SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2026] FAI 43

EDI-B1427-25

DETERMINATION

BY

SHERIFF F C M THOMSON

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

into the deaths of

PHILIP QUINN
RICHARD MCCORMICK
ALEXANDER MORGAN

Edinburgh, 3 August 2026

DETERMINATION

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

When and where the deaths occurred

1. In terms of section 26(2)(a) of the Act, Philip Ross Quinn (born 28 July 1970) died on 14 December 2021, aged 51 years old. He died in the Royal Infirmary of Edinburgh, 51 Little France Crescent, Old Dalkeith Road, Edinburgh, EH16 4SA having been

transferred there from HM Prison Edinburgh, 33 Stenhouse Road Edinburgh, EH11 3LN where he was in legal custody.

2. In terms of section 26(2)(a) of the Act, Richard McCormick (born 15 September 1947) died on 19 December 2021, aged 74 years old. He died in the Royal Infirmary of Edinburgh, 51 Little France Crescent, Old Dalkeith Road, Edinburgh, EH16 4SA, having been transferred there from HM Prison Edinburgh, 33 Stenhouse Road, Edinburgh, EH11 3LN where he was in legal custody.

3. In terms of section 26(2)(a) of the Act, Alexander James Morgan (born 22 March 1948) died on 20 December 2021, aged 73 years old. He died in the Royal Infirmary of Edinburgh, 51 Little France Crescent, Old Dalkeith Road, Edinburgh, EH16 4SA, having been transferred there from HM Prison Edinburgh, 33 Stenhouse Road, Edinburgh, EH11 3LN where he was in legal custody.

When and where any accidents resulting in the deaths occurred

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

The cause or causes of the deaths

5. In terms of section 26(2)(c) of the Act, the cause or causes of death of Philip Ross Quinn were: 1a) Hospital acquired pneumonia, 1b) Pneumothorax, 1c) COVID – 19 disease.

6. In terms of section 26(2)(c) of the Act, the cause or causes of death of Richard McCormick were: 1a) COVID – 19 disease, 2) Left neck of femur fracture, Ischemic heart disease.

7. In terms of section 26(2)(c) of the Act, the cause or causes of death of Alexander James Morgan were: 1a) COVID – 19 disease, 2) Emphysema.

The cause or causes of any accidents resulting in the deaths

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

Precautions

9. In terms of section 26(2)(e) of the Act, there were no precautions which (i) could reasonably have been taken and (ii) had they been taken might realistically have resulted in any of the deaths being avoided. There was no accident that resulted in any of the deaths.

System of working

10. In terms of section 26(2)(f) of the Act, there were no defects in any system which contributed to any of the deaths. There was no accident that resulted in any of the deaths.

Other facts relevant to the circumstances of the deaths

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

Recommendations

12. No recommendations are made in terms of section 26(1)(b) of the Act as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

NOTE

Introduction

[1] A fatal accident inquiry was held at Edinburgh Sheriff Court on 25 and 29 May 2026 into the deaths of Philip Ross Quinn, Richard McCormick and Alexander James Morgan. Preliminary hearings took place on 2 December 2025 and 21 January, 18 February and 19 May 2026.

[2] Three parties were represented at the inquiry. Mr Hill, procurator fiscal depute, appeared for the Crown. Ms McDonald, solicitor, appeared for the Scottish Ministers as representing the Scottish Prison Service (the "SPS"). Ms Robertson, solicitor, appeared for Lothian Health Board (the "Health Board"). The inquiry was advised that extensive efforts had been made to engage with the next of kin of Mr Quinn, his sister, but that she was content to be advised by the Crown as to the proceedings and did not wish to

participate directly. The inquiry was advised that the next of kin of Mr McCormick and Mr Morgan had indicated no wish to be involved in any way.

[3] For the purposes of the inquiry parties tendered a signed joint minute of agreement which covered all the evidence, including witness statements, expert reports and other productions which required to be placed before the court. Due to the comprehensive nature of the joint minute, no parole evidence was led.

[4] Parties helpfully lodged written submissions in advance.

[5] All parties invited the inquiry to make substantive determinations only in respect of section 26(2)(a) and (c) of the Act. The inquiry was not invited to make recommendations under section 26(4) of the Act.

