SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2026] FAI 35

GLW-B261-26

DETERMINATION

BY

SHERIFF J MCDONALD

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

into the death of

DAVID CRAWFORD

Glasgow, 13 July 2026

DETERMINATION

The Sheriff, having considered the information presented at the Inquiry, determines in terms of section 26 of the Inquiries into Fatal Accident and Sudden Deaths etc. (Scotland) Act 2016 ("the Act") that:

STATUTORY FINDINGS

1. In terms of section 26(2)(a) of the Act, David Crawford was born on 29 June 1964. He died within cell 2-9, Bravo Hall ,HMP Barlinnie 81, Lee Avenue, Glasgow, G33 2QX on 2 February 2024. The time of his death was recorded at 1145 hours.

2. In terms of section 26(2)(c) of the Act, the cause of David Crawford's death was ischaemic heart disease and chronic lung disease.

3. I have no findings to make under paragraphs (b), (d), (e), (f) or (g) of section 26(2) of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016.

4. I have no recommendations to make under section 26(1)(b) of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016.

LEGAL FRAMEWORK

5. This inquiry was held in terms of section 1 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the 2016 Act"). Mr Crawford died while in custody as a convicted prisoner. In terms of section 2, the inquiry was a mandatory inquiry. The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 Rules").

6. The procurator fiscal represents the public interest in investigating, arranging and conducting an inquiry.

7. The purpose of the inquiry is, in terms of section 1(3) of the 2016 Act, to establish the circumstances of the death of Mr Crawford and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It is not the purpose of the inquiry to establish civil or criminal liability (section 1(4) of the 2016 Act).

8. Section 26 of the Act sets out the matters to be covered in the determination. These include setting out findings on the following:

(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 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 death;

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

9. The inquiry is also empowered make such recommendations, if any, as the inquiry considers appropriate 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; and

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

Procedural history of the inquiry and personnel

[1] The Inquiry was assisted by Miss Watt, Procurator Fiscal for the Crown and Miss Brett, Solicitor, representing the Scottish Ministers.

[2] The first notice of Inquiry was lodged on 16 February 2026 and preliminary hearings were held on 16 April 2026 and 23 June 2026.

[3] At the final hearing of the Inquiry on 10 July 2026 parties tendered a joint minute of agreement which covered all the necessary chapters of evidence that required to be placed before the court, and no parole evidence was presented. I received written submissions from both parties in relation to the findings sought.

Background

[4] David Crawford (hereinafter referred to as Mr Crawford) was born on 29 June 1964.

[5] On 17 August 2004 Mr Crawford was sentenced to life imprisonment. Mr Crawford was released on licence in 2013 which was revoked in 2017. Having spent some time in the open estate in 2021, he was returned to closed conditions within HMP Barlinnie on 30 December 2021, where he remained until his death.

Medical history

[6] On his admission to HMP Barlinnie on 31 December 2021, Mr Crawford had a consultation with Dr Senthil and his medical notes were updated to reflect his health issues. There was nothing noted within Mr Crawford's medical history whilst he was imprisoned within the SPS estate which was relevant to his death.

[7] Mr Crawford had no history of substance abuse and had no input from addiction or mental health services.

Circumstances of death 2 February 2024

[8] On 2 February 2024, prison officers Nelson and Deary carried out numbers check at approximately 0645 hours within Bravo Hall, HMP Barlinnie where Mr Crawford responded to a verbal and visual check.

[9] Numbers checks are used by prison staff to (amongst other things) check on the welfare of prisoners and require that prison officers obtain both visual and verbal responses from prisoners.

[10] At approximately 0715 hours, officer Nelson opened Mr Crawford's cell and spoke with him. Mr Crawford was provided with breakfast and stated that he had no requests. His cell door was closed.

[11] At approximately 1138 hours, during the numbers check conducted by prison officer Deary, Mr Crawford did not respond to a verbal check and the view into his cell was obscured by the toilet door within the cell.

[12] Prison officer Deary entered the cell and found Mr Crawford unresponsive within the toilet area. Assistance was requested and a "Code Blue" was radioed by the officer. This is an emergency code to indicate that an individual is having trouble breathing and may or may not be unresponsive.

[13] Prison officer Gitten and prison officer McGougan attended at Mr Crawford's cell in response to the "Code Blue" radio call. The prison officers noted that Mr Crawford was lying in the foetal position on his right hand side and that his face and

right arm were purple in colour. First Line manager McGarey attended the cell and was advised by prison officer McGougan that he believed Mr Crawford had passed away

[14] Primary care nurse MacLennan and health care assistant Mulgrew attended at Mr Crawford's cell, followed by Dr Akinsemolu. Mr Crawford showed no signs of life and Dr Akinsemolu declared Mr Crawford deceased at approximately 1145 hours on 2 February 2024.

Postmortem examination

[15] On 2 February 2024 a postmortem examination was carried out at the Queen Elizabeth University Hospital by Dr Melmore who found that the cause of Mr Crawford's death was ischaemic heart disease (a condition where the coronary arteries are narrowed, reducing the blood supply to the heart) and chronic lung disease.

[16] Dr Melmore noted that there was significant ischaemic heart disease and sudden death could have occurred at any time.

DIPLAR (Death in Prison Learning Audit and Review)

[17] A DIPLAR is the process of reviewing deaths in custody and is completed after the death of any individual who dies in prison. It provides a system for the Scottish Prison Service (SPS) or a private prison operator and the applicable NHS Board to record any learning and identify any actions following a death.

[18] On 25 March 2024 a DIPLAR in relation to Mr Crawford's death took place. Two action points were identified:

a. The family support booklet was not sent timeously to Mr Crawford's family. This is a booklet which provides to the bereaved family details on the DIPLAR process (including how to participate), who to contact within the relevant establishment, information relating on what support is available to them and what steps will be taken in relation to the review of the death of their family member; and

b. Police Scotland had failed to notify the family of the death timeously.

[19] The SPS have responded to the DIPLAR action points as noted:

a. A letter of condolences is sent to the next of kin and a family support booklet is now sent. This was implemented in March 2025.

b. It is now the role of the Governor or Deputy Governor to contact the family of the deceased within 24 hours of their death.

c. The Governor appoints a member of the management team as a main contact for the deceased's family.

Conclusion

[20] I accepted the submissions made by each party that formal findings should only be made in terms of section 26(2)(a) and (c) of the Act. Those are set out above.

[21] I am satisfied that David Crawford died of natural causes and there was no failure on the part of any individual or organisation that could be said to have led or contributed to Mr Crawford's death.

[22] I wish to express my thanks to parties, and their agents, for their professional and efficient approach to this inquiry

[23] I give my sincere condolences to the family and friends of Mr Crawford for their loss.