SHERIFFDOM OF NORTH STRATHCLYDE AT KILMARNOCK

[2024] FAI 12

KIL-B472-23

DETERMINATION

BY

SUMMARY SHERIFF LAURA MARGARET MUNDELL

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

into the death of

WILLIAM HERON

KILMARNOCK, 28 FEBRUARY 2024

Determination

The Sheriff, having considered all the evidence presented at the Inquiry and the submissions of parties, determines, in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths Etc. (Scotland) Act 2016 ("the 2016 Act"), that:

1. **In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred):**

   William Heron, born 22 August 1969, died between 03.00 hours and 08.00 hours on 19 April 2021 within cell G36, at His Majesty's Prison, Kilmarnock. Life was formally pronounced extinct at 08.26 hours.

2. In terms of section 26(2)(a) of the 2016 Act (where and when any accident resulting in the death occurred):

Mr Heron's death did not result from an accident.

3. In terms of section 26(2)(c) of the 2016 Act (the cause or causes of death):

The cause of Mr Heron's death was:

I (a) Hanging

4. In terms of section 26(2)(d) of the 2016 Act (the cause of any accident resulting in the death):

Mr Heron's death did not result from an accident.

5. In terms of section 26(2)(e) of the 2016 Act (the taking of precautions):

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

6. In terms of section 26(2)(f) of the 2016 Act (defects in any system of working):

There were no defects in the system of working within HM Prison, Kilmarnock which contributed to Mr Heron's death.

7. **In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death):**

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

Recommendations:

1. **In terms of section 26(1)(b) of the 2016 Act (recommendations (if any) 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 steps which might realistically prevent other deaths in similar circumstances):**

   There are no recommendations made.

NOTE

Introduction

[1] This is an Inquiry into the death of Mr William Heron, who died on 19 April 2021, within his cell at HM Prison, Kilmarnock. He was aged 51 at the time of his death. As Mr Heron was in legal custody at the time of his death, this is a mandatory Inquiry in terms of section 2(4)(a) of the 2016 Act.

The Legal Framework

[2] This Inquiry is held under section 1 of the 2016 Act. In terms of section 1(3) of the Act, the purpose of an Inquiry is to establish the circumstances of death and consider

what steps, if any, might be taken to prevent other deaths in similar circumstances. The Inquiry is an inquisitorial process. In terms of section 1(4) of the Act, it is not the purpose of the Inquiry to establish civil or criminal liability.

[3] A Preliminary Hearing was held on 17 October 2023. The Inquiry was held on 18 December 2023, in person, at Kilmarnock Sheriff Court.

[4] Ms Allan, Procurator Fiscal Depute, represented the Crown. The Scottish Prison Service was represented by Ms Turner, Solicitor. Serco Limited were represented by Mr Kane, Solicitor Advocate.

[5] Although Mr Heron's family were not formal participants at the Inquiry, his three sisters attended Kilmarnock Sheriff Court to observe the Inquiry. One of his sisters was also present at the Preliminary Hearing.

[6] The circumstances surrounding Mr Heron's death were not in dispute and the evidence before the Inquiry was not contentious. All of the evidence was agreed in advance in a substantial Joint Minute of Agreement. I accepted all of the facts set out in the Joint Minute of Agreement. No witnesses gave parole evidence at the Inquiry.

[7] Also before the Inquiry was the following information:

- Crown Production 1: Intimation of Death Form relating to Mr Heron
- Crown Production 2: Post Mortem Report relating to Mr Heron prepared by Consultant Pathologist Lorna Cottrell and Dr Kate Tilley, dated 11 May 2021
- Crown Production 3: The Death in Prison Learning, Audit and Review (DIPLAR) Report relating to Mr Heron's death

- Crown Production 4: The Death in Prison Learning, Audit and Review (DIPLAR) Action Plan relating to Mr Heron's death
- Crown Production 5: The NHS Adverse Event Review Report relating to Mr Heron's death
- Crown Production 6: The NHS Adverse Event Review Action Plan relating to Mr Heron's death
- Crown Production 7: Book of Photographs of Mr Heron's cell area
- Crown Production 8: Prison Records relating to Mr Heron
- Crown Production 9: Handwritten letter addressed to Mr Heron's former partner
- Crown Production 10: Handwritten letter addressed to one of Mr Heron's sisters
- Crown Production 11: CCTV Viewing Log from 19 April 2021
- Crown Production 12: NHS Prison Healthcare Records relating to Mr Heron
- Crown Production 13: Prisoner Medical Consultation Records relating to Mr Heron's time in HM Prison, Kilmarnock
- Crown Label 1: CCTV Footage from 19 April 2021
- Crown Label 2: Recording of Mr Heron's Prison Phone Calls