The legal framework

[6] The inquiry was held under section 1 of the Act. It was a mandatory inquiry in terms of section 2(4)(a) of the Act as Mr Quinn, Mr McCormick and Mr Morgan were in legal custody at the time of their death. The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (SSI 2017 No 103).

[7] In terms of section 1(3) of the Act, the purpose of an inquiry is to establish the circumstances of the death and to consider what steps, if any, may be taken to prevent other deaths in similar circumstances. Section 26 requires the sheriff to make a determination which in terms of section 26(2), is to set out factors relevant to the circumstances of the death, in so far as they have been established to his satisfaction. These are (a) when and where the death occurred; (b) when and where any accident

resulting in the death occurred; (c) the cause or causes of the death; (d) the cause or causes of any accident resulting in the death; (e) any precautions which could reasonably have been taken and if they had been taken might realistically have resulted in the death being avoided; (f) any defect in any system of working which contributed to the death or to the accident; and (g) any other facts which are relevant to the circumstances of the death. In terms of sections 26(1)(b) and 26(4), the inquiry is to make such recommendations (if any) as the sheriff considers appropriate as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, and (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances. The procurator fiscal depute represents the public interest. An inquiry is an inquisitorial process and the manner in which evidence is presented is not restricted. The determination must be based on the evidence presented at the inquiry. It is not the purpose of an inquiry to establish criminal or civil liability.

Summary

Overview

[8] Philip Ross Quinn (born 28 July 1970) died on 14 December 2021, aged 51 years old. He died in the Royal Infirmary of Edinburgh, 51 Little France Crescent, Old Dalkeith Road, Edinburgh, EH16 4SA having been transferred there from HM Prison Edinburgh, 33 Stenhouse Road Edinburgh, EH11 3LN where he was in legal custody.

[9] Richard McCormick (born 15 September 1947) died at 1920 hours on 19 December 2021, aged 74 years old. He died in the Royal Infirmary of Edinburgh, 51 Little France Crescent, Old Dalkeith Road, Edinburgh, EH16 4SA, having been transferred there from HM Prison Edinburgh, 33 Stenhouse Road, Edinburgh, EH11 3LN where he was in legal custody.

[10] Alexander James Morgan (born 22 March 1948) died on 20 December 2021, aged 73 years old. He died in the Royal Infirmary of Edinburgh, 51 Little France Crescent, Old Dalkeith Road, Edinburgh, EH16 4SA, having been transferred there from HM Prison Edinburgh, 33 Stenhouse Road, Edinburgh, EH11 3LN where he was in legal custody.

Provision of healthcare in Scottish Prisons

[11] On 1 November 2011, responsibility for the provision of healthcare to prisoners was transferred from the Scottish Prison Service to the NHS (under the Health Board Provision of Healthcare in Prisons (Scotland) Directions 2011). Since then, each individual regional NHS health board has been responsible for the delivery of healthcare services within prisons in Scotland which fall within their geographical ambit for the provision of medical care.

DIPLAR

[12] A Death in Prison Learning, Audit, and Review ("DIPLAR") is a process for reviewing deaths in custody. This type of review is completed after the death of any

person in prison custody in Scotland and provides a system for SPS (or private prison operator) and the applicable NHS Board to record any learning and identify actions following a death.

Mr Quinn - Imprisonment

[13] On 23 August 2017 Mr Quinn appeared on petition at Edinburgh Sheriff Court and was remanded in custody. On 5 June 2018 at the High Court of Justiciary at Edinburgh Mr Quinn was convicted of (1) assault to serve injury; and (2) assault to severe injury, danger to life and attempted murder. On 3 August 2018 he was sentenced to 8 years imprisonment, backdated to 23 August 2017. His earliest date of liberation was 21 February 2025. At the time of his death, Mr Quinn was an inmate of HMP Edinburgh. He ordinarily resided within single-occupancy cell 59, Level 1, Ingliston House.

Mr Quinn - Medical care and treatment

[14] Mr Quinn had a history of alcohol and drug misuse. Mr Quinn suffered from arthritis to his right hip, acute pancreatitis, iliac vein thrombosis, pulmonary emphysema and poor mobility. Mr Quinn was awaiting full hip and knee replacement surgery prior to his death and had previously suffered from poor mental health. In 2021, he also began to develop confusion, poor focus and altered memory and cognition. This was attributed to his past alcohol and drug misuse.

