SHERIFFDOM OF SOUTH STRATHCLYDE DUMFRIES AND GALLOWAY AT HAMILTON

[2023] FAI 21

HAM-B412-21

DETERMINATION

BY

SHERIFF LINDA MARGARET NICOLSON

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

into the death of

JAMES KELLY MACGREGOR

Determination

The Sheriff having considered the information presented at the inquiry, in terms of the 2016 Act, finds that:–

a) In terms of section 26(2)(a):

James Kelly MacGregor (the deceased), born 15 August 1998, died at approximately 05:50 hours on 26 August 2019 at University Hospital, Wishaw, North Lanarkshire. At the time of his death the deceased was in legal custody.

No accident occurred which resulted in the death.

b) In terms of section 26(2)(c):

The cause of death was 1a) multiple organ failure, due to 1b) cardiac arrest, 1c) consistent with cocaine intoxication.

c) In terms of section 26(2)(b):

The cause of death was 1a) multiple organ failure, due to 1b) cardiac arrest, 1c) consistent with cocaine intoxication.

d) In terms of section 26(2)(d):

There were no cause or causes of any accident resulting in the death, there being no accident that occurred which resulted in the death.

e) In terms of section 26(2)(e):

No precautions could reasonably have been taken which might realistically have resulted in the death being avoided.

f) In terms of section 26(2)(f):

There were no defects in any system of working which contributed to the death.

g) In terms of section 26(2)(g):

i. At some time while in police custody on 16 August 2019, the deceased placed a bag containing cocaine into his mouth. This item was placed in his mouth after his being initially searched on arrest on 16 August 2019, and it remained concealed until the deceased's presentation at the charge bar of Motherwell Police Office, over two hours after his arrest. During this period the deceased was handcuffed and police officers were responsible for monitoring him. The officers did not notice the deceased retrieving the item from any place or placing it in his mouth.

ii. Police officers who arrested him, escorted him to the police office, and monitored him while waiting in a holding area at the police office, did not

act in accordance with some aspects of the Standard Operating Procedure in relation to the Care and Welfare of Persons in Custody (Crown Production 20). These aspects of the Standard Operating Procedure, if applied, mitigate against the risks of a person illicitly consuming drugs while in police custody which might result in the person's death. The failure to act in accordance with the Standard Operating Procedure was not, in some instances, justified by any dynamic risk assessment, and there was a lack of basic knowledge of the guidance contained within the Standard Operating Procedure.

iii. Further, an extended wait with the deceased at the holding area of Motherwell Police Office, before he was taken to the charge bar and subsequently strip searched, resulted in a loss of concentration by the officers tasked with monitoring the deceased at that time.

iv. In some aspects, the Standard Operating Procedure might be updated to further reduce risk.

Recommendations

a) A review of the training of officers should take place in order to ascertain whether specific and sufficient reference to the Standard Operating Procedure is included. Thereafter, consideration should be given to officers being tested as part of their training, potentially by way of open book examination, in order to ascertain

whether they are familiar with referencing the Standard Operating Procedure and have a basic knowledge of the contents of the Standard Operating Procedure.

b) Consideration should be given to the inclusion of the mouth and ears as part of the initial search of a person in police custody.

c) The Standard Operating Procedure should provide that, where a cage van is being used for the carriage of prisoners, the escort will occupy the seat nearest the cage, unless it is not feasible to do so, so that they may keep the prisoner under observation at all times. Rear facing seats should be kept accessible and in use at all times unless it is not feasible to do so.

d) When police officers are tasked with monitoring persons in police custody, they should maintain their attention on that person. The Standard Operating Procedure should be reviewed to consider whether they should include guidance on being alert to any situation arising which impacts on their ability to maintain concentration on their task, such as a delay in the processing of persons in custody. Consideration should also be given as to whether guidance or training, or both, should include steps that might be taken to reduce the impact loss of concentration, such as officers taking turns in maintaining observations during any extended delay in the process.

e) Where an officer is monitoring a detained person, the officer should not make use of a mobile telephone or other device unless it is strictly necessary for operational reasons at that time. Where an officer requires to use such a device in these circumstances, they should bring this to the attention of any accompanying colleague in

order that the colleague can maintain attention to the detained person; and the officer should end their use of the device as soon practicably possible.