Background and Mr Heron's circumstances

[8] At the time of his death on 19 April 2021, Mr Heron was on remand at HM Prison, Kilmarnock awaiting trial on a summary complaint in relation to eight charges in contravention of section 57(1) of the Civic Government (Scotland) Act 1982 and four charges of theft of a motor vehicle. Mr Heron had pled not guilty to these charges at Kilmarnock Sheriff Court on 9 April 2021. An intermediate diet had been assigned for 28 April 2021 and a trial diet had been assigned for 5 May 2021. On 9 April 2021, Mr Heron was remanded in custody pending his trial.

[9] Mr Heron had a significant number of previous convictions. He had previously spent periods on remand and been sentenced to custodial sentences throughout his life. Mr Heron had previously been imprisoned within HMP, Kilmarnock in 2017, in 2019, and in 2020. He had also spent period of imprisonment or remand in HM Prisons, Inverness, Barlinnie, Dumfries, and Addiewell. Prior to his remand on 9 April 2021, Mr Heron's most recent period of imprisonment was at HMP, Kilmarnock from 24 December 2020 until 9 March 2021.

Mr Heron's time within HMP, Kilmarnock

[10] At the time of his admission to HMP, Kilmarnock on 9 April 2021 the "Prisoner Escort Record" (PER) recorded that Mr Heron had "drugs/alcohol issues", was a known user of heroin, and suffered from depression. On arrival the PER was handed to Prison Officer Craig McGregor who carried out a prisoner admission interview with Mr Heron, alongside mental health nurse Kirsty Fingland who carried out a healthcare assessment.

[11] The prisoner admission interview raised no immediate concerns. A Talk To Me assessment was carried out with Mr Heron as part of the prison's suicide prevention strategy. Mr Heron's mood was noted to be good. He was recorded to have good eye contact, rapport, and communication throughout the assessment. He did disclose that he had a history of depression, however he reported that he had no thoughts of suicide or deliberate self-harm at that time. As a result of this assessment Mr Heron was recorded as "no apparent risk" on the Talk To Me paperwork. Mr Heron was allocated to cell 36 on G wing. This was a double occupancy cell. Mr Heron shared this cell with prisoner "JF".

[12] During the healthcare assessment, Kirsty Fingland carried out observations on Mr Heron, including blood pressure, temperature, weight, and height. It was recorded that he had good eye contact and rapport throughout and that he denied any thoughts of suicide or deliberate self-harm, although he did again report a history of depression. Mr Heron also reported that he smoked and consumed alcohol, heroin, cannabis and valium. He said he had last consumed drugs two days prior to his admission to prison on 7 April 2021. A drug urine screening taken at this time tested positive only for benzodiazepines. Mr Heron was recorded as not appearing to be experiencing any withdrawal symptoms. No immediate concerns were identified during this assessment.

[13] On 10 April 2021 Mr Heron had a routine medical appointment and was reviewed by Dr Paul Dunlop. Mr Heron confirmed again at this time that he had no thoughts of suicide or deliberate self-harm. During this review he was prescribed a diazepam detox, which is a gradual decreasing prescription of diazepam, due to his

reported drug misuse and the results of the urine screening. No other medication was prescribed to him at the time of his admission and no other concerns were raised.

[14] Mr Heron was not known to any community mental health team or addictions team at the time of his admission to HMP, Kilmarnock, and there were no self-referrals, or referrals made on his behalf, for any addictions or mental health support during his time at HMP, Kilmarnock.

[15] On 15 April 2021 the prison healthcare team received a medical application from Mr Heron. This advised that he was experiencing regular stomach pain which was affecting his sleep, general wellbeing, and his state of mind. The application stated that Mr Heron wished to speak to a prison doctor as soon as possible. The application was reviewed by Dr Paul Church on the same day and Mr Heron was prescribed Omeprazole 20mg for a period of one month. Dr Church issued a letter to Mr Heron confirming the prescription and advising that the stomach pain likely related to poor diet and his history of drug misuse. The letter also advised Mr Heron to speak to the healthcare staff again after this date should the issue continue. Mr Heron was provided with a single dose of Omeprazole on 16 April 2021, and on 17 April 2021 he was given a seven-day supply on an "in-possession" basis. However, as a result of his diazepam detox prescription, which was provided daily in person, Mr Heron had face to face contact with healthcare professionals each day.

