SHERIFFDOM OF GRAMPIAN HIGHLAND AND ISLANDS AT PETERHEAD

[2024] FAI 17

PHD-B197-23

DETERMINATION

BY

SHERIFF ROBERT MCDONALD

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

into the death of

WILLIAM DUNCAN KIRKWOOD

PETERHEAD, 22 DECEMBER 2023

Determination

The Sheriff having considered the information presented at the inquiry determines as follows:

1. In terms of section 26(2)(a) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act"), that William Duncan Kirkwood died at 1426 hours on 29 April 2022 within Cell 15, Delta section of Ellon Hall, level 2 of HMP Grampian, South Road, Peterhead;
2. In terms of Section 26(2)(c) of the Act, that the cause of death was due to hanging, with no other significant injuries, and no significant natural disease found.

3. In terms of Section 26(2)(e) there were no precautions which could reasonably have been taken which might realistically have resulted in the death being avoided.

4. In terms of Section 26(2)(g) there are no other facts which are relevant to the circumstances of the death.

Recommendations

In terms of 26(1)(b) of the Act, no recommendations are made.

NOTE

Introduction

[1] The Inquiry was held under the Fatal Accidents and Sudden deaths etc. (Scotland) Act 2016 ("the Act") into the death William Duncan Kirkwood ("Mr Kirkwood")

[2] The Inquiry is a mandatory inquiry under section 2(4)(a) of the Inquires into the Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, death having occurred while the deceased William Duncan Kirkwood, born 25 June 1971, was in legal custody within HMP and YOI Grampian.

[3] The first notice in the Inquiry was lodged by the Crown on 22 December 2023.

[4] There was a preliminary hearing on 14 February 2024 and the hearing of the Inquiry took place on 18 April 2024.

[5] Prior to the preliminary hearing the following parties indicated their intention to participate at the inquiry:

Grampian Health Board;

The Scottish Ministers acting through the Scottish Prison Service;

The Prison Officers Association Scotland.

[6] At the hearing of the Inquiry the Crown was represented by Mr Andrew Hanton, Procurator Fiscal Depute with Cockburn, Advocate for Grampian Health Board, Rodgers, Solicitor, for the Prison Officers Association of Scotland and Richmond, Solicitor, for the Scottish Ministers acting through the Scottish Prison Service. Mr Kirkwood's daughter and next of kin and Mr Kirkwood's former partner were also in attendance at the hearing as observers.

The evidence

[7] In advance of the hearing the participants entered into a Joint Minute of Agreement. The Procurator Fiscal Depute also lodged a number of productions. The participants were agreed that no evidence required to be led and Mr Hanton read out the terms of the Joint Minute for the record. The hearing of the Inquiry was conducted by means of a Webex video conference.

[8] The participants were agreed that I should make no more than a formal determination under Sections 26(2)(a) and 26(2)(c) of the Act and I was satisfied that this was appropriate in the circumstances as indicated above.

The statutory framework

[9] The Inquiry is held under section 1 of the Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act") and is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 rules"). The purpose of such an Inquiry is set out in section 1(3) of the 2016 Act and is to:

(a) establish the circumstances of the death, and;

(b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

[10] Section 26 of the 2016 Act states, among other things, that:

(1) As soon as possible after the conclusion of the evidence and submissions in an Inquiry, the sheriff must make a determination setting out –

(a) in relation to the death to which the Inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection,

and

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

(2) The circumstances referred to in subsection 1(a) are –

a) when and where the death occurred;

b) when and where any accident resulting on the death occurred;

c) the cause or causes of the death;

d) the cause or causes of any accident resulting in the death;

e) any precautions which –

(i) could reasonably have been taken, and

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

f) any deficits in any system of working which contributed to the death or any accident resulting in the death;

g) any other facts, which are relevant to the circumstances of the death.

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

(a) if the precautions were not taken, or;

(b) as the case may be, as a result of the defects.

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

(a) the taking of reasonable precautions;

(b) the making of improvements to any system of working;

(c) the introduction of a system of working

(d) the taking of any other steps which might realistically prevent other deaths in similar circumstances.

[11] The procurator fiscal represents the public interest. An Inquiry is an inquisitorial process and it is not the purpose of an Inquiry to establish civil or criminal liability.

Issues for the Inquiry

[12] In the Notice of The Inquiry lodged by the Procurator Fiscal on 22 December 2023 the Crown indicated that it was anticipated that the Inquiry would give consideration to the following issues:

i. To determine when and where the death occurred in terms of section 26(2)(a) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016; and

ii. To determine the cause or causes of death in terms of section 26(2)(c) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016.

Summary of facts

[13] I found the following facts admitted or proved:

1. That William Duncan Kirkwood (born 25 June 1971), hereinafter referred to as "the deceased", was remanded on petition warrant at HMP Grampian, Peterhead, on 18 November 2020, following an appearance at Aberdeen Sheriff Court and was allocated Cell 15 within the Delta section of Ellon Hall on level 2 on a single occupancy basis.

2. That the deceased underwent a risk assessment by a trained prison officer following his most recent appearance in court on 31 January 2022 when he stated that he was not suicidal and had no thoughts of self-harm. He was assessed as being at no apparent risk and, as such, no additional healthcare risk assessment was carried out as per the protocol.

3. That at about 1100 hours on 29 April 2022 the deceased began work within the pantry at the said HMP Grampian, finishing at between 1130 and 1145 hours, same day, before returning to his cell at which time the cell door was locked by a prison officer.

4. That at about 1345 hours, same day, the door to the deceased's cell was unlocked by a prison officer, with the occupant of the adjacent cell, Y, exiting his own cell and looking for the deceased within the communal area of the hall.

5. That having failed to locate the deceased, the said Y attended at the deceased's cell and found him hanging from a blue ligature attached to the shower room door within the cell. The deceased was lifeless.

6. That the said Y exited the deceased's cell in a distressed state and a prison officer then entered the said cell and found the deceased as described, thereafter raising the alarm by using his prison radio to call out a "code blue" which relates to an individual who is experiencing severe breathing difficulties and may or may not be unresponsive, requesting attendance

from other prison staff, NHS staff and that an ambulance be called when instructed.

7. That appropriate lifesaving efforts were made but without success and at 1426 hours, same day, life was pronounced extinct by a prison GP, Dr Graham Strachan.

8. That between 31 January 2022, when the most recent reception risk assessment was carried out, and 29 April 2022 when the deceased died, no concerns were raised by any prison officer about the deceased's wellbeing.

9. That no suicide note was discovered and there is nothing to suggest why the deceased chose to end his life.

10. That the death of the deceased was reported to the Procurator Fiscal at Aberdeen on 1 May 2022.

11. That the body of the deceased was subject to a postmortem examination by Dr Leighanne Margaret Deboys, Senior Lecturer in Forensic Medicine, on 6 May 2022 at Aberdeen Mortuary, and it was her considered opinion that he died due to hanging, with no other significant injuries, and no significant natural disease found to account for his death.

Conclusion

[14] The formal findings I am required to make in terms of the Act are set out at the beginning of this determination. There were no matters in dispute at this inquiry and I

am grateful to the participants for their assistance in producing the Joint Minute of Agreement setting out the agreed facts.

[15] Finally I would again express my condolences to Mr Kirkwood's family and his former partner for their sad loss.