FINDINGS IN FACT

I found the following facts proved:

Background and Medical History

1. James Kelly MacGregor (hereinafter referred to as 'the deceased) was born on 15 August 1998 and was aged 21 years old at the time of his death on 26 August 2019. The deceased was unemployed and resided alone. He was in a relationship with a partner, with whom he had a child. The deceased was known to have abused illicit drugs, namely cocaine and cannabis, for some time.

2. The deceased was registered as a patient at Oak Lodge Medical Practice, Hamilton. The deceased is noted to have attended at a consultation with a Consultant Psychiatrist on 28 May 2019. Following this consultation, the deceased was diagnosed with alcohol dependency, cannabis misuse, and possible cocaine misuse, and was thereafter referred to addiction services. Addiction services later recorded, in a letter dated 21 June 2019, that "James described a pattern of drinking most days of the week, consuming anywhere between 4-15 bottles of Miller lager… he smokes 2-3 joints of Cannabis daily… he was abusing Cocaine on a regular basis recently but reports that he has managed to curtail this completely". The deceased's medical records further show that the deceased had no prior cardiac conditions (as shown at Crown Production Number 18 at pages 550 - 555).

Events leading to the arrest of the deceased

3. On the evening of 15 August 2019, the deceased held a party at his home address to celebrate his 21st birthday. This party carried on into the early hours of 16 August 2019. The deceased was observed to be consuming alcohol, and some saw him taking cocaine, which he had in his possession, and smoking cannabis. Witness RS described the deceased telling him that he had seven grams of cocaine for which he had paid £450. He saw that the deceased kept this in his pocket in a bag. The witness also described the deceased staying up throughout that night, drinking alcohol and taking cocaine until around midday on 16 August. Witness KN, the deceased's cousin, who was with the deceased on and off from around midday on 15 August, described that the deceased had "half an ounce" of cocaine in his possession, as well as cannabis, but that he did not know how much cocaine the deceased had consumed during that period. He did state that the deceased was 'still consuming drugs' at around 1000 hours on 16 August.

4. At around 1300 to 1400 hours on 16 August the deceased's partner attended at the deceased's home address along with the deceased's mother. They spoke to the deceased who was angry and agitated. The deceased engaged in an argument with his mother which resulted in the deceased throwing an audio speaker towards her. The deceased's mother and partner then left the deceased's home address, returning to the deceased's mother's address. The deceased followed them there and threw a concrete slab at the glass panel of his mother's door causing it to smash. The deceased's mother then contacted Police to attend (as detailed within Crown Production Number 3 and Crown Production Number 7 at pages 140 and 142).

The arrest of the deceased

5. The call was placed by the deceased's mother at approximately 1416 hours on 16 August 2019, with officers arriving at the scene around five minutes later (as shown at Crown Production Number 3). On arrival, Police Constables KA and BR spoke to the deceased's partner and mother, while Police Constables MM and FY attended at the deceased's home address to trace him. Constables MM and FY arrived at the deceased's address at around 1425 hours and spoke to the deceased who was within the property. The deceased was informed that he was being arrested in terms of Section 1 of the Criminal Justice (Scotland) Act 2016 in relation to an alleged assault and contravention of Section 38(1) of the Criminal Justice and Licensing (Scotland) Act 2010. The deceased was initially argumentative and appeared to be under the influence of alcohol and drugs however presented as lucid in his communication with officers at the time. Officers placed the deceased in handcuffs, stacked to the rear position, and he was taken to a police cell van. The deceased was subject to a cursory search (including of his pockets, collar line and waistband), by Police Constable FY prior to being placed in the police van, with a small piece of cannabis being recovered from the deceased's left hand trouser pocket. On arrest, the accused was talkative and there was no indication of his having any foreign object in his mouth at that time.