[15] Mr Quinn's medication included: Amitriptyline; Nefopam; Methadone; Duloxetine; Omeprazole; and Meloxicam.

[16] Mr Quinn was not vaccinated for COVID-19, having refused the vaccine.

[17] On 22 November 2021, Mr Quinn failed to attend at the medication hatch within Ingliston Hall to receive his daily medication. Due to this, prison nurse Allen Beatson attended at Mr Quinn's cell. Mr Quinn reported that he was unable to walk owing to a wound on the top of his left foot. Mr Beatson noted the foot to be swollen and assessed there to be a possible infection. Mr Quinn refused to allow Mr Beatson to dress the wound and requested antibiotics. Mr Quinn's foot was not assessed again by a doctor or Advanced Nurse Practitioner (ANP) and he was not prescribed antibiotics.

[18] On 24 November 2021, Mr Quinn presented at the medication hatch within Ingliston Hall and was short of breath. Nurse Alan McInally took Mr Quinn's observations which showed his oxygen saturation to be sitting between 50-60%. Nurse McInally radioed for ANP Elaine McAdam to attend as he was concerned for Mr Quinn's breathing. ANP McAdam attended immediately with ANP Amy Dunn and they found Mr Quinn to be seated, pale and short of breath. ANP McAdam and ANP Dunn donned personal protective equipment (noted to be FFP3 masks, visors, aprons and gloves) and took Mr Quinn to a consultation room to be assessed. They took Mr Quinn's full observations including his oxygen saturation, temperature, pulse, blood pressure, blood glucose, and respiration rate. The nurses were concerned with Mr Quinn's oxygen saturation as this was sitting between 60 and 70%. It should have been above 90%. They placed him on high flow oxygen. ANP Dunn noted Mr Quinn to

appear delirious and dehydrated when conducting cognitive and hydration assessments, then listened to his chest, which presented a reduced bilateral air entry, suggesting he either had chest sepsis or COVID-19. As a result, ANPs Dunn and McAdam contacted prison management, and ambulance was arranged to take Mr Quinn to hospital as an emergency.

[19] Whilst waiting for the ambulance, ANPs Dunn and McAdam noticed the aforementioned wound on Mr Quinn's left foot. Mr Quinn had no recollection of this due to his delirium. ANP Dunn noted the wound to be necrotic, approximately the size of a 50 pence piece, red and warm to touch indicating infection.

[20] At 11:50 hours on 24 November 2021, Mr Quinn arrived at the Royal Infirmary of Edinburgh's Emergency Department. Mr Quinn looked unwell and was behaving in a confused manner. Mr Quinn was assessed. His oxygen saturation was found to be 98% whilst still on high flow oxygen. He had his observations taken again. He was also observed to have a pitting oedema to his left knee and a necrotic ulcer on his left foot. Mr Quinn was tested for COVID-19, which returned a positive result. He was taken for a chest x-ray which confirmed that he had COVID Pneumonitis. Mr Quinn was then taken to Ward 204 (the Royal Infirmary of Edinburgh's Respiratory Department) where he was treated with dexamethasone and sarilumab, which was the protocol for patients with severe COVID-19, and was monitored and given supplementary oxygen.

[21] Mr Quinn thereafter had a varying clinical course and was frequently desaturating. On 4 December 2021, Mr Quinn became more confused and paranoid. On 5 December 2021, Mr Quinn's oxygen requirement increased. He was taken for a further

chest x-ray which showed a right-sided pneumothorax. A chest drain was inserted to treat this. Mr Quinn's oxygen saturations briefly stabilised following this, but he quickly desaturated again. On 8 December 2021, Mr Quinn began treatment for hospital acquired pneumonia via intravenous antibiotics. At this point, medical staff attempted to discuss a "Do Not Attempt Cardiopulmonary Resuscitation" (DNACPR) order with Mr Quinn but it was deemed he lacked capacity. A medical decision was made to implement a DNACPR after unsuccessful attempts to contact his next of kin. A DNACPR is a clinical decision that does not require the consent of the NOK.

