might realistically prevent future deaths in similar circumstances.

[112] In respect of the Crown's recommendation regarding improvements to the RRA, the Health Board submitted that such a recommendation is not required insofar as it would be directed towards the board. In terms of the TTM guidance in place, the responsibility to hand over the RRA form with the prisoner to the healthcare team, lies with the SPS and not the Health Board.

The POAS

[113] The POAS had no submissions to make.

Decision and reasons

Section 26(2)(a) of the 2016 Act (when and where the death occurred)

[114] There was no dispute about when and where the death occurred. The finding I have made accords with the evidence and the terms of the joint minute.

Section 26(2)(b) of the 2016 Act (when and where any accident resulting in the death occurred)

[115] There was no dispute that Mr Morrison died by suicide. The finding I have made accords with the evidence and the terms of the joint minute.

Section 26(2)(c) of the 2016 Act (the cause or causes of death)

[116] There was no dispute with regard to the cause or causes of death. The finding I have made accords with the evidence and the terms of the joint minute.

Section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in death)

[117] There was no dispute that Mr Morrison died by suicide. The finding I have made accords with the evidence and the terms of the joint minute.

Section 26(2)(e) of the 2016 Act (the taking of precautions)

[118] The Crown has asked the court to make a finding that the removal of the bunk beds from Mr Morrison's cell would have been a reasonable and realistic precaution that may have prevented his death.

[119] The Crown's submission is that the SPS had been aware since at least 2018 of the general risk posed by a single prisoner being accommodated on their own in a cell with bunk beds. Therefore, Mr Morrison should not have been accommodated on his own in cell 2/22 because it had bunk beds.

[120] The SPS' awareness of this general risk was not in dispute. The question then is whether an awareness alone of the general risk would have required or justified the removal of the bunk beds specifically from Mr Morrison's cell. The answer to that question requires an assessment of Mr Morrison's circumstances specifically and the circumstances in HMP Edinburgh more generally at the time he was placed in cell 2/22.

[121] There was no evidence about Mr Morrison's behaviour while he was in HMP Edinburgh in 2022 that suggested there was a risk he would attempt to die by suicide. This is an important factor when assessing whether it would have been a reasonable precaution for the SPS to have removed the bunk beds in his cell prior to his death. Further, Mr Morrison's cell was not a designated single-occupancy cell. Therefore, at any time another prisoner could have been accommodated alongside him in cell 2/22. In fact, Mr Morrison had shared this cell with another prisoner between 7 and 14 April 2022.

[122] As I have set out above, in seeking this finding, the Crown relies on part of a single paragraph from the Polmont Determination. In the section referred to, the sheriff found that it would have been a reasonable precaution for the SPS to have removed double bunk beds in relation to all single occupancy cells for young prisoners in HMPYOI Polmont prior to 2018. The sheriff also found that this step could have been taken relatively cheaply and easily and would not have required substantial capital expenditure. The Crown accepts that the precaution identified was in relation to young prisoners. In terms of the prison rules, Mr Morrison was not classified as a young

prisoner. However, the Crown's argument is that such a precaution would also have been reasonable in respect of an adult prisoner.

[123] The Crown did not lodge a full copy of the Polmont Determination. It runs to 419 pages and that inquiry heard evidence over 19 days. A large number of witnesses gave evidence in person. There was also evidence by way of affidavits and statements. The productions ran to thousands of pages. It was a FAI specifically into the deaths of two young people in HMPYOI Polmont. While the removal of bunk beds was not the only issue considered, it is clear that the precaution identified and the finding made were arrived at with the benefit of a significant body of supporting evidence having been presented to that inquiry.

[124] By contrast at this inquiry, no parole evidence was led about the issue. None of the productions lodged by the Crown regarding bunk beds relate specifically to the death of Mr Morrison. None of the productions were prepared for this inquiry or concern HMP Edinburgh specifically. The statement of Mr McKean is unsigned and undated, although I understand it was prepared for the Polmont FAI. The statement also refers to other reports which Mr McKean prepared but these were not lodged as productions in this inquiry.

[125] The Crown's submissions did not refer to the specific finding made under this section about bunk beds in the Polmont Determination. The finding was that:

> "William could reasonably have not been accommodated alone in a cell with a double bunk bed, which was readily capable of being used as a ligature anchor point without ingenuity or adaptation."

