SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2026] FAI 46

GLW-B440-26

DETERMINATION

BY

SUMMARY SHERIFF ANNA REID

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

into the death of

ARCHIBALD HUNTER

Glasgow, 20 August 2026

The summary sheriff, having considered the evidence and information presented at an inquiry on 28 July 2026 and submissions thereon, under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act"), finds and determines that:

Statutory findings

1. In terms of section 26(2)(a) of the Act, Archibald Hunter ("Mr Hunter") died on 14 June 2024 at 2130 hours at Glasgow Royal Infirmary.

2. In terms of section 26(2)(b) of the Act, no accident took place and therefore no finding requires to be made.

3. In terms of section 23(2)(c) of the Act, the causes of death were

(i) Infective exacerbation of chronic obstructive disease;

(ii) Congestive heart failure

4. In terms of section 23(2)(d) of the Act, there was no accident and therefore no finding requires to be made.

5. In terms of section 26(2)(e) of the Act, there were no precautions which could reasonably have been taken which might realistically have resulted in Mr Hunter's death being avoided.

6. In terms of section 26(2)(f) of the Act, there were no defects in any system of working which contributed to Mr Hunter's death.

7. In terms section 26(2)(g) of the Act, there are no facts which are relevant to the circumstances of Mr Hunter's death.

Recommendations

The summary sheriff having considered the information presented at the inquiry, makes no recommendation in terms of section 26(1)(b) of the Act.

NOTE:

Introduction

[1] This was a mandatory inquiry held under section 2(4) of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act") as a result of Archibald Hunter ("Mr Hunter") having died while in legal custody, being a prisoner

at His Majesty's Prison Barlinnie, 81 Lee Avenue, Glasgow ("HMP Barlinnie"), at the time of his death. A preliminary hearing was held, in person, on 1 May 2026. The inquiry was held via Webex on 28 July 2026.

[2] Charlotte Watt, procurator fiscal depute, represented the Crown. James Halley solicitor, represented the Scottish Ministers, acting on behalf of the Scottish Prison Service ("SPS"). Mr Hunter's next of kin did not participate in the inquiry, though asked to be updated afterwards.

The legal framework

[3] This inquiry was held in terms of sections 1 and 2 of the Act and was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 Rules").

[4] In terms of section 1(3) of the Act, the purpose of the inquiry is to establish the circumstances of death and to consider what steps, if any, may be taken to prevent any other deaths occurring in similar circumstances. Section 26 requires the sheriff to make a determination which, in terms of section 26(2), is to set out the factors relevant to the circumstances of death, in so far as they have been established to her satisfaction. These are found at section 26 of the Act and reads as follows:

> "(1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out—
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> (a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and
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> (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers 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 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—
(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 defects 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.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to—
(a) a participant in the inquiry,
(b) a body or officeholder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature."

[5] The procurator fiscal represents the public interest. An inquiry is an inquisitorial process. 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 (section 1(4) of the Act).

Evidence and information made available to the inquiry

[6] All of the facts were agreed between the parties and were contained in a joint minute lodged with the court.

[7] The following Crown productions were lodged and admitted into evidence:

(i) Intimation from registrar, detailing the cause, time and place of death;

(ii) Death in custody records;

(iii) Death in Prison Learning, Audit and Review ("DIPLAR");

(iv) Medical records relating to Mr Hunter.

[8] The following witness statements were provided and admitted into evidence:

(i) Dr Claire Wood, consultant, rheumatology, Glasgow Royal Infirmary;

(ii) James Hampsay, prison custody officer.

Facts

[9] Mr Hunter was born on 9 September 1944 and died on 14 June 2024. Mr Hunter was 79 years old when he died.

[10] At the time of his death Mr Hunter was serving a sentence of imprisonment at HMP Barlinnie. On 14 March 1968, when he was 23 years old, Mr Hunter was sentenced to life imprisonment at the High Court of Justiciary in Edinburgh in respect of murder and assault. On 1 March 1979, having applied successfully for parole, Mr Hunter was released on licence.

[11] On 12 January 2018, Mr Hunter was convicted after a jury trial at Glasgow Sheriff Court, in respect of sexual offences. His bail was revoked. On 2 February 2018, Mr Hunter was sentenced to 27 months' imprisonment.

[12] On 9 July 2018, the Parole Board revoked Mr Hunter's licence and directed he be detained within HMP Barlinnie on life recall.

Underlying health conditions

[13] Mr Hunter suffered from a number of medical issues throughout his life and during his time in prison, including:

(i) Chronic Obstructive Pulmonary Disease ("COPD")

(ii) Atrial fibrillation

(iii) Diabetes

(iv) Prostate cancer

(v) Heart failure

[14] COPD is a lung condition which causes breathing difficulties. Atrial fibrillation is a heart condition which causes an irregular and often fast heartbeat.

Medical care and treatment

[15] Mr Hunter became increasingly frail during his time at HMP Barlinnie.

[16] Mr Hunter was supported by carers from Ailsa Care Services daily with washing and dressing.

[17] Mr Hunter had a "do not attempt cardiopulmonary resuscitation" ("DNACPR") direction in place, counter-signed by a senior clinician on 5 March 2024, being an instruction to medical staff not to try to re-start his heart in the event of his heart or breathing stopping.

Previous admission of Mr Hunter to hospital

[18] On 20 April 2024 Mr Hunter was assessed within HMP Barlinnie. He appeared to be breathless. Observations were taken by prison staff, who became concerned about possible heart failure.

[19] An ambulance was ordered and Mr Hunter was taken to Glasgow Royal Infirmary. Mr Hunter was kept in the acute assessment unit overnight on 21 April 2024. Mr Hunter was thereafter transferred to the cardiology department. Mr Hunter remained in hospital until 20 May 2024.

[20] Mr Hunter received treatment for heart failure, pneumonia and poor swallowing. Compassionate release was considered. However, Mr Hunter's condition improved and he returned to HMP Barlinnie.

Circumstances of Mr Hunter's death

[21] On 9 June 2024, Mr Hunter was "wheezy" during the morning drug round carried out by healthcare staff at HMP Barlinnie. Mr Hunter was given his inhaler, and his observations were taken for monitoring.

[22] Mr Hunter began to complain of chest pain radiating to his back and shortness of breath which was not alleviated with inhalers. An emergency ambulance was called by prison staff.

[23] Mr Hunter's condition continued to deteriorate. Paramedics arrived to assess him.

[24] Mr Hunter was transferred to Glasgow Royal Infirmary. He was admitted to ward 20, under the care of Dr Claire Wood, consultant, rheumatology.

[25] Mr Hunter continued to receive treatment within the hospital. Notwithstanding that treatment, Mr Hunter deteriorated further.

[26] Mr Hunter died on 14 June 2024. Life was pronounced extinct at 2130 hours.

Cause of death

[27] Mr Hunter's cause of death was (i) Infective exacerbation of chronic obstructive disease and (ii) Congestive heart failure. Additional significant contributing factors were identified as (i) Fast atrial fibrillation and (ii) Type II diabetes mellitus.

Death in Prison Learning, Audit, and Review ("DIPLAR")

[28] A DIPLAR is a process for reviewing deaths in custody. It provides a system for the SPS and NHS to record any learning and identify actions following a death.

[29] On 1 August 2024 a DIPLAR was carried out in relation to Mr Hunter's death. There were learning points identified in relation to notification procedures after death. Nothing substantive was identified in relation to Mr Hunter's care.

Submissions

[30] The Crown and SPS submitted that only formal findings in terms of the Act should be made. No findings in terms section 26(2)(e), (f) or (g) were sought, nor any recommendations.

Findings and recommendations

[31] Having considered all of the evidence in this inquiry, I consider that Mr Hunter died of natural causes. I consider there to be no evidence to suggest any precautions which could reasonably have been taken whereby Mr Hunter's death might realistically have been avoided; nor any defects in any system of working which contributed to his death. I have no recommendations to make.

[32] As invited by the procurator fiscal and SPS, I have made formal findings in respect of sections 26(2)(a) and (c) as set out within the statutory findings section above.

[33] I am grateful to the solicitors involved for their professionalism in investigating matters, seeking agreement of evidence and preparing focussed submissions.

[34] Finally, I wish to express my condolences to Mr Hunter's family and friends, which were echoed in the submissions made by the procurator fiscal and by the SPS.