SHERIFFDOM OF LOTHIAN AND BORDERS AT LIVINGSTON

[2026] FAI 42

LIV-B422-25

DETERMINATION

BY

SUMMARY SHERIFF J MACDONALD, ADVOCATE

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

into the death of

RONALD HARRISON

LIVINGSTON, 17 July 2026

For the Crown: Townsend, procurator fiscal depute

For Sodexo: Clark

For NHS Lothian: McGinley

Determination under section 26(2) of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016

When and where the death occurred (section 26(2)(a))

Mr Harrison died at sometime after 1744 hours on 9 April 2022 within Forth Bravo Wing, HMP Addiewell.

When and where any accident resulting in the death occurred (section 26(2)(b))

As above.

The cause or causes of the death (section 26(2)(c))

Mr Harrison died due to acute drug toxicity arising from poly illicit substance misuse, thereby resulting in cardiac arrest, exacerbated by pre-existing cardiomegaly.

The cause or causes of any accident resulting in the death (section 26(2)(d))

Mr Harrison died as a result of ingestion of illicit drugs within HMP Addiewell.

Any precautions which could reasonably have been taken (section 26(2)(e))

None.

Any defects in any system of working which contributed to the death (section 26(2)(f))

None.

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

Not applicable.

Findings in fact

1. That the deceased Mr Harrison was born 31 May 1963. At the time of his death, he was 58 years of age. He was being held in lawful custody at the prison of Addiewell, 9 Station Road, West Calder EH55 8QF.

2. That on 25 June 2021, Mr Harrison appeared on petition at Kilmarnock Sheriff Court. He was committed for further examination and remanded in custody.

3. That on 28 June, 2 July, 6 July, 23 July and 30 July, all 2021, further warrants to detain Mr Harrison in relation to several further charges were granted.

4. That Mr Harrison had a significant schedule of previous convictions, which had resulted in sentences totalling more than 24 years between 1995 and 2020.

5. That Mr Harrison's death occurred between 1800 hours on 9 April 2022 and 0800 hours on 10 April 2022 within cell 38, Forth Bravo Wing, HMP Addiewell. His life was pronounced extinct at 0847 hours on 10 April 2022.

6. That Mr Harrison was subject of "Rule 41" orders on 23 September and 9 December, both 2021, in respect of being suspected as under the influence of a substance within HMP Addiewell.

7. That following Mr Harrison's death, a Death in Prison Learning, Audit and Review ("DIPLAR") was carried out at HMP Addiewell. After any death in custody this type of review is carried out by the Scottish Prison Service and the National Health Service.

8. That on 1 November 2011, responsibility for provision of healthcare to prisoners transferred from SPS to NHS (Health Board Provision of Healthcare in Prisons

(Scotland) Directions 2011). Since then, individual regional NHS health boards have been responsible for delivery of healthcare services within prisons in Scotland which fall within their geographical area for the provision of medical care.

9. That Sodexo operate HMP Addiewell under contract to Scottish Ministers as representing the Scottish Prison Service. HMP Addiewell is operated independently of the rest of the prison estate in Scotland,

10. That Mr Harrison had a long history of substance misuse. He had previously undergone drug addiction therapy during previous periods of imprisonment. He had previously been prescribed methadone, Suboxone and buprenorphine.

11. That Mr Harrison had previously been removed from oral buprenorphine due to concealing it.

12. That Mr Harrison has told NHS staff of his use of illicit substances on multiple occasions.

13. That on 26 June 2021 Mr Harrison had an admission assessment for HMP Addiewell. During same, he admitted that he smoked heroin and crack cocaine. A urine sample returned positive results for opiates, cocaine, benzodiazepines and buprenorphine. Mr Harrison further disclosed his drug use when allocated to his wing at HMP Addiewell.

14. That on 26 July 2021, Mr Harrison had a review of his pre-existing moderate Chronic Obstructive Pulmonary Disease (COPD) and was prescribed with a second inhaler. During said review he reported to healthcare staff that he had been snorting

"subbies" (Suboxone) and pregabalin. Mr Harrison was encouraged to self-refer to the addictions team and was strongly advised against using drugs.

15. That on 21 September 2021 Mr Harrison was assessed as being under the influence of an unknown substance by the prison healthcare team. Mr Harrison was placed on HMP Addiewell's Under the Influence Policy (MOAUP). Mr Harrison was made subject of a Rule 41 order and confined to his cell with 30-minute observations. He was removed from the Rule 41 order the following day.