No evidence was led or presented to this inquiry about whether the same would have been the case for Mr Morrison. There was no evidence at all whether, as a matter of fact, the replacement of the double bunk bed in Mr Morrison's cell with a single bed, or his being moved to a cell with only a single bed, could have been done quickly and cheaply. HMPYOI Polmont and HMP Edinburgh accommodate a different number of prisoners. The make-up of the prison population in each establishment is also different. No evidence was led about the impact these two factors would have when assessing whether it was reasonable for the bunk beds in Mr Morrison's cell to have been removed.

[126] Overall, the evidence relied on by the Crown in its submissions about the removal of bunk beds is from some years ago and related to another prison. It does not follow that because a finding was made in another FAI relating to a death by suicide in prison that the same finding can, or should, be made as a matter of course in another similar FAI. Such a finding can only be made on the basis of supporting facts and evidence.

[127] For all these reasons, I do not consider that there was sufficient evidence at this inquiry to make the finding sought by the Crown.

Section 26(2)(f) of the 2016 Act (any defects or any system of working which contributed to the death or the accident resulting in death)

[128] None of the parties proposed that I made a finding under this section. The finding I have made accords with the evidence and the terms of the joint minute.

Section 26(2)(g): Any other facts which are relevant to the circumstances of the death.

[129] I accept that there was evidence led about the two facts which the Crown have identified but I do not consider that either is relevant to the circumstances of Mr Morrison's death. The first fact is that the RRA forms dated 18 March and 22 March 2022 were not correctly completed. However, the evidence was clear that this was not a factor in Mr Morrison's death. The second fact is that the prison officers who found Mr Morrison were not carrying a personal radio. However, this made no meaningful difference to the speed at which the code blue was communicated or to the speed of response by prison staff.

[130] I have therefore made no finding that there were other relevant facts.

Section 26 (1)(b): Recommendations

[131] The Crown have proposed a recommendation that the SPS remove double bunk beds from cells within HMP Edinburgh. Alternatively, the Crown propose a recommendation that no prisoner should be accommodated alone in HMP Edinburgh within a cell with bunk beds.

[132] The continuing use of bunk beds within prisons is clearly an important and complicated issue.

[133] The Crown is critical of what it sees as a lack of action on the part of the SPS in removing bunk beds from prisons generally. The Crown submits that no action has been taken since 2018 by the SPS to address the risk of bunk beds being used as a

ligature anchor point other than at HMPYOI Polmont and that action was only taken because of the Polmont FAI. However, the Crown's submissions make no reference to the affidavit of Linda Pollock. As I have narrated in paras [73] to [77] above, Ms Pollock explained a number of steps which the SPS already has taken and plans to take around the issue.

[134] There was no evidence led at this inquiry about the current cost of removing bunk beds at HMP Edinburgh. There was no evidence about whether the principles and assumptions underpinning the 2019 Costings Report are still valid.

[135] The Crown also invites an alternative recommendation that in HMP Edinburgh there should be no single occupancy of a cell which has bunk beds. The evidence about this issue, from Dr Skilling, does not support such a recommendation. Dr Skilling's evidence was that it would be only one of a range of protective factors which could be put in place. However, it would not entirely prevent a prisoner who wished to die by suicide from doing so. Although no evidence was led about the daily prison regime, I think it can readily be understood that cell mates will not be in each other's company within their cell at all times. There was no evidence to justify a policy that would force prisoners to share a cell when they could have their own cell simply to avoid them being accommodated alone in a cell which had bunk beds.

[136] I do not consider therefore that the evidence before this inquiry is adequate or sufficient to allow me to make either of the recommendations regarding bunk beds within HMP Edinburgh suggested by the Crown.

Availability of personal radios for use by prison officers

[137] The issue regarding the availability to prison officers of personal radios was first raised by the court and not by any of the parties.

[138] In preparation for the first preliminary hearing, I had reviewed the witness statements which had been lodged by the Crown. I was concerned to read that on discovering Mr Morrison's body, ME had required to run to a colleague to ask him to raise the code blue. This was because neither ME nor CP were carrying or had been issued with personal radios. To address my concern, I asked parties to ensure that appropriate witnesses were called to give evidence at the inquiry about this issue.