6. The deceased was then placed in the rear cage area of the police cell van at the locus. The deceased remained hand cuffed to the rear during his time within the police cell van. Constable KA had driven the cell van to the locus. He had searched the cage at the rear of the cell van at the commencement of his shift at around 7am that day.

Constables MM and FY swapped their police vehicle for the cell van in order for them to transport the deceased to the police office. Constable MM swapped kit between the police car and the police van while Constable FY searched the deceased. The cell van cage was not searched immediately before the deceased was placed in it.

7. The deceased's mother told Police Constable KA that the deceased had been taking alcohol and illicit substances through the immediately preceding night. This information was passed to Constables MM and FY by Constable KA.

8. Once the deceased was placed in the cell van, Constables MM and FY attended at his home, on his request, to ensure that the guests remaining there left the property. There were signs of drug and alcohol use within the property and one of the guests informed the police officers that the deceased was known to inhale gas from a canister of Nuprol, a propellant used for air weapons.

9. Constable KA maintained observation of the deceased in the cell van cage by standing at the rear of the vehicle and watching the deceased through the open rear doors while Constables MM and FY attended at the deceased's home. Constable KA spoke to the deceased while they waited. There was no indication of the deceased having any item in his mouth and nothing arose which caused Constable KA concern. On returning to the cell van, Constable MM then drove the van to Motherwell Police Office, Windmillhill Street, Motherwell, with Constable FY sitting in the front passenger seat. There was not a discernible reason why Constable FY did not sit in the rear facing seat of the cell van, which allows for best observation of occupants of the cage. During the time that the deceased was within the van he communicated little, but without issue.

On the journey to the police office, Police Constable FY advised the custody suite of the impending arrival of the deceased, giving his name, date of birth, address, and reason for apprehension. Information, about the deceased being under the influence of substances and having had drugs on his person, was not passed on at this stage.

Events within Motherwell Police Office

10. The deceased arrived at Motherwell Police Office at approximately 1447 hours on 16 August 2019. He walked independently and without difficulty at that time. On his arrival the deceased was taken into the holding area where he sat on a wooden bench, still handcuffed to the rear. The charge bar was extremely busy at this time and, due to there being several other prisoners within the charge bar area during the same period, a queue of persons waiting to be processed had built up (as shown at Crown Production Number 9). The decision was made by the Custody Sergeant on early shift to hold the deceased and other prisoners within the holding area to await processing. Once in the holding area police officers have no means of communicating with custody staff other than by telephone or knocking on the glass door giving access to the charge bar. The deceased was held within the holding area for a period of 1 hour and 46 minutes prior to being processed at approximately 1637 hours.

11. At around 1600 hours the early duty Custody Sergeant handed over to the "backshift" Custody Sergeant, Police Sergeant DW. There was also a changeover of Police Custody and Security Officers at around 1530 hours. Sergeant DW and the custody staff on backshift were not made aware that the deceased was waiting in the

holding area to be processed. Moreover, a CCTV screen at the charge bar which normally showed the holding area was not working on this date.

12. Between the time of arriving at Motherwell Police Office at around 1447 hours until around 1635 hours on 16 August 2019, the deceased was under the supervision of Constables MM and FY. During this time the deceased appeared to be intoxicated and, whilst sitting on the bench, spent most of the time leaning forward with his head between his legs and appeared to be sleeping intermittently. The deceased did not initiate communication but could be roused and he understood and responded to instructions. While in the holding area the deceased fidgeted on occasion. His hands were handcuffed to the rear. He was able to move his hands round to the area of his left trouser pocket. On an occasion when this happened, Constable MM was looking out of the glass door of the holding cell while Constable FY was looking to the floor. Neither officer noticed this movement. The time spent waiting in the holding cell was longer than usual and the concentration of the officers was affected by this. At one point, Constable FY took out his mobile phone and began scrolling through it. His task at the time was to observe the deceased. At approximately 1609 hours Constables MM and FY moved the deceased’s handcuffs from the rear position to the front position, stating to the deceased that this was because they had been in the rear position for too long. At one point after this the deceased moved his hands to the sock area. During his time in the holding area, neither officer noticed any movement of the deceased indicative of him retrieving an item from his person or placing an item in his mouth.