16. That on 23 September 2021 Mr Harrison was advised to go to hospital by Senior Charge Nurse L Johnstone. He refused. He was placed in isolation and subject to 15-minute welfare observations, under a Rule 41 order as he was showing symptoms of COVID-19.

17. That on 24 September 2021, Mr Harrison attended St Johns' Hospital, Livingston for assessment. He informed staff there that he had smoked spice the previous night.

18. That on 27 September 2021, Mr Harrison was identified as a close COVID-19 contact.

19. That on 28 September 2021, Mr Harrison returned a negative COVID-19 test.

20. That on 29 September 2021, Mr Harrison collapsed in his cell because of respiratory cardiac failure. He was taken to hospital and diagnosed as having suffered a cardiac arrest.

21. That on 25 October 2021, Mr Harrison was listed to attend the addiction clinic but was unable to attend due to a lack of prison officers.

22. That on 28 October 2021, Mr Harrison had a triage with the mental health team. He expressed using Subutex, 3mg daily and indicated a wish to commence on Buvidal, an opioid replacement therapy. He was placed on the "work-up" list for same, a list to prepare patients for commencement on medication or other course of treatment.

23. That on 15 November 2021, Mr Harrison returned a positive drug screen for heroin, buprenorphine, pregabalin and etizolam. He was listed to attend for a treatment assessment.

24. That on 9 December 2021, Mr Harrison was assessed as being under the influence of an unknown substance by the prison healthcare team. He was placed on MOAUP, given a Rule 41 order and confined to his cell with 60-minute observations requiring a verbal response. He was removed from the Rule 41 order on 10 December 2021.

25. That on 17 December 2021, Mr Harrison was assessed as requiring a treatment assessment at the addiction clinic relative to opiate dependence, but the prison was unable to facilitate same due to his wing being in "command mode".

26. That on 29 December 2021, Mr Harrison was unable to be reviewed at the addiction clinic because he was isolating.

27. That on 30 December 2021, Mr Harrison was reviewed by the drug addiction therapy team, who visited him in his cell. He provided two positive drug screens for buprenorphine. He had a treatment assessment for Buvidal. He admitted to using illicit substances. He recognised that he had an issue with buprenorphine and pregabalin and that he had been "knocked out twice" with them. He told the healthcare team that he

wanted treatment, that if he received it he would "feel stable" and would stay away from other substances.

28. That on 6 January 2022, Mr Harrison commenced on buprenorphine, until he changed to Buvidal on 11 January 2022.

29. That on 11 January 2022, Mr Harrison received a 16mg injection of Buvidal and was advised to contact the healthcare team if he required a top-up. Top-up injections are sometimes required at the outset of a course of Buvidal until the correct dosage is established.

30. That on 13 January 2022 Mr Harrison presented to healthcare as under the influence. He requested a top-up of Buvidal and admitted to having illicitly taken buprenorphine.

31. That on 14 January 2022, Mr Harrison received a top-up Buvidal injection. He admitted continuing to illicitly use buprenorphine.

32. That on 18 January 2022, Mr Harrison received a 24mg injection of Buvidal.

33. That on 25 January 2022, Mr Harrison received a 24mg injection of Buvidal. He enquired about moving to a monthly injection, expressing that he felt "rough" on the current dosage.

34. That on 26 January 2022, Mr Harrison was prescribed an 8mg Buvidal top-up and a 32mg Buvidal prescription commencing 1 February 2022. He reported having taken illicit pregabalin for discomfort and irritability. He was advised not to use illicit substances over and above his prescription medication.

35. That on each 1, 8 and 15 February 2022, Mr Harrison received a 32mg injection of Buvidal.

36. That on 21 February 2022, Mr Harrison received a 32mg injection of Buvidal.

37. That on 21 February 2022, Mr Harrison received 128mg injection of Buvidal.

38. That on 28 February 2022, Mr Harrison reported using illicit pregabalin, when available, for treatment of pain.

39. That on 21 March 2022, Mr Harrison received a 128mg Buvidal injection from trainee Advanced Nurse Practitioner Julie Cameron. Mr Harrison informed Ms Cameron that he was struggling as his dose was wearing off. He said he was using illicit pregabalin on the wing. Ms Cameron discussed with him the risks associated with taking pregabalin.

40. That Mr Harrison was due a further 128mg Buvidal injection on 18 April 2022.

41. That at about 1000 hours on 9 April 2022, Mr Harrison was seen by PCOs Bagcheband and Lewty making toast in the pantry area of the wing.

