

Under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

Determination

by

Sheriff Andrew Christie Normand , Sheriff of Glasgow and Strathkelvin

in the Fatal Accident Inquiry into the death of

Walter Semple

Glasgow, 16 March 2009

The Sheriff, having heard evidence, determines that

1. In terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 Walter Semple, born 2 April 1971, 29B Hardridge Road, Glasgow, died at about 2.30 pm on 23 April 2006 within the Waterside Miners' Club, Duntiblae Road, Kirkintilloch.
2. In terms of section 6(1)(b) of the Act the primary cause of death was restraint asphyxia, and a contributory cause was acute alcohol intoxication.
3. In terms of section 6(1)(c) of the Act the reasonable precautions, if any, whereby the death or any accident resulting in the death might have been avoided – no finding.
4. In terms of section 6(1)(d) of the Act the defects, if any, in any system of working which contributed to the death or any accident resulting in the death – no finding.
5. In terms of section 6(1)(e) any other facts which are relevant to the circumstances of the death – The events that culminated in Mr Semple's untimely death followed directly from the commission by Mr Semple of a serious criminal offence involving an imitation firearm within the Waterside Miners' Club on 23 April 2006. The deceased had consumed a considerable quantity of alcohol.

(Signed) Andrew C Normand

NOTE

The Inquiry

1. Following a series of preliminary hearings in the period between March and August 2008 the hearing of evidence in the Inquiry commenced on 1 September 2008 and continued until 4 September 2008. The Inquiry was adjourned and the hearing of evidence resumed on 12 January 2009 and was concluded on 13 January. I heard evidence from the witnesses shown in the list annexed to this Determination. At a hearing on 3 March 2009 parties' submissions were presented to the court, written submissions having been previously lodged and circulated. I am grateful for the very helpful participation in the Inquiry of the Divisional Procurator Fiscal Mr Green, for the Crown, Mr Brown, Solicitor representing Mrs Anne Semple and the family of the deceased, and Mr Hennessy, Solicitor Advocate for the Chief Constable, Detective Inspector Wilson McMillan and Police Constable Peter Anderson.

Summary of Events

2. The death of Walter Semple occurred following an incident in the Waterside Miners' Club, Duntiblae Road, Kirkintilloch on Sunday 23 April 2006. The deceased was a visitor in the club and was drinking there. He had in his possession a handgun, which was a realistic imitation firearm. He presented the gun at another person in the club and threatened to shoot him. Two off-duty police officers, Peter Anderson and Wilson McMillan, who were members of the club, were informed that the deceased was in possession of a handgun in the club and had threatened to shoot a person in the club. They seized hold of the deceased and attempted to restrain him, detain him and remove him from the club. When the deceased struggled with them they ended up in a lounge of the club where other club members became involved in trying to assist in detaining the deceased. There, immediately following the removal from the person of the deceased of a handgun, the deceased resisted restraint, a struggle ensued and the deceased fell to the floor along with the two off-duty police officers and other club members. While being restrained on the floor by the two off-duty police officers and four other club members Mr Semple suffered a cardiac arrest as a result of asphyxia and died.

The Cause of Death

3. Walter Semple died while being restrained on the floor of a lounge in the Waterside Club in Kirkintilloch. I heard evidence from several witnesses of the circumstances in the "quiet lounge" (as it was described) immediately preceding Mr Semple's death – in particular the circumstances pertaining to the position of the deceased and other persons on the floor of the lounge. The other persons on the floor were Peter Anderson, Wilson McMillan, Daniel McPhee, Thomas Scott, John Moore, Stuart Marshall. In addition to those witnesses, James Whiteford and John Miller (the deceased's nephew) also gave an account of the incident in the lounge. No two accounts were the same. Several of the versions were reasonably similar. Two were significantly different. I do not intend to rehearse the various versions.

4. Notwithstanding the differences in their accounts the witnesses were, in my assessment, generally trying to recollect and describe the events honestly to the best of their ability. Their descriptions of the circumstances were clearly dependent on the particular physical positions from which they observed events. The accuracy and reliability of their accounts may have been affected by the passage of time, the unexpected, dramatic and indeed traumatic circumstances in which they were involved. There was one witness of whose credibility and reliability I was less sure - John Miller. He gave his evidence in a somewhat agitated and confused manner and there were discrepancies between his evidence in court and what he told the police. His was the only account that suggested any form of assault on the deceased. I did not find that evidence credible and I am unable to regard Mr Miller's evidence as reliable in view of its inconsistency with not only the evidence of the other eye-witnesses, but also the expert medical evidence – including that of Professor Busutill.