13. At around 1620 hours Police Custody and Security Officer (PCSO) IM became aware of the deceased within the holding area waiting to be processed. At around 1625 hours PCSO IM entered the holding area to begin collecting details to allow the deceased to be processed. The officers did not tell the PCSO of the finding of drugs on the deceased's person or of the deceased being under the influence of drugs. The form being used by the PCSO to capture information at that time did not include questions which elicited such information.

14. At approximately 1635 hours Police Constable KS and Police Constable CW attended at the holding area to take over, due to Constables MM and FY finishing their shift (as shown at Crown Production Number 8 at pages 171, 192 – 193 and 201 - 203). Neither of the latter two officers passed on information to the relieving officers about the consumption of drugs by the deceased nor the finding of cannabis on his person.

15. At around 1637 hours the deceased was taken to the charge bar. He had to be supported by the two accompanying officers, Constables KS and CW. He was processed on the Police National Custody System by PCSO IM. The deceased appeared unsteady on his feet and drowsy. PCSO IM then asked the deceased a number of questions in relation to the deceased's processing however the deceased responded by nodding and using hand gestures and, when prompted to speak, answered whilst barely opening his mouth. Constable KS, suspecting the deceased to have something in his mouth, then told the deceased to open his mouth while Constable CW attempted to open the deceased's mouth with his fingers. When the deceased failed to open his mouth, he was taken to the floor by both officers on the instruction of the Bar Officer and placed in a

face down position. For several minutes the officers attempted to make the deceased spit out the package before the deceased finally did so. The deceased was then lifted back onto his feet and the package was placed in a clear plastic bag. PCSO IM then continued processing the deceased, now in the presence of Police Sergeant DW who had also arrived at the Charge Bar (as shown at Crown Production Number 7 at page 153 and Crown Production Number 8 at pages 205 – 207).

16. At approximately 1648 hours the deceased suddenly began retching, indicating that he may be about to be sick. Constables KS and DW removed the deceased from the Charge Bar area, taking him to a nearby detention cell which contained a toilet. The deceased continued retching but was not sick. Constable DW and PCSO IM then conducted a strip-search of the deceased within the detention cell, which was to a negative result. The deceased was then returned to the Charge Bar at approximately 1703 hours, still handcuffed to the front. Police Sergeant DW, who was acting in the capacity of Custody Sergeant during this period, concluded that the deceased required to be taken to hospital because of his intoxication and retching. At 1705 hours the deceased was taken from the custody suite area to the rear yard of the Police Officer, where he was placed into a Police van for transportation to hospital. The deceased is captured on CCTV to walk unaided to the Police van (as shown at Crown Production Number 7 at page 153, Crown Production Number 8 at pages 208 – 2010, and Crown Label Number 1).

University Hospital, Wishaw

17. At approximately 1720 hours on 16 August 2019 the deceased arrived at University Hospital, Wishaw, and was taken into the waiting area. The deceased had not retched or vomited during his journey to the hospital. At the time of arrival, the deceased was alert, talkative, and compliant with the officers. However, at around 1735 hours the deceased's behaviour changed, becoming aggressive, agitated, and swearing at Constables KS and CW. Due to his behaviour attracting attention within the waiting area, hospital staff requested that the officers remove the deceased to one of the triage rooms. Within the triage room the deceased continued to be aggressive, kicking out and attempting to head-butt and punch the officers. As a result of this behaviour, the deceased was placed on a bed within the room and 'fast-straps' were applied to his legs to prevent him from kicking out. After a period of two or three minutes the deceased calmed down, however Constables KS and CW then noticed that the deceased was shaking, tensing his body, and had a red, foamy substance coming from his mouth. The officers thought that the deceased may be having a fit or seizure and placed him on his side and immediately sought medical assistance (as shown at Crown Production Number 17 at pages 328 - 329 and 331).