[139] The evidence at the inquiry clarified that the fact that the prison officers who discovered Mr Morrison's body on 20 April 2022 were not carrying personal radios was not a factor in his death. The concern which I had prior to the inquiry was satisfactorily addressed by the evidence which I heard. While it is true that some of the witnesses indicated they would like prison officers to have a personal radio in addition to a personal alarm, the overall thrust of the evidence was that this would be welcome but not essential. No evidence was led about the costs of implementing the recommendation proposed by the Crown. Neither was there any evidence about what impact, if any, such a recommendation would have on the IT infrastructure of HMP Edinburgh. For all these reasons, I am not prepared to make the recommendation suggested by the Crown.

Ligature cutters

[140] The Crown invited me to make a recommendation that all prison staff working on residential wings should carry ligature cutters or at least have easy access to them. There is no evidence that this not being the case had any impact on Mr Morrison's death. It should be noted that this was not an issue referred to in the various iterations of the Crown's Rule 3.7 Note. More importantly no evidence was led from any witness about the issue. There is no information before the court about the financial impact of such a recommendation or as importantly about the obvious security and safety implications of all prison officers on residential wings carrying a ligature cutter. The evidence was that ligature cutters are already readily accessible and are contained in the crash packs situated at the desk on each landing. There is therefore no basis for making this recommendation.

The Reception Risk Assessment process

[141] The Crown proposed a recommendation that certain improvements are made to the RRA process. There was no evidence that the quality of the various reception risk assessments completed at HMP Edinburgh in respect of Mr Morrison contributed in any way to his death. It is important to remember that the last of these assessments was completed on 30 March 2022. Mr Morrison died on 20 April 2022. He would have been observed by prison staff frequently in the period between these dates. Dr Skilling recognised the shortcomings of certain aspects of the completed assessments but was

not overly critical of them. He did not recommend making any changes to the current procedures.

[142] The evidence before this inquiry was that prison staff and NHS staff working within HMP Edinburgh are already sent reminders about the RRA procedure and receive regular refresher training. The Crown's submissions regarding this recommendation did not refer to Ms Pollock's affidavit. The affidavit confirms that a formal and independent review of the TTM Suicide Prevention policy is already underway. The RRA forms and process will be looked at as part of that review.

[143] I am not satisfied that there is any need or basis on which to make this recommendation.

The speed of paramedic access to HMP Edinburgh

[144] This was another issue which was first raised by the court and not by any of the parties. My concern stemmed from the witness statement of Ms Pagliarulo, the NHS paramedic who was dispatched in response to the 999-call made when Mr Morrison's body was discovered. In that statement which had been lodged by the Crown in advance of the first preliminary hearing, Ms Pagliarulo stated that it had taken her about 10 minutes to "get through security" before she reached Mr Morrison's body. Again, to address my concern, I asked parties to ensure that appropriate witnesses were called to give evidence at the inquiry about this issue.

[145] The evidence at the inquiry clarified that the length of time that it took Ms Pagliarulo from her arrival at the prison gates to reach Mr Morrison was not a factor

in his death. Again, the concern which I had raised was satisfactorily addressed by the evidence led at the inquiry.

[146] The Crown's submissions invite a recommendation that the SPS take all steps to ensure that the time it takes emergency personnel arriving at the prison gates to reach the casualty is as quick as possible. The Crown suggested that might involve a formal review of the current procedure and the introduction of a KPI regarding ambulance access times. However, there was no evidence presented to the inquiry as to what a suitable access time would be. The evidence from SM was that as far as he was aware, no issues or adverse comment had been raised by any paramedic attending an incident at HMP Edinburgh about the time it had taken them to reach the casualty.

[147] I do not think that it is a controversial proposition that a paramedic attending in response to an emergency call at a prison should be able to get from the prison gates to the casualty as quickly as possible. Equally, the security measures within HMP Edinburgh are there for good reason. There was no evidence as to what could safely be done to make the process any quicker. The evidence that was led about this issue suggested that only changes to the physical layout of the prison, eg fewer security gates, would speed up access times. There was no evidence to suggest that the current procedures were unfit for purpose. Further it is not clear to me how a recommendation in such general and aspirational terms could be judged to have been achieved. I am therefore not satisfied that there is any basis to make the recommendation sought by the Crown.

Postscript

[148] Mr Morrison's mother attended the first day of the inquiry. It would have been difficult for her to hear the evidence led on that day. As I did on that occasion, I offer my sincere condolences to her as well as to Mr Morrison's wider family and his friends for their loss.