5. My conclusion from the evidence is that the situation whereby the deceased and others were on the floor of the lounge was an accidental, rather than a deliberate or planned situation. It was not a case of those detaining and restraining him – in particular the two off-duty police officers - deliberately placing Mr Semple on the floor as part of the exercise of restraining him while awaiting the arrival of the police. The deceased and those holding onto him ended up on the floor because the deceased's struggles while being held beside the bar in the lounge resulted in him and others losing their balance and falling to the floor. This, I consider, is relevant to the causation of Mr Semple's death because all parties, including the deceased, found themselves in positions which were not of their deliberate choosing – and which as events turned out were not well suited to the continuing restraint of the deceased. The accident of the deceased and those restraining him falling to the ground unintentionally created a situation that proved to be hazardous to the deceased - because of the positioning of the various parties, the continuing attempts to restrain the deceased and the deceased's continuing efforts to resist such restraint, which efforts I recognize at some stage may have been efforts to prevent asphyxia.

6. The death was caused as a result of asphyxia. This was probably caused by a combination of pressure on the chest of the deceased while he was being restrained on the ground in the lounge and physical restraint of the deceased. A factor which contributed to his death was the consumption of alcohol by the deceased prior to the incident. This had the effect of shortening the time required to lead to his asphyxiation.

7. The cause of death was originally certified by the pathologists who carried out the autopsy, Dr Clark and Dr Hatter, as 1. Crush Asphyxia; 2. Acute Alcohol Intoxication

8. However, when he gave evidence Dr Clark stated that, having had the various accounts of the circumstances described to him, he was now of the view that the cause of death was "Restraint Asphyxia", rather than "Crush Asphyxia" as that condition is normally understood.

9. In his view death was due to a combination of factors connected with the deceased being restrained on the ground – namely, he was probably face down, there may have been some weight on his back, he had a high blood alcohol level which can depress the brain and make it vulnerable to lack of oxygen, the circumstances were stressful – causing high adrenalin, which can cause the heart to stop.

10. Dr Clark felt able to exclude strangulation because of the absence of injury to the neck and throat. On reflection, this was not a true case of crush asphyxia. There had been a lesser degree of compromise of breathing, but this was combined with a high level of alcohol and stress. His

conclusion was that this was a case of situational asphyxia occurring while the deceased was being restrained. For that reason he had now concluded that the cause of death was "Restraint Asphyxia", rather than "Crush Asphyxia".

11. The deceased's post mortem blood analysis showed the level of alcohol as 257mg/100ml, and urine analysis showed 299mg/100ml. This according to Dr Clark was a high level, indicative of substantial intoxication.

12. Professor Busuttil gave evidence on behalf of Mrs Semple and the deceased's family. His expert opinion was in accord with Dr Clark's.

13. Although it appeared from the expert evidence that "Crush Asphyxia" and "Restraint Asphyxia" are almost synonymous I have decided, in light of the pathologists' evidence, that the appropriate finding as to the primary cause of death is "Restraint Asphyxia". I was satisfied that the evidence fully justified the finding that the contributory cause of death was acute alcohol intoxication. As noted above, the death was accidental.

Reasonable Precautions whereby the death and any accident resulting in the death might have been avoided

14. The Procurator Fiscal submitted that the evidence that I had heard did not justify any findings under this heading.

15. Mr Brown made submissions about two aspects of the circumstances of Mr Semple's death which, he argued, justified findings by the Court under this heading. These related, firstly, to the manner in which Mr McMillan and Mr Anderson dealt with the deceased and secondly, failures of the management of the club.

16. Mr Hennessy submitted that this finding primarily relates to precautions of an organisational or systematic nature. His position in relation to the first of the matters raised by Mr Brown was that there were no circumstances giving rise to the restraint of the deceased which could have been avoided by the exercise of reasonable precautions. He raised for consideration a matter related to Mr Brown's second submission.

17. Mr Brown's first submission was that if the two Police Officers, Mr McMillan and Mr Anderson, had dealt with the problem as if they had been on duty, sought the assistance of colleagues, planned the detention of the deceased and identified themselves (as police officers) the outcome may have been different. If, he submitted, they had conducted themselves as if they were on duty, had sought assistance and prevented others becoming involved the death may have been avoided. Interpreting Mr Brown's submissions in terms of reasonable precautions, I took his position to be that precautions which would have been reasonable in the circumstances and which might have prevented the accidental death of Mr Semple were for Mr McMillan and Mr Anderson to have phoned the police to seek assistance from on-duty officers before they themselves took action to detain the deceased, for them to have planned their intervention before taking action, for them to have told the deceased that they were off-duty police officers and for them to have prevented other persons in the club from becoming physically involved.

18. The Procurator Fiscal and Mr Hennessy, in summary, argued that the actions of Mr McMillan and Mr Anderson were entirely reasonable in the particular sudden, unexpected, urgent and fast-

moving circumstances and their alleged omissions did not constitute reasonable precautions whereby the death and any accident resulting in the death might have been avoided.

19. My view of the evidence is that Mr McMillan and Mr Anderson took action to detain and remove the deceased from the club after limited discussion between them about the course of action to be followed and without themselves phoning the police or making arrangements for anyone else in the club to do so. They had taken steps to confirm the information they were initially given. On the evidence it appears that their agreed intention was to seize the deceased by a form of controlling hold that would enable them to prevent him from having access to the gun in his possession and to remove him from the club as quickly and with as little fuss as possible. I noted that one eyewitness gave evidence that the intervention by the off-duty police officers looked as if it was planned. The first time that either off-duty officer asked for someone to phone the police was when they were beside the bar in the quiet lounge with the deceased. Mr McMillan's evidence was that he believed that acting covertly and taking advantage of the element of surprise would enable them to deal with the situation more effectively. The off-duty officers' explanation for immediately taking action in the way that they did was that, having regard to the credible information they had received, the situation was one of urgency and potential danger to other persons in the busy club, many of whom were elderly.

20. I consider that the assessment of the situation by Mr McMillan and Mr Anderson was a reasonable assessment, having regard to the evidence as to the circumstances. The priority was perceived by these experienced police officers to be to remove the deceased from the premises and with him the risk of potentially serious danger to persons in the club. In my view it was open to them to phone the police immediately or to ask for club staff or others to do so, before they took action physically to seize the deceased. I do not consider that this would have significantly delayed or compromised their action to detain and remove the deceased. However, whether or not with the benefit of hindsight criticism of Mr McMillan and Mr Anderson for failing to make or arrange an immediate phonecall to the police may be justified, I am unable to conclude that such action was in all the circumstances a reasonable precaution that might have resulted in Mr Semple's accidental death being avoided. It is not possible to predict what, if any, difference to the course of events an immediate phonecall to the police would have made. The events occurred quickly and I note that there appears to have been a delay of 10 minutes between the first phonecall that was made to the police and the arrival of uniformed officers at the club.

21. The evidence about whether or not the deceased knew at any stage that Mr McMillan and Mr Anderson were police officers was unclear, but it was clear that the off-duty officers did not tell him this when they initially took hold of him and then were trying to remove him from the hall of the club. This was a deliberate decision on the part of Mr McMillan (the senior of the two), who considered that the element of surprise was important and that giving the deceased the information that he and his colleague were off-duty police officers may have been counterproductive and produced a violent reaction. It is not possible, on the evidence, to say that this was an incorrect assessment or that it may reasonably be concluded that the deceased would have calmly accepted and co-operated with his removal from the club and the removal of the imitation firearm from his possession had he been told by Mr McMillan and Mr Anderson that they were off-duty police officers. Having regard to the deceased's intoxicated and volatile state, his violent behaviour towards a club member who was a friend of his and his continued struggling and attempts to get away in the lounge, when he must have known that the police had been called, I am quite satisfied that it cannot be concluded that for Mr McMillan and Mr Anderson to have told the deceased that they were off-duty police officers would have been a reasonable precaution that might have resulted in Mr Semple's accidental death being avoided.

22. The submission that Mr McMillan and Mr Anderson should have prevented other persons in the club from becoming physically involved in their dealings with the deceased was described by Mr Hennessy as unrealistic, having regard to the circumstances and in particular the deceased's violent resistance to restraint and the difficulty experienced by Mr McMillan and Mr Anderson in holding him before and after the removal of the imitation firearm from his possession. I agree with Mr Hennessy's view and would also observe that this was not a situation in which members of the public came to the assistance of the police in an incident in a public place. This happened in a club and those who intervened were members of the club, including committee members, who had a legitimate interest in the preservation of order and protection of the safety of members in the club, and in assisting their fellow club members (who they knew to be police officers) in dealing with Mr Semple, a visitor who had caused trouble in the club and was in possession of a gun. I am not prepared to find that for Mr McMillan and Mr Anderson to have prevented other persons in the club from becoming physically involved would have been a reasonable precaution that might have resulted in Mr Semple's accidental death being avoided.

23. I do not consider that, either individually or taken together, the alleged omissions by Mr McMillan and Mr Anderson constitute reasonable precautions whereby the death and any accident resulting in the death might have been avoided.

24. Mr Brown's submission about the management of the club was that the manager of the club delegated his responsibility to the two off-duty officers and other members of the club in respect of the incident. He did not control or supervise the situation as it developed. There were no first aid facilities available in the club. There appeared to be no protocol arrangements in place to deal with such a situation as it developed. Arrangements for first aid facilities and access to trained staff and equipment to assist in resuscitation might have assisted the deceased on 23 April 2006.

25. In his submission Mr Hennessy suggested that it was for consideration whether any form of precaution by way of the provision of equipment or training to staff in resuscitation would have made any difference. He submitted, however, that the balance of evidence from the pathologists was that death would not have been avoided even if cardio pulmonary resuscitation had been carried out at the time when the condition of the deceased had become apparent. The Procurator Fiscal did not invite me to make any finding in this regard. Although he drew attention to medical evidence that immediate CPR might have saved Mr Semple's life he submitted that the evidence overall suggested that CPR would not have made any difference.

26. I agree with the Procurator Fiscal's and Mr Hennessy's view of the evidence. The evidence of witnesses who were directly involved in the struggle and restraint of the deceased in the lounge was that the deceased was dead when those restraining him released their hold on him. I note, for example, that Daniel McPhee, who had some knowledge of first aid having been a nursing assistant, thought instantly that Mr Semple was dead and that was the reason he gave for not considering CPR.

27. The Waterside Miners' Club was not a party to and was not represented at the Inquiry, although the President as well as committee members and club members gave evidence. There was evidence about the existence of first aid equipment, although not that there was any training of staff in resuscitation.

28. The evidence does not, in my judgment, justify a finding that any form of precaution by way of the provision of equipment or training of staff in resuscitation or better management would

have been a reasonable precaution whereby the death and any accident resulting in the death might have been avoided.

29. Overall then I make no finding under this provision of the Act.

The Defects, if any, in any system of working which contributed to the death or any accident resulting in the death

30. There were no submissions that there were defects in any system of working which contributed to the death or any accident resulting in the death and no evidence to that effect. It is not appropriate to make any finding in this respect.

Other Facts Relevant to the Circumstances of Death

31. There were no submissions about specific findings under this heading. However, I am of the view that it is relevant to record under this heading that the events that culminated in Mr Semple's untimely death flowed directly from the commission by Mr Semple of a serious criminal offence, involving an imitation firearm, within the Waterside Miners' Welfare Club on 23 April 2006. Also relevant, in my view, was the fact that the deceased had been drinking prior to the incident and had consumed a considerable amount of alcohol.

Concluding Comments

32. Mr McMillan and Mr Anderson intervened in the reasonable belief that they were dealing with a man in possession of a genuine firearm who had threatened to use it. In the circumstances their actions were courageous and commendable.

33. The actions of Mr McMillan and Mr Anderson and the other club members involved in restraining Mr Semple were not in the circumstances inappropriate, excessive or reckless.

34. The fatal outcome of these events was an unintended and tragic accident. It was sincerely regretted by those directly involved. It was extremely unfortunate and very sad for the deceased's widow, Mrs Anne Semple, and family, to whom the court's sympathy is extended.

(Signed) Andrew C Normand

WITNESSES IN THE INQUIRY

The witnesses who gave evidence to the Fatal Accident Inquiry for the Crown were as follows:-

1. Anne Semple - widow of the deceased.
2. Detective Constable Peter Anderson - off duty police officer and club member within the club.
3. Detective Inspector Wilson McMillan - off duty police officer and club member within the club.
4. John Moore - committee member within the club.
5. James Whiteford – member of the public within the club.
6. Thomas Scott - club member within the club.
7. Daniel McPhee – club member within the club.
8. George Watson - President of the club within the club.
9. Francis McKenna - committee member within the club.
10. John Miller - nephew of the deceased within the club.
11. Stephen Mason - paramedic who attended the deceased.
12. Alexander Gordon - Strathclyde Police Training Officer.
13. Hazel Torrance - Toxicologist.
14. Dr John Clark - Pathologist.
15. David Ambrose - member of the public within the club.
16. Gerard Brownlee - taxi driver who had driven the deceased from and back to the club prior to the incident.
17. Stuart Anderson – club member within the club.
18. Stuart Marshall – club member within the club.

The following witnesses were led on behalf of the family of the deceased:

19. Robert Keenan – club member within the club.
20. Patrick Mooney – club member (Psychiatric Nurse) within the club.
21. Professor Anthony Busuttil - Pathologist.

The following witnesses were led on behalf of the Chief Constable, Mr McMillan and Mr Anderson:-

22. Peter Anderson Junior - member of public within the club.
23. Robert Boyle - bar manager of the club.
24. Sergeant Andrew Dolan - police officer who had taken a statement from William McDowall, a member of the public, who had been with the deceased prior to the critical events.