18. Medical staff attended at the triage room at which time the deceased was breathing but not responding to medical staff. The deceased was thereafter moved to the resuscitation room. At around 1800 hours the deceased was assessed by Dr Andrew Graham who found him to be unresponsive, not breathing, and to have no pulse. Dr Graham immediately activated the emergency button and other medical staff

attended at the resuscitation room, including Dr Stephan Dalchow, Consultant Anaesthetist and Intensive Care Physician. The deceased was intubated, and cardiopulmonary resuscitation ('CPR') was commenced. A defibrillator was then attached to the deceased which showed that the deceased was asystolic with no shockable rhythm. Manual CPR was then recommenced, and the deceased was given adrenaline and calcium gluconate, due to high potassium levels. Three cycles of CPR were done on the deceased, in two-minute cycles and with adrenaline given every four minutes, at which time there was a return of spontaneous circulation. The deceased was administered with anticonvulsant medication and transferred to the Intensive Care Unit ('ICU') for further treatment.

19. On the evening of 16 August 2019, the deceased was recorded to be presenting with profound metabolic acidosis, to be hyperglycaemic, and blood tests showed an acute kidney injury. As a result, the deceased was sedated and on renal replacement therapy. On the morning of 17 August, the deceased was recorded as continuing to be unresponsive and he was taken for a CT scan. His kidney and liver function appeared to be worsening. On 18 August the deceased was reviewed by Dr Stephan Dalchow who recorded that the deceased's circulation had become more stable, but that he should continue to be sedated to allow for uninterrupted renal replacement therapy. A second CT scan was undertaken on 22 August which showed signs of evolving cerebral oedema. During the deceased's time in ICU he also underwent daily blood tests and received multiple chest x-rays. On 23 August the deceased was reviewed on the ward by Dr Kathryn Bennett and a chest drain was inserted for a pneumothorax. Dr Bennett

considered that the deceased was in multi organ failure. A Do Not Attempt Cardiopulmonary Resuscitation order ('DNACPR') was put in place on 23 August 2019, and the deceased's family were advised of this (as shown at Crown Production Number 17 at pages 333 – 343, 365 – 371, and 523).

20. On 24 August the deceased was recorded to be struggling in relation to his lungs despite being on maximum support. The deceased was reviewed again by Dr Kathryn Bennett on 25 August who recorded a significant deterioration in the deceased's condition in relation to the cerebral oedema and acute kidney injury. He was also recorded to have respiratory failure and sepsis. In the early hours of 26 August 2019 there was a rapid deterioration of the deceased's condition, including a rapid loss of output despite the administration of adrenaline and noradrenaline, and he was noted to have enlarged pupils which were unreactive. The deceased showed no central pulse (as shown at Crown Production Number 17 at pages 376, 380 – 381, and 384).

21. The deceased was pronounced life extinct at approximately 0550 hours on 26 August 2019 (as shown at Crown Production Number 1 and Crown Production Number 2).

22. At the time of his death at 0550 hours on 26 August 2019, the deceased's status was of a person in legal custody.

23. Whilst within University Hospital, Wishaw, toxicological tests were undertaken on the deceased's blood and urine. These tests were undertaken on 17 August 2019 and the results showed the presence of both cocaine and cannabinoids; although these positive samples were not further quantified (as shown at Crown Production

Number 15). These sample were not available at the time of post mortem examination and due to the number of days that had passed between hospital admission and the death of the deceased, no further toxicological analysis was completed due to any drugs and/or alcohol that could have been present being metabolised.

24. Following the death of the deceased, Dr Stephan Dalchow was asked for his opinion on whether the delay in the deceased being taken to the charge bar, and that he was found to have a small package of drugs in his mouth at that time, would have had any impact on the deceased becoming unwell and going into cardiac arrest. Dr Dalchow commented that, in his opinion, 'as he was already in hospital/emergency department when he collapsed' and the 'drugs had already been ingested I don't think an earlier presentation would have made any difference to (the deceased's) management or ultimate outcome'.