42. That shortly thereafter, Mr Harrison took his toast back to the landing outside his cell and threw it from the top of the landing across the wing. PCOs Bagcheband and Lewty placed him in his cell and requested healthcare attend to assess Mr Harrison for being under the influence.

43. That on same date, Charge Nurse Alison Forbes attended at Mr Harrison's cell and assessed him. She noted his observations to be within normal range. Mr Harrison was noted as capable of holding a normal conversation and lacked slurred speech or incoherence. Mr Harrison asked for pregabalin to be re-prescribed. Ms Forbes

explained that it would not be re-prescribed as he had previously misused that and other substances. Ms Forbes made a clinical decision not to place Mr Harrison on any form of observations.

44. That around 1730 hours on same date, PCO Lewty attended at Mr Harrison's cell. He entered the cell to check on Mr Harrison because Mr Harrison was sleeping and not responding to his verbal check. PCO Lewty woke Mr Harrison up and obtained a verbal response from him.

45. That around 1744 hours on same date, PCOs Lewty and Bagcheband carried out a further welfare and look check. Upon checking Mr Harrison's cell, the officers found Mr Harrison in bed sleeping and snoring.

46. That HMP Addiewell does not have a formal locking and unlocking policy. A training package is delivered to staff on keys and locks.

47. That on 9 April into 10 April 2022, PCOs Hunter and Howard conducted the back and night shifts. Mr Harrison did not come to their attention and had not been placed on their observation list.

48. That approximately 0805 hours on 10 April 2025, during the morning unlocking of cells, PCOs Bagcheband and Dorward attended at Mr Harrison's cell, opened the cell door and called out to him. Upon receiving no response, they entered the cell and found Mr Harrison lying on his bed, fully clothed and unresponsive. PCO Bagcheband touched his arm which he felt to be cold.

49. That PCO Bagcheband called a "code blue" over the radio to summon assistance. A "code blue" signifies an individual experiencing severe breathing difficulties and who may be unresponsive.

50. That at approximately 0810 hours same date, Charge Nurse Alison Forbes and Staff Nurse Michaela Rennie responded to the code blue arriving at Mr Harrison's cell shortly thereafter. No signs of life were found. The medical staff noted a congealed brown substance around Mr Harrison's left nostril and mouth.

51. That Forbes and Strachan noted an empty biro pen with white powdery residue within, papers rolled up into a small tube, a blade from a razor on the desk and white residue on the desk itself within the cell.

52. That CPR was not commenced due to a lack of any signs of life and rigor mortis having already set in.

53. That Paramedic Craig Steel attended HMP Addiewell in response. He attended alone due to the call being to the effect that Mr Harrison had died. Upon arrival at Mr Harrison's cell and examining the body, Steel was satisfied that Mr Harrison was deceased because of the presence of rigor mortis, hypostasis and post-mortem staining. Steel pronounced Mr Harrison's life as extinct at 0847 hours.

54. That powder seized from Mr Harrison's cell was subsequently analysed as buprenorphine. Two and a half small white tablets were found within Mr Harrison's right trouser pocket. These were subsequently analysed and found to be dihydrocodeine and buprenorphine.

55. That on 26 April 2022 a post-mortem examination of Mr Harrison's body was conducted by Consultant Forensic Pathologist Dr Robert Ainsworth. Blood and urine samples were obtained which were sent for toxicological analysis. These showed the presence of buprenorphine, its metabolite norbuprenorphine, etizolam and its metabolite alpha-hydroxyetizolam, flubromazepam, dihydrocodeine and mirtazapine, along with two cocaine metabolites in Mr Harrison's blood. Toxicological examination of Mr Harrison's urine showed the presence of buprenorphine and norbuprenorphine.

56. That Dr Ainsworth concluded that there were two potential pathologies that would have been of direct relevance to Mr Harrison's death. Firstly, death may have been due to "acute drug toxicity … resulting in respiratory failure and cardiac arrest". Secondly, death may have been associated with Mr Harrison's cardiomegaly "with his elevated heart size increasing his risk of suffering sudden cardiac death at any time". This may have been likely to occur after the use of cocaine.

57. That cause of death was certified as 1 a) multi-drug intoxication and cardiomegaly.

58. That HMP Addiewell has various measures in place to prevent illicit substances entering the prison.

59. That the Management of an Offender at Risk due to any Substance ("Sodexo MORS") policy came into force at HMP Addiewell on 1 January 2018. The policy was replaced by the SPS MORS policy on 13 August 2024.

60. That under Sodexo MORS, where a member of staff identifies an offender who is suspected of being at risk due to any substance, the guidance requires the following process to be followed:

a. Completion of the Observation Referral within Appendix A;

b. Healthcare staff should examine the offender and provide details of an appropriate care plan within the form provided at Appendix C. This should include the frequency of observations, and when the offender will be reviewed by healthcare staff.

c. A multi-disciplinary case conference should be convened with a SPCO officer and a nurse to discuss and agree upon future management of the offender. This should take place as soon as practicable and should be documented in the form provided at Appendix D.

d. PCOs should carry out observations in accordance with the care plan, and record there within the form provided at Appendix E. Officers are responsible for carrying out general observations that monitor the offender's need for medical intervention. If the offender's condition deteriorates, they should alert the SPCO and if necessary, contact ambulance services.

e. Healthcare should follow up on an offender placed on MORS within 24 hours. Once healthcare staff are satisfied that the offender is no longer at risk due to any substance, observations should be discontinued.

61. That Mr Harrison was not on observations under the MORS at the time of death. In the morning of 9 April 2022, PCOs Bagcheband and Lewty called for healthcare to perform a check due to concerns that he was presenting as under the influence of a substance. Charge Nurse Alison Forbes deemed his observations to be normal. She did not consider him to have shown any sign of being under the influence of any substance and so did not place him on MORS. No further action was taken.

62. That the SPS MORS policy was introduced on 20 December 2014 but had not been implemented at HMP Addiewell at the time of Mr Harrison's death. It was subsequently implemented on 13 August 2024. New staff at HMP Addiewell receive training on SPS MORS. The purpose of SPS MORS is to provide assurance that offenders are being appropriately managed and receiving an appropriate level of care to ensure preservation of life.

63. Under SPS MORS, where a member of staff identifies an offender who is suspected of being at risk due to a substance, the following process requires to be followed:

a. Completion of the Observation Referral within Appendix A;

b. Healthcare staff should attend immediately to assess the offender. They should undertake an assessment to establish the substance taken;

c. Healthcare staff should provide details of an appropriate care plan within the form provided in Appendix C. This should include the frequency of observations, the type of observation, and when the offender will be reviewed by healthcare staff;

d. A multi-disciplinary case conference should be arranged by the residential first line manager with health representation to discuss and agree future management of the offender. This should take place within 24 hours and should be documented on the form within Appendix E;

e. Prison officers should carry out observations in accordance with the care plan and record these within the form provided within Appendix D. Officers are responsible for carrying out general observations that monitor the offender's need for medical intervention. If the offender's condition deteriorates, SPS staff should contact health centre staff immediately;

f. A completed narrative of events in writing should be made available at handover for oncoming staff;

g. Once healthcare staff are satisfied that the offender is no longer at risk due to any substance, observations should be discontinued.

64. That SPCOs and PCOs at HMP Addiewell are not medically qualified. There is training provided on SPS MORS which is now in place at HMP Addiewell. They are trained on how to respond if they identify someone as being at risk from substance. The content of the training is contained within the MORS training package.

65. That a Death in Prison Learning, Audit and Review ("DIPLAR") was conducted by Sodexo, the SPS and NHS. The DIPLAR identified several learning points/recommendations to take forward, namely:

a. NHS and Sodexo communication regarding sharing information may require review to ensure all staff managing the care of residents are aware of the risks associated with individuals at risk due to a substance;

b. The lock up procedure should be reviewed with consideration given to clarifying what level of response is appropriate;

c. Consideration should be given to provide colleagues with more information on signs and clues of drug use to help them identify indicators of particular concern.

Note

Introduction

[1] The Fatal Accident Inquiry was held on 27 April 2026 within Edinburgh Sheriff Court.

[2] The court heard one parole witness, Mr Steven Little, HMP Addiewell.

[3] All documents were agreed within joint minutes of agreement.

Evidence

[4] All documentary productions in the inquiry were a matter of agreement.

[5] The inquiry heard evidence from a single witness, namely Mr Steven Little.

[6] Mr Little is the safety unit manager at HMP Addiewell. He has held that role for 5 years and has worked at the prison for 16 years in total. Among Mr Little's responsibilities is substance misuse reduction.

[7] The witness informed the court that on the date of Mr Harrison's death there had been 70 prisoners located on the upper landing of the Forth Bravo wing at HMP Addiewell, some 8 beyond capacity. Two PCOs were allocated to take charge of the entire wing on any shift. Their role, the witness explained, included moving prisoners to various activities, conducting patrols of the landing, looking out for prisoners under the influence and those engaged in subversive behaviour.

[8] Mr Little was shown the CCTV depicting the upper landing of Forth Bravo (Crown Label production 1). He confirmed that the time stamp on those recordings was broadly accurate, with perhaps a disparity of some 2 minutes. He explained further that the CCTV footage was not viewable by the officers on duty within the wing, instead it was administered in a different part of the prison.

[9] Mr Little recognised Mr Harrison at approximately 3.00pm on the CCTV system, walking along the landing in the direction of his cell at approximately 3.00pm. The impression of the witness was that Mr Harrison was unsteady on his feet. Mr Little expressed the view that had he seen this footage at the time; he would have sought the assistance of the healthcare team for Mr Harrison. The witness suggested that Mr Harrison's demeanour may have been due to him being under the influence of a substance.

[10] The witness agreed that in the morning of the same date, Mr Harrison had been placed behind the door of his cell to await medical investigation as he had been suspected of being under the influence. However, the nurse who had subsequently assessed him that morning had found Mr Harrison's presentation to have been normal.

Mr Little explained that this finding brought the investigation to an end. He said therefore Mr Harrison was not subject to any residual observations on the afternoon or evening of 9 April 2022.

Submissions

[11] It was common ground between all parties that I should make a formal determination in relation to Mr Harrison's death.

Decision and reasons

[12] Before turning to the reasons for my determination, I take this opportunity to express my condolences to Mr Harrison's family for their loss.

[13] Mr Harrison had a long history of illicit poly-substance abuse within a custodial setting.

[14] Mr Harrison was last seen alive when his cell was locked before 6.00pm on 9 April 2022. On that occasion he was asleep and snoring. He was depicted on CCTV at approximately 3.00pm on the same date as unsteady on his feet. Some hours earlier, prison staff had suspected that he was under the influence of a substance. This suspicion had not been confirmed on medical examination.

[15] There was no evidence led to suggest in any way that the medical finding by Charge Nurse Forbes in the morning was inaccurate. The evidence of Mr Harrison's demeanour depicted at 3.00pm on the same date however suggests that following upon

his medical assessment, Mr Harrison did in fact consume illicit substances and was under the influence of same by 3.00pm that day.

[16] Further, the presence of illicit drugs and paraphernalia within Mr Harrison's cell when his body was discovered suggest that Mr Harrison had either consumed more illicit drugs following upon his cell door being locked, or at least that he had intended to. By dint of the fact that Mr Harrison's drug use was illicit albeit documented within HMP Addiewell, it is reasonable to infer that he would have not openly advertised his drug consumption to prison staff. There was no suggestion in the evidence of his having been caught in the act of taking illicit substances. On the contrary, the largest contributor in the evidence to the prison intelligence regarding Mr Harrison's drug use was Mr Harrison himself in after the fact admissions.

[17] The above issue, taken together with the toxicological findings from the post-mortem samples in conjunction with the fact that when his body was discovered, he was in possession of illicit substances, amply permit the drawing of an inference that Mr Harrison lost consciousness and died in his cell at some point after 5.29pm when his cell door was locked. By the time he was discovered the following morning, rigor mortis had set in. In my judgement it is probable that he had died closer in time to the locking of the cell door than its opening.

[18] Mr Harrison had an enlarged heart at the time of his death. He was consequently at a high risk of sudden death. In my judgment, the evidence permits the inference that he had taken illicit substances in the early afternoon of the date of his death and again later then his cell door was closed. Drugs paraphernalia was found in

his cell when his body was discovered. This repeat dose could readily have resulted in acute toxicity and cardiac arrest, to which Mr Harrison was significantly predisposed due to his existing cardiac issue.

[19] At the time of Mr Harrison's death, he was not subject to any specific monitoring. On the morning of the date of death, he had been assessed as not being under the influence by a charge nurse, notwithstanding concerns of prison staff to the contrary. This assessment had removed him from the prison's applicable MORS policy. Staff at HMP Addiewell had accordingly acted in accordance with the applicable policy at the time of locking his cell in the evening of the date of his death.

[20] Following Mr Harrison's death, a DIPLAR review was conducted. It highlighted issues of communication between disciplines and the need for an improvement in the training of non-medically qualified staff as to the potential signs of drug use and intoxication.

[21] I do not however consider that the above DIPLAR finding would have brought about a different outcome had the recommended practice been in placed on 9 April 2022. On the evidence, prison staff had indeed identified and communicated their suspicions that Mr Harrison had been under the influence of a substance in the morning of 9 April due to unusual behaviour on his part. Those suspicions were reported to medical staff. A subsequent medical examination had in essence held those suspicions to have been unfounded.