[16] No issues arose in relation to Mr Heron during his time in custody, and no intelligence was received by the prison to indicate that there were any concerns regarding Mr Heron.

[17] Prior to being remanded to HMP, Kilmarnock on 9 April 2021, Mr Heron had been in a relationship with "WS" for a period of around two years. Whilst in custody, Mr Heron had access to a telephone within his cell. He used this telephone frequently to make calls, with most calls being made to "WS".

[18] On 18 April 2021, Mr Heron spoke to "WS" by telephone on several occasions throughout the day. During these calls "WS" told Mr Heron that she wished to end their relationship. Their last call was at around 22.40 hours on 18 April 2021, which ended with Mr Heron stating that this would be the last time that "WS" heard from him. Mr Heron thereafter attempted to call "WS" several times, with all calls going to voicemail. He subsequently left three voicemails for "WS" at around 22.55 hours and 23.28 hours on 18 April 2021, and finally at 00.05 hours on 19 April 2021. During the voicemail at 00.05 hours on 19 April 2021, Mr Heron stated that this would be the last call and the last time that "WS" would hear his voice.

[19] Calls made from all cells were recorded by the prison however were not listened to in live time. As such, prison staff were not aware of the nature of these calls prior to Mr Heron's death.

The day of Mr Heron's death – 19 April 2021

[20] Mr Heron was last seen alive at approximately 03.00 hours on 19 April 2021 by his cellmate "JF". Around this time, "JF" woke up and observed Mr Heron listening to the radio, which was not unusual. "JF" asked Mr Heron if he was okay. Mr Heron responded that he was fine. "JF" then went back to sleep.

[21] At approximately 07.45 hours on 19 April 2021, Prison Officers Ashley Hardcastle and Carol Aherns began carrying out the morning roll count on G Wing. PO Hardcastle began unlocking and entering each cell, counting the number of prisoners within, and providing the number to PO Aherns, who was filling out the count sheet. On attendance at Mr Heron's cell G36, PO Hardcastle visually counted "one" prisoner and provided this number to PO Aherns, who recorded it on the count sheet. When the roll count was concluded it was noted that 73 prisoners had been counted, however the number for that particular count should have been 74. PO Hardcastle checked the handover book and established that cell G36 should have two prisoners instead of one.

[22] PO Aherns returned to cell G36 and opened the door, entering the cell. She spoke to "JF", who was lying on the bottom bunk, and asked if his cellmate was on the top bunk. "JF" replied that Mr Heron was there and PO Aherns left the cell without having completed a visual confirmation. PO Aherns could not see the top bunk due to her height and the darkness of the cell. The roll count sheet was updated, confirming the presence of two prisoners in cell G36.

[23] At around 08.00 hours PO Aherns re-attended at the deceased's cell in order to open the cell for the medication round. PO Aherns opened the cell door, shouted to the occupants that it was morning medication, and then left, leaving the door ajar, to continue opening other cells. At this time Mr Heron's cellmate "JF" got out of bed and looked at the top bunk but could not see Mr Heron. "JF" then went to the toilet within the cell, thinking this was the only place Mr Heron could be, and pushed the door open.

"JF" saw that Mr Heron was hanging by a ligature from behind the toilet door. "JF" immediately ran out of the cell and shouted for help from the staff members present on G wing.

[24] PO Hardcastle was the first to arrive at cell G36, closely following by Prison Officer Courtney Hamilton. On arrival, "JF" stated to PO Hardcastle: "I think he's dead". PO Hardcastle entered the toilet area within the cell and observed Mr Heron hanging behind the door. Mr Heron had used a piece of bedding as a ligature. PO Hardcastle called a "code blue, prisoner hanging" over her prison issue radio. PO Hardcastle and PO Hamilton managed to retrieve Mr Heron from this position and place him on the floor, commencing cardiopulmonary resuscitation (CPR). PO Aherns also attended at the cell, alongside Prison Officers Amy McGillivray and Mollie MacKenzie, and Custodial Operations Manager, James Philipson.

[25] Prison nurses Graham Trundle and Fraser Woodrow, and mental health nurse Kirsty Fingland, all attended at cell G36 in response to the "code blue" call. On their arrival, Mr Heron was lying on the floor of the cell with his legs in the toilet area of the cell. He was showing no signs of life. His skin was discoloured and he appeared to have been deceased for some time, with rigor mortis evident in his jaw, legs, and arms. CPR was continued by the healthcare staff, assisted by Custodial Operations Manager, James Philipson, and a defibrillator was attached which showed "no shockable rhythm".

[26] A call was placed to the Scottish Ambulance Service at around 08.10 hours, with a first responder paramedic arriving at cell G36 at around 08.25 hours. The paramedic entered the cell and attached an electrocardiogram (ECG) to Mr Heron which confirmed

that he was "asystole" there being no cardiac output. It was agreed by all healthcare professionals present that further CPR and treatment should cease.

[27] Mr Heron's life was pronounced extinct at 08.26 hours on 19 April 2021.

[28] At 08.28 hours cell G36 was secured and the cell door double locked. Police Scotland were notified of Mr Heron's death and CID officers Craig Semple and Nicola Fraser attended at the prison, arriving at around 10.35 hours on 19 April 2021. Also in attendance was a scenes of crime photographer who arrived at approximately 11.19 hours. Photographs were taken of Mr Heron's body in situ and of the contents of the cell. A private ambulance arrived at around 12.44 hours and Mr Heron's body was removed from the cell and conveyed to the mortuary at Crosshouse Hospital, Kilmarnock.

[29] Later in the day on 19 April 2021, mail which was received at HMP, Kilmarnock addressed to Mr Heron, failed the initial security checks with a positive indication via a drug dog. The mail was opened and found to contain two A4 sheets of paper and 15 pounds in cash. The contents failed the Rapiscan itemiser test, indicating positive results for cocaine. The mail was thereafter forwarded to Police Scotland. Records detail a similar incident during an earlier period in custody within HMP, Kilmarnock in August 2020.

Cause of death

[30] A post mortem examination was undertaken by Dr Kate Tilley and Consultant Pathologist, Dr Lorna Cottrell on 26 April 2021 at the mortuary at Crosshouse Hospital. The cause of Mr Heron's death was hanging.

Search of Mr Heron's home

[31] Five days prior to Mr Heron's death, on 14 April 2021, facilities workers for North Ayrshire Council had attended at Mr Heron's temporary accommodation in Irvine in order to clear the property as a result of Mr Heron being remanded to prison. Mr Heron's personal property was bagged and returned to one of Mr Heron's sisters, following his death on 19 April 2021. Within Mr Heron's property were two handwritten letters which had been found within Mr Heron's flat. The letters had not been read by the council workers who had cleared the property on 14 April 2021. One handwritten letter was addressed to Mr Heron's former partner "WS", and the other letter was addressed to one of Mr Heron's sisters.

[32] The letter addressed to Mr Heron's former partner "WS" discussed many aspects of their relationship. The letter addressed to Mr Heron's sister was marked "private" and also discussed Mr Heron's relationship with "WS". Both letters were undated and it is therefore unclear exactly when they were written by Mr Heron prior to his arrest on 8 April 2021.

Review of Mr Heron's death by the Scottish Prison Service and SERCO Ltd

[33] Following Mr Heron's death, a review was carried out of the telephone records relating to his calls. Mr Heron had made 119 outgoing calls between his admission to HMP, Kilmarnock on 9 April 2019 and his death on 19 April 2021. The majority of these calls were to "WS", although some calls were made to other friends. The final call made by Mr Heron was the voicemail he left for "WS" at approximately 00.05 hours on 19 April 2021.

[34] On 21 July 2021 a Death in Prison Learning, Audit & Review (DIPLAR) was undertaken into Mr Heron's death. This was overseen by the Assistant Director of Business Services and Governance for SERCO. NHS Ayrshire and Arran were also involved with the DIPLAR, as were representatives from the Scottish Prison Service and other stakeholders. The DIPLAR noted that Mr Heron had been a medium risk prisoner during his time on remand, received no breach of discipline, and no complaints were submitted by Mr Heron as part of the Prisoner Complaints Procedure.

[35] One recommendation which resulted from the DIPLAR process was that consideration should be given to the monitoring of telephone calls from within cells during the night time period. Training was subsequently given to some staff members within the Dedicated Search Team in accessing and monitoring calls within the prisoner telephone system. However, such monitoring would be controlled and limited, and would only occur following a particular concern being raised in respect of a prisoner.

Review of Mr Heron's death by NHS Ayrshire and Arran

[36] NHS Ayrshire and Arran also carried out their own internal review into Mr Heron's death, and the healthcare and treatment he received whilst in custody. The NHS internal review noted that Mr Heron made no self-referrals for addictions or mental health support during his period on remand and that he was not known to the community mental health or addictions teams at the time of his admission to HMP, Kilmarnock. He was not prescribed any regular medication by his GP. It was noted that, during Mr Heron's time in HMP, Kilmarnock between 9 April 2021 and 19 April 2021, there was no record of any member of prison staff raising any concerns regarding Mr Heron's mental health or ability to maintain his own safety.

[37] One recommendation which resulted from the NHS Ayrshire and Arran internal review was that all admissions to HMP, Kilmarnock should be given the opportunity to refer to the mental health and/or addictions team at the time of admission, and that staff undertaking the admission process should be prompted to ask all prisoners in relation to this. As a result, a change was made to the reception paperwork to include a section for generating a mental health referral at the time of admission. The Prison Healthcare Admission local operating procedure was updated to reflect this change.

Issues raised by Mr Heron's Family

[38] Although they were not formal participants at the Inquiry, Mr Heron's three sisters were present in court at the Inquiry. The Procurator Fiscal Depute, Ms Allan, helpfully highlighted in her closing submissions, three issues that had been raised by

Mr Heron's sisters in the lead up to the Inquiry which they wanted the Inquiry to be made aware of.

[39] The first issue Mr Heron's family wished to raise was that they considered that the cell shared by Mr Heron and his cellmate "JF" was not properly checked on the morning of 19 April 2021. They felt that Prison Officer Aherns ought to have ensured she received a verbal response from Mr Heron himself, and had sight of Mr Heron within the cell, before leaving to carry out other cell checks. On their behalf, the Procurator Fiscal Depute noted that it was accepted by the family of Mr Heron that while this would have been unlikely to have led to a different outcome, nonetheless they considered it an example of poor practice in the undertaking of the task of carrying out cell checks.

[40] The second issue Mr Heron's family wished to raise related to a matter following the death of Mr Heron which was not covered by the terms of the Joint Minute of Agreement presented to the Inquiry. Mr Heron's family had advised the Procurator Fiscal Depute during the preparation for the Inquiry that Mr Heron's cellmate "JF" had been able to make contact with individuals outside the prison, via the in-cell telephone, after Mr Heron's body had been discovered. "JF" had provided certain information to those individuals regarding the events of 19 April 2021, all prior to Mr Heron's family being formally notified by the prison that Mr Heron had died. Although this is an issue which occurred after Mr Heron's death, and as such is not a matter which falls directly within the scope of the Inquiry, the Procurator Fiscal Depute noted that it was a matter which had caused considerable distress to the family of Mr Heron.

[41] The third and final issue that Mr Heron's family wished to highlight was in relation to the clearance of Mr Heron's property by North Ayrshire Council and the process by which the contents of the letters, written by Mr Heron prior to his remand to prison, were dealt with. They considered it a matter of regret that the contents of the letters were not able to be considered, or acted upon, prior to Mr Heron's death.

[42] In relation to the second and third points raised by Mr Heron's family, it was not submitted or suggested on their behalf that any reasonable precautions could have been taken, that may have altered the outcome in relation to Mr Heron's death. Rather the points were raised on behalf of Mr Heron's family to ensure that the Inquiry was aware that these matters had caused them additional distress following Mr Heron's death.

Submissions

[43] The Procurator Fiscal Depute, the solicitor for the Scottish Prison Service, and the solicitor advocate for Serco Ltd, all asked me to make formal findings in terms of section 26(2)(a) and section 26(2)(c) of the Act only.

Conclusions

[44] On the basis of the evidence before the Inquiry, I am satisfied it is appropriate to make the formal findings noted at the start of this determination in terms of section 26(2)(a) and section 26(2)(c).

[45] I have found no precautions which, had they been taken, might have prevented Mr Heron's death, and I have found no defect in any system of working which contributed to his death. I have no recommendations to make.

[46] I am grateful to all those who assisted the Inquiry, in particular to Ms Allan for the careful and sensitive manner in which she presented the agreed evidence at the Inquiry, and for the time she had obviously taken to communicate with Mr Heron's sisters in preparation for the Inquiry.

[47] At the outset of the Inquiry, I extended my condolences to Mr Heron's family. All parties to the Inquiry expressed their own condolences to Mr Heron's family and friends during the course of their submissions. I offer my sincere condolences once again to Mr Heron's family, and all those affected by his death, but especially to his three sisters on the loss of their brother, William.