[22] At approximately 2345 hours on 9 December 2021, Mr Quinn went into respiratory distress and a further chest x-ray showed a reoccurrence of his right-sided pneumothorax. A new chest drain was inserted, and Mr Quinn was treated with maximum oxygen therapy, however he continued to deteriorate. On 12 December 2021, active care ceased and Mr Quinn began palliative care. This included medication through a syringe driver to keep him as comfortable as possible in the circumstances)

Mr Quinn - Death

[23] At 2310 hours on 14 December 2021, Mr Quinn had stopped breathing, and his life was pronounced extinct at 2325 hours by Advanced Nurse Practitioner Jennifer Slight. There was no post-mortem examination conducted on Mr Quinn's body. Dr Rachel Partakis certified the death and cause of death was attributed to:

I(a). Hospital acquired pneumonia

I(b). Pneumothorax

I(c). COVID-19 disease

[24] A DIPLAR meeting was held on 9 February 2022. There were no learning points or actions identified.

Mr McCormick - Imprisonment

[25] On 12 October 2016 at the High Court of Justiciary at Edinburgh Mr McCormick was convicted of multiple sexual offences and remanded in custody. On 30 November 2016 at the High Court of Justiciary at Glasgow he was sentenced to a period of 8 years imprisonment, backdated to 12 October 2016. His earliest date of liberation was 11 April 2024. At the time of his death, Mr McCormick was an inmate of HMP Edinburgh. He ordinarily resided within single-occupancy cell 43, Level 2, Hermiston Hall.

Mr McCormick - Medical care and treatment

[26] Mr McCormick was Type 2 diabetic, a heavy smoker of cigarettes and had previously been a heavy drinker of alcohol. However, he did not have a significant background of ill health until June 2014 when he suffered a heart attack whilst he was working in Doha, Qatar. In July 2014, he underwent a triple heart bypass in Doha.

[27] In November 2018, Mr McCormick was diagnosed with vascular dementia. His health was deteriorating, with Mr McCormick experiencing cognitive decline, disorientation, incontinence, vision deterioration, frailty and frequent falls. He was a known to be at risk of falls and his care plan in place at HMP Edinburgh identified control measures in respect of this. Mr McCormick was cared for by carers from

independent care contractor Robinson Specialist Care and prison nursing staff. He required carers to assist with feeding, hygiene and dressing. He was also provided with mobility aids such as a rollator frame, anti-slip socks, appropriate footwear and a wheelchair.

[28] Mr McCormick's medication included: clopidogrel; lansoprazole; bisoprolol; metformin; sertraline; furosemide; atorvastatin; cocodamol and gliclazide.

[29] On or around 23 February 2021, Mr McCormick received a letter from the Chief Medical Officer advising him to shield, however he declined to do so.

[30] Mr McCormick was not vaccinated for COVID-19, having refused the vaccine.

[31] On 8 December 2021, Mr McCormick suffered an unwitnessed fall in his cell in the early hours of the morning. He was found on the floor of his cell at approximately 0420 hours. A record of who found Mr McCormick has not been located. HMP Edinburgh has no medical or nursing staff working in the prison between 2000 hours and 0700 hours on weekdays and 1700-0700 hours on weekends.

[32] Later in the morning on 8 December 2021, staff nurse Kirsten Sykes, after commencing work for the day at 0700 hours, attended at Mr McCormick's cell to assess him. She had been alerted to his overnight fall at the start of her shift. Ms Sykes' assessment confirmed that Mr McCormick was alert and had no confusion, no pupil abnormality or disorientation, and no dizziness. Mr McCromick advised that he had fallen when attempting to get a drink of water from the sink. His observations were taken and noted to be stable. He complained of left-sided hip pain and was unable to weight bear. Ms Sykes alerted prison management, and a non-urgent ambulance was

requested to take Mr McCormick to hospital at approximately 1120 hours. At this point, Mr McCormick was not presenting with any symptoms of COVID-19.

[33] Mr McCormick arrived by ambulance at the Emergency Department of the Royal Infirmary of Edinburgh at approximately 1647 hours. He was assessed by triage and found his observations to be within normal parameters except his blood pressure which was low. His left hip was tender, and he was unable to straighten or raise his left leg, complaining of pain when attempting to move it. Mr McCormick was sent for a pelvic x-ray which revealed he had a fracture through left neck of femur. As a result, Mr McCormick was transferred to the Orthopaedic Department for surgical repair and placed under the care of Consultant Orthopaedic Surgeon Mr Iain Brown. He was tested for COVID-19 on admission to the Royal Infirmary of Edinburgh and this test returned a negative result.

[34] On 9 December 2021, Mr McCormick was taken to theatre where his fracture was surgically fixated with a dynamic hip screw. The surgery was performed without complication and Mr McCormick initially recovered well. However, soon after Mr McCormick developed what was initially thought to be a chest infection and was treated with antibiotics.

[35] On 11 December 2021, HMP Edinburgh prison staff identified Mr McCormick as a close contact of another prisoner who had tested positive for COVID-19. Prison staff contacted the Royal Infirmary of Edinburgh to advise hospital staff of this. He was tested for COVID-19 on 13 December 2021 and this returned a positive result. It is

unclear whether Mr McCormick acquired COVID-19 in HMP Edinburgh or in the Royal Infirmary of Edinburgh.

[36] On 14 December 2021, Mr McCormick underwent a further chest x-ray which showed signs of COVID-19 infection. Later that day, medical staff attempted to discuss implementation of a DNACPR order with Mr McCormick but this was not possible due to his delirium. They contacted HMP Edinburgh to ascertain whether Mr McCormick had any family with whom they could discuss the matter and HMP Edinburgh staff subsequently confirmed that they had no next of kin details for Mr McCormick and that he had previously made it clear to prison staff that he did not wish his family to be contacted by them. It was the clinical opinion of the medical staff that any attempt at resuscitation would be unlikely to be successful given Mr McCormick's comorbidities and was thus not in his best interests. A DNACPR order was then put in place by clinical fellow Dr Mary Flinn.

[37] Following his positive COVID test, Mr McCormick was treated with oxygen, dexamethasone and toculizumab, however due to his dementia he repeatedly removed his oxygen mask. He was regularly reviewed by respiratory specialists but he did not respond well to treatment and continued to deteriorate over the next few days.

[38] On 17 December 2021, Mr McCormick was moved to the COVID ward (ward 204) before being placed on palliative care, with the use of a syringe driver, as it was deemed that there was no reasonable hope of recovery and this was to ensure he remained pain free.

Mr McCormick - Death

[39] On 19 December 2021 at 1920 hours, Mr McCormick's life was pronounced extinct by Dr Louisa Greenhalgh, Foundation Year 1 Doctor, the Royal Infirmary of Edinburgh. There was no post-mortem examination conducted on Mr McCormick's body. Dr Maria Gabriela Bridger, Foundation Year 1 Doctor, the Royal Infirmary of Edinburgh, certified the death and cause of death was attributed to:

I(a) COVID-19 disease

II Left neck of femur fracture

Ischaemic heart disease

[40] A DIPLAR meeting was held on 9 February 2022. There were no learning points or actions identified.

Mr Morgan - Imprisonment

[41] On 30 March 2015 at the High Court of Justiciary at Glasgow, Mr Morgan was convicted of (1) lewd, indecent and libidinous practices and behaviour; and (2) assault and rape. On 24 April 2015 at the High Court of Justiciary at Edinburgh he was sentenced to a total of 12 years imprisonment, backdated to 30 March 2015. This sentence was reduced to a total of 10 years imprisonment on appeal on 28 July 2015. On 16 March 2021 at the High Court of Justiciary at Glasgow Mr Morgan was convicted of two further charges of lewd, indecent and libidinous practices and behaviour. On 15 April 2021 at the High Court of Justiciary at Glasgow he was sentenced to a further 8 years imprisonment, to run from the expiry of the sentence then being served for his

2015 convictions. His earliest date of liberation was 30 March 2027. At the time of his death, Mr Morgan was an inmate of HMP Edinburgh. He ordinarily resided within single-occupancy cell 46, Level 2, Hermiston Hall.

Mr Morgan – Medical care and treatment

[42] Mr Morgan had a medical history of asthma, cholesterol, skull fracture (1975), migraines, visual impairment (for which he wore glasses) and hearing impairment (for which he had hearing aids in both ears). He was fully mobile and worked as a Pass Man where he would aid with cleaning and stocking within Hermiston Hall.

[43] Mr Morgan had a history of poor mental health. He suffered from depression and anxiety. He resided at Merchiston Hospital mental health facility in Port Glasgow for 9 years before being discharged in 1980. Whilst there, he was diagnosed with a mild learning disability. A further assessment in the community in 2008 confirmed this diagnosis but concluded he could live independently.

[44] Mr Morgan's medication included: nortryptiline; sertraline; simvastatin; and omeprazole.

[45] On or around 23 February 2021, Mr Morgan received a letter from the Chief Medical Officer advising him to shield, however he declined to do so.

[46] Mr Morgan was not vaccinated for COVID-19, having refused the vaccine.

[47] On 8 December 2021, Mr Morgan fell during an external eye appointment. This was not witnessed by prison staff and was not known to prison staff until 9 December 2021. He suffered bruising and swelling on his left hand and was assessed by prison

nursing staff as not requiring an x-ray. Mr Morgan had no history of falling, was independently mobile, and the incident was categorised as a trip, therefore no falls risk assessment was carried out. He was treated with paracetamol for pain relief and a Tubi grip bandage for support.

[48] On 10 December 2021, Mr Morgan awoke in his cell with flu-like symptoms, namely a headache and cough. He was attended to by Advanced Nurse Practitioner Shelley Jones, who was on the wing carrying out COVID-19 tests on prisoners at the time. Ms Jones took nasal and throat swabs of Mr Morgan for lab testing. However, Ms Jones did not have equipment to take his observations as she was merely on the wing to conduct COVID-19 testing. Ms Jones requested for a nursing follow-up to take Mr Morgan's observations. Mr Morgan was placed in isolation in terms of Rule 41 of The Prisons and Young Offenders Institutions (Scotland) Rules 2011.

[49] On 11 December 2021, Mr Morgan's COVID-19 test returned a positive result. Mr Morgan was seen by Nurse Manager Michelle Kinnear, and Advanced Nurse Practitioner Elaine McAdam. Mr Morgan's full observations were taken and he was noted to have low oxygen saturation. The other results from his observations were not properly recorded but were considered to be within normal parameters by the nurses. Nurse Manager Michelle Kinnear made a note in the medical diary for further observations to be taken on 12 December 2021. Mr Morgan was advised to make prison staff aware if he became more unwell in the meantime.

[50] On 12 December 2021, Mr Morgan was seen by nurses Ms Kinnear and Ms McAdam. Mr Morgan's oxygen saturation level was noted to be 81%, which was lower

than it was the previous day. As a consequence of this the nurses arranged for an ambulance to be called to take Mr Morgan to hospital.

[51] At 1541 hours on 12 December 2021, Mr Morgan arrived via ambulance at the Emergency Department of the Royal Infirmary of Edinburgh. Mr Morgan appeared alert and comfortable on oxygen with his saturation levels now noted to be up to 90%. Mr Morgan complained of lethargy, a shortness of breath and of chest pain when he coughed. He was sent for a chest x-ray which showed consolidation of his lower left lobe. As a result of this and his prior positive COVID test, Mr Morgan was transferred to the COVID ward where he was treated with oxygen, dexamethasone and ronapreve.

[52] On the evening of 15 December 2021, Mr Morgan's condition began to rapidly deteriorate. He began to appear more fatigued, unsettled and confused. His oxygen saturation levels dropped again. He resisted attempts to take a blood sample from him for an arterial blood gas reading. He was referred to the Critical Care team.

[53] In the early hours of 16 December 2021, Mr Morgan was assessed for critical care admission. He was noted to be frail and not to be complying with all his treatment. It was considered that admission to the Intensive Care Unit would unlikely affect the outcome.

[54] At approximately 1151 hours on 16 December 2021, Mr Morgan was assessed by Dr James Tiernan, Consultant in Respiratory Medicine. Dr Tiernan noted that Mr Morgan's recent deterioration came one week into his COVID-19 diagnosis, in keeping with the timeline when most of those that were overwhelmed with COVID-19 would deteriorate. Dr Tiernan noted Mr Morgan to be delirious and in a state of

respiratory failure. In his professional opinion, it was apparent that he would not recover. Dr Tiernan took the medical decision to stop active treatment and implement a DNACPR order for Mr Morgan. Attempts were made to contact HMP Edinburgh to obtain details of any next of kin who could be informed of Mr Morgan's condition who ultimately confirmed that he had no next of kin. On 17 December 2021, Mr Morgan was placed on palliative care. He continued to receive care prioritising his comfort over the next few days.

Mr Morgan - Death

[55] On 20 December 2021 at 0010 hours, Mr Morgan's life was pronounced extinct by Dr John Paul Haugh, Foundation Year 2 Doctor, the Royal Infirmary of Edinburgh. There was no post-mortem examination conducted on Mr Morgan's body. Dr Maria Gabriela Bridger, Foundation Year 1 Doctor, the Royal Infirmary of Edinburgh, certified the death and cause of death was attributed to:

I(a) COVID-19 disease

II Emphysema

[56] A DIPLAR meeting was held on 9 February 2022. There were no learning points or actions identified.

Management of COVID-19 in HMP Edinburgh

[57] HMP Edinburgh houses up to 900 prisoners. The prison has five accommodation blocks – Glenesk House (remand prisoners, approximate capacity 180); Hermiston

House (sentenced male prisoners, approximate capacity 300); Ingliston House (sentenced male prisoners, approximate capacity 300); Ratho House (female prisoners, approximate capacity 120); and the Separation & Reintegration Unit (capacity 14). As noted, Mr Quinn resided in Ingliston House, Mr McCormick resided in Hermiston House, and Mr Morgan resided in Hermiston House.

[58] During September 2021, a number of prison staff members tested positive for COVID-19. NHS Lothian's Health Protection Team were informed and carried out risk assessments as appropriate. Eleven prison staff members tested positive between 19 September 2021 and 21 October 2021, with no clear links between them. The first positive case amongst the prisoners was a new admission recorded on 13 October 2021. On 18 October 2021, a further nine prisoners in Glenesk House tested positive. Close contacts of those prisoners were identified, tested and placed under Rule 41 isolation within their cells.

[59] The escalating situation at HMP Edinburgh prompted a "Problem Assessment Group" ("PAG") multi-agency meeting to be convened on 21 October 2021. This meeting was chaired by NHS Lothian Consultant in Public Health Dr Ike Anya and involved representatives from HMP Edinburgh, NHS Lothian and Public Health Scotland. A PAG meeting is the initial response to public health incidents and the purpose is to conduct an initial assessment of the situation to determine whether an "Incident Management Team" ("IMT") is required. At this PAG meeting, it was noted that there had been 26 positive COVID-19 cases amongst the remand prisoners at Glenesk House since 16 October 2021, that a contact tracing process was underway, and

infection prevention and control measures were in place. The PAG resolved not to fix any follow-up meeting at this stage and to continue discussions away from the meeting meantime.

[60] An IMT multi-agency meeting was convened on 1 November 2021. This meeting was chaired by NHS Lothian Consultant in Public Health Dr Ike Anya and involved representatives from HMP Edinburgh, NHS Lothian, Public Health Scotland, and the Scottish Government. At this IMT meeting, it was noted that there had now been 93 positive COVID-19 cases amongst prisoners since 16 October 2021, now across three of the accommodation blocks – Glenesk, Hermiston and Ingliston – and that there had been a further nine staff members to test positive. It was noted that 25 prison staff members were absent from work due to COVID-19 or close-contact isolation. It was noted that it was difficult for the prison to maintain social distancing and to prevent mixing of prisoners. The IMT considered the vaccination rate at HMP Edinburgh to be good. It was resolved that those prisoners who had refused the vaccination would have it offered to them again. It was resolved that the IMT would meet again the following week but this did not happen until 19 November 2021.

[61] A further IMT multi-agency meeting was convened on 19 November 2021. This meeting was chaired by NHS Lothian Consultant in Public Health Dr Ike Anya and involved representatives from HMP Edinburgh, NHS Lothian, and the Scottish Government. At this IMT meeting, it was noted that there had now been 148 positive COVID-19 cases amongst prisoners since 16 October 2021, now across four of the accommodation blocks – Glenesk, Hermiston and Ingliston and the Separation &

Reintegration Unit – and that there had been a further five staff members to test positive. It was noted that good progress was being made with the vaccination of prisoners, and that the NHS vaccination buses would be attending HMP Edinburgh on 8, 9 and 10 December 2021 to offer COVID-19 and influenza vaccination. It was resolved that the IMT would meet again after the vaccination buses attended at HMP Edinburgh on 8, 9 and 10 December 2021.

[62] A further IMT multi-agency meeting was convened on 16 December 2021. This meeting was chaired by NHS Lothian Consultant in Public Health Dr Ike Anya and involved representatives from HMP Edinburgh, NHS Lothian, and the Scottish Government. At this IMT meeting, it was noted that there had been a further 32 confirmed or suspected COVID-19 cases amongst prisoners and staff since 1 December 2021, all across Hermiston House and Ingliston House. It was noted that six prisoners were currently hospitalised with COVID-19 and that one (Mr Quinn) had died. It was noted that the NHS vaccination buses that attended HMP Edinburgh on 8, 9 and 10 December 2021 had provided vaccinations to more than half of the prisoners. It was noted that Hermiston House had mostly elderly residents aged between 60 and 80 years old, that many had underlying health conditions and were being closely monitored. It noted that all but three of the Hermiston House residents had received the COVID-19 vaccination. It was noted that infection prevention and control measures were in place. It was resolved that the IMT would meet again on 23 December 2021.

[63] A further IMT multi-agency meeting was convened on 23 December 2021. This meeting was chaired by NHS Lothian Consultant in Public Health Dr Ike Anya and

involved representatives from HMP Edinburgh, NHS Lothian, Public Health Scotland, and the Scottish Government. At this IMT meeting, it was noted that as at the date of the meeting there were 27 prisoners isolating in terms of Rule 41, with ten having tested positive and five awaiting test results. It was noted that a further nine staff members had tested positive since 19 December 2021 and that seven more were isolating having been identified as close contacts of positive cases outside of HMP Edinburgh. It was noted that two prisoners were currently hospitalised with COVID-19 and that three (Mr Quinn, Mr McCormick and Mr Morgan) had died in hospital. It was noted that infection prevention and control measures were in place. It was resolved that no further IMT meeting would be scheduled but the group would continue to monitor the situation and keep in contact.

[64] NHS Lothian's Health Protection Team maintained regular contact with HMP Edinburgh to provide advice on the implementation of infection prevention and control measures, managing new cases, and continuation of the vaccination programme.

[65] In total, there were 325 confirmed COVID-19 cases amongst prisoners and staff at HMP Edinburgh from 21 October 2021 to 9 May 2022. NHS Lothian's Health Protection Team declared the outbreak over on 9 May 2022, following 28 consecutive days without any positive cases.

[66] During 2024, Caroline Kenny, Lead Nurse for Prison Healthcare Services in NHS Lothian, drafted a Standard Operating Procedure for the prevention and management of falls in the prison setting. This Standard Operating Procedure was effective from 30 July 2025.

[67] In FAI reference EDI-B1674-22 it was stated that the Crown Expert, Julie Bowmaker Gibson had consulted with the NHS lead, Caroline Kenny regarding the creation of a falls prevention and management policy and, having reviewed the Standard Operating Procedure, regarded it as adequate and appropriate.

Conclusions

[68] Mr Quinn, Mr McCormick and Mr Morgan were 51, 74 and 73 years old respectively at the time of their deaths. Each became infected with COVID-19 during a nationwide outbreak and succumbed inter alia to that disease despite their transfer to, or existing presence in, hospital and the treatment received.

[69] Having considered the circumstances of their deaths in the context of the pandemic and the developing understanding of transmission of the disease and the responses required within the prison setting, the steps taken to assess and control spread of the disease in the prison, the steps taken to assess the state of health of each man, and the care and treatment given in both HMP Edinburgh and in hospital, I am satisfied that appropriate care and treatment was provided to Mr Quinn, Mr McCormick and Mr Morgan throughout.

[70] I am satisfied that substantive determinations are appropriate only in respect of paragraphs (a) and (c) of section 26(2) of the Act.

[71] I would add, to those expressed by parties at the inquiry, my own condolences to all family, friends or others who may have been affected by the deaths of Mr Quinn, Mr McCormick and Mr Morgan.