Post mortem examination

25. A post mortem examination was conducted on 4 September 2019 at the Queen Elizabeth University Hospital, Glasgow, by Consultant Forensic Pathologists, Dr Julia Bell and Dr Marjorie Turner and the cause of death was recorded as:

1a. Multiple organ failure

due to

1b. Cardiac arrest

due to

1c. Consistent with cocaine intoxication

26. The conclusions section of the Post Mortem Report, at pages 8 and 9 of the Crown Productions, states as follows:-

> "The post mortem findings were correlated with the clinical history provided…
>
> "On the 16th August 2019, this man had a cardiac arrest which was suspected to have been due to drug intoxication and, although a cardiac output was restored, he went on to develop multiple organ failure which led to his death 10 days later. At post mortem examination, there were features consistent with this – there was global ischaemic brain injury and evidence of liver necrosis and the lungs showed features consistent with diffuse alveolar damage. In addition to this, there was also evidence of acute infection within the lungs (bronchopneumonia) which probably developed terminally – a not uncommon complication of unconsciousness/multiple organ failure…
>
> "As to the cause of the cardiac arrest, there was no evidence of any injuries or natural disease to account for it; there were a few small healing abrasions on the hands and wrists but there were no injuries that were considered to have contributed to or caused his death and he had no significant pre-existing natural disease. Clinically it was suspected that he was intoxicated when he presented to hospital and analysis performed in hospital on urine samples obtained during the admission were positive for cocaine (not further quantified) and cannabinoids but negative for other drugs although the screening was limited. Given that a number of days had passed between hospital admission and this man's death, any drugs or alcohol that could have been present would have been metabolised and therefore no further toxicological analysis was completed on post mortem blood samples. Unfortunately no hospital blood samples were available for analysis…
>
> "Given these findings coupled with the history provided, it would all be in keeping with this man's death having been due to multiple organ failure following a cardiac arrest and the cause of this would be consistent with cocaine intoxication. Cocaine is a stimulant type drug and its toxic effects are not necessarily dose dependent and can include cardiac arrhythmias, seizures and cardiac arrest. This would be in keeping with the symptoms and circumstances surrounding this man's admission to hospital. The use of cannabinoids was considered unlikely to have played a significant role but given that a full toxicological analysis was not performed, it is not possible to completely exclude the contribution of any other drugs or alcohol that may have been present – alcohol consumption with cocaine can be particularly cardiotoxic".

Post-incident police action

27. The package recovered from the deceased's mouth within Motherwell Police Office on 16 August 2019 was later presumptively tested on 21 August 2019 by Police Constable Ross Beaton and Police Constable Ross Matthew. The package was found to weigh 7.07 grams, with the contents testing positive for cocaine. The package was later examined and photographed and found to measure approximately 9cm x 6cm. At the time of examination the package was described by Police Constable Ross Beaton as 'a small bag that appeared tore apart with a white paste like substance within and clear residue thereon' (as shown at Crown Production Number 12).

Police Scotland Care and Welfare of Persons in Police Custody

28. The Police Scotland Care and Welfare of Persons in Police Custody Standard Operating Procedure, as at the time of the deceased's death in August 2019, is reference material which provides instruction and guidance to officers (as shown at Crown Production Number 20 at page 675). Officers may deviate from the Standard Operating Procedure, acting on a dynamic risk assessment.

29. On 24 December 2019, Police Scotland issued a memorandum, reminding officers and staff, of the requirement of appropriate control, accompaniment, and observation at various stages when a person is held in custody. This included that a person being transported in a cell van must be under constant observation at all times. The memorandum was issued having regard to a duty of care owed to ensure persons in police custody are prevented from harming themselves.

30. A further communication was issued stating that arresting and escorting officers must provide updates to custody staff of any issues that they have knowledge of which may affect the care and welfare of a person while in custody.

31. Since Mr MacGregor's death, work has been initiated by Police Service Scotland to improve, streamline, and standardise the handover procedures between shifts in custody suites in order to mitigate against undue delay in the processing of persons in police custody and measures are in place meantime while that work is ongoing. There has been a significant increase in infrastructure which will assist in improving handover procedures.

Note

[1] Representation at this inquiry was as follows: Amanda Allan, Procurator Fiscal Depute for the Crown, Simon Gilbride, Counsel for the family of James MacGregor, Marie Cartney, Solicitor for the Chief Constable, Police Service of Scotland, Robert Vaughan, Solicitor for Police Constables KS and CW, Gordon Williams, Solicitor for Police Constable KA, and Peter Watson, Solicitor for Police Constables MM and FY.

[2] The court is grateful to the representatives for their meticulous preparation of the joint minute. That made the task of the court easier. More importantly, it sets out in some detail information, repeated in the above findings in fact, which the family of Mr MacGregor is entitled to know.

Evidence

[3] The joint minute agreed the following numbered Crown productions to be true and accurate copies:

1. The Intimation of Death Form relating to the deceased.

2. The Post Mortem Report prepared by Dr Julia Bell and Dr Marjorie Turner dated 20 November 2019.

3. The Police Scotland STORM Incident Report in relation to the incident on 16 August 2019 which led to the arrest of the deceased.

4. A set of photographs taken at the deceased's home address.

5. A set of photographs taken at Motherwell Police Office showing the Custody Suite area and the Police Cell Vans.

6. The Prisoner Contact Record for the deceased during his time being held in Motherwell Police Office.

7. The Police Scotland Full National Custody Record in relation to the deceased's arrest on 16 August 2019.

8. A CCTV Timeline prepared in relation to the deceased's time in custody at Motherwell Police Office from 1447 hours to 1706 hours on 16 August 2019.

9. A summary prepared in relation to the Activity at the Charge Bar at Motherwell Police Office between 1316 hours and 1637 hours on 16 August 2019.

10. A Full Transcript prepared in relation to the activity at the Charge Bar at Motherwell Police Office between 1316 hours and 1637 hours on 16 August 2019.

11. A Transcript prepared in relation to the activity within the Holding Area at Motherwell Police Office between 1448 hours and 1637 hours on 16 August 2019.

12. Photographs taken of the Drugs Package Recovered from the Mouth of the Deceased on 16 August 2019.

13. Photographs taken of the deceased's Clothing and the Drugs Package Recovered from the Mouth of the Deceased on 16 August 2019.

14. A Transcript prepared in relation to the activity within the A&E Department at University Hospital, Wishaw, on 16 August 2019.

15. The Toxicology Report in relation to the analysis of the deceased's blood and urine undertaken at University Hospital, Wishaw, on 17 August 2019.

16. Photographs taken of the Post Mortem Examination of the Deceased on 4 September 2019.

17. Medical Records relating to the deceased's admission to University Hospital, Wishaw, between 16 August 2019 and 26 August 2019.

18. GP Medical Records relating to the deceased. The information contained therein is a true and accurate record of the deceased's medical history and treatment within the community.

19. Police Scotland Guidance in relation to Adverse Incidents in Police Custody.

20. Police Scotland Standard Operating Procedure in relation to the Care and Welfare of Persons in Police Custody.

21. Police Scotland Management Guidelines for Persons Suspected of Having Drugs Concealed Internally.

22. Police Scotland Standard Operating Procedure in relation to Drugs Investigations.

23. Police Scotland's response to the contents of the Investigation Report prepared by PIRC.

24. Police Scotland Memorandum, dated 24 December 2019.

25. The Subject Matter Expert Report prepared by Police Inspector Margaret Seagrove, dated 14 February 2022.

[4] It was also agreed that Crown Label Number 1 is a true and accurate copy of CCTV footage obtained from Motherwell Police Office and University Hospital, Wishaw, showing the deceased's movements on 16 August 2019. I accepted that the productions and label were as had been agreed by the parties.

[5] The following witnesses gave evidence:

Police Constable KA spoke to searching the cage of the police cell van on commencing duty on 16 August 2019 (he was aware of stories of items being found in cages of cell vans and the need to search them), attending at the locus later that day, speaking to the deceased's mother nearby; swapping the police cell van he had arrived in for the police car being used by Constables MM and FY; passing on information to the two officers about the deceased's consumption of alcohol and drugs all night; and monitoring the deceased when he was in the cage of the cell van at the locus while the two officers entered the deceased's home.

[6] Police Constables MM and FY, spoke to attending at the locus on 16 August 2019; detaining and searching the deceased there; placing him in the police cell van they had taken from Constable KA at the locus and transporting the deceased to Motherwell Police Office; and supervising him in the holding area there until they were relieved from duty by Constables KS and CW.

[7] Constable MM was aware of and had seen the Standard Operating Procedure before the death of the deceased. He was aware of specific aspects of it which he was asked about. He and his colleague had been told that the deceased was under the influence of drugs and he was aware of this from his observations as well as being aware that the deceased had been drinking all day. Constable MM swapped kit between the police car and the police cell van while Constable FY searched the deceased. Constable MM called to alert the police office of the imminent arrival of the deceased but did not share information about the deceased being under the influence of substances nor of cannabis having been found. When two colleagues arrived to relieve him and Constable FY in the holding area as they waited with the deceased, he told the colleagues about the deceased's quiet demeanour but did not share with them the information about the deceased being under the influence of substances or of cannabis being found.

[8] He thought the deceased might need to be taken to hospital but only because the custody sergeants do not take any chances when it comes to drugs and alcohol. He agreed that the deceased could be described as drunk and drowsy in the holding area but many people who are arrested are under the influence of alcohol and/or drugs and they are not all put in the recovery position.

[9] Constable FY explained that, as a result of medical treatment for a neurological disorder, his memory was not good and there were some questions he was unable to answer because of that. Where Constable FY was unable to recollect a matter he said so and otherwise he gave substantive answers to questions, based on his memory. He said the deceased was chatty when the officers first arrived at his door. He was able to walk freely (and video footage of the deceased arriving at the police office showed this). The search of the deceased at the locus went as far as it could while maintaining the deceased's dignity in a public place and it included the waistband collar and pockets. He would not conduct a more intrusive search in public in order to allow the person to maintain their dignity. He said that, given that cannabis was found, a full search would be carried out at the police office later where the medical history of the deceased would also be taken and the deceased would be asked questions which would elicit information about drug use.

[10] The officer did not search the cell of the van before placing the deceased in it but said it was part of their procedure that the van would be searched before being taken out. He said that while Constable MM drove the van to the police office he maintained observation on the deceased by sitting to the side in the front seat of the van so that he could see the deceased. He did not recall a reason for not sitting in the rear facing seat of the van. Constable FY was asked about earlier statements he had given, as well as a statement made by Constable MM, which gave varying accounts of how Constable FY sat in the front seat during the journey and which were inconsistent with the evidence

he gave to the enquiry. Constable MM's statement had been that Constable FY had sat in the front facing position and occasionally looked round.

[11] While in the holding area at the police office he did not notice the deceased make any movement indicative of the deceased moving any item to his mouth. He believed he would have noticed if the deceased had.

[12] Prior to the incident he was made aware of the Standard Operating Procedure. When various sections in the procedure were put to him, he said that he knew of the sections. However later in his evidence, he said that, although the Standard Operating Procedure was available as part of officer training, it was not really emphasised. He did not recall being trained with reference to specific documents from Standard Operating Procedure. He had not read it prior to this incident. He said that he was not aware what was in the Standard Operating Procedure and that nobody had brought it to his attention. He was not aware at the time of the incident that it was recommended that the escorting officer should sit in the rear facing seat of a cell van.

[13] Constable FY agreed that they waited in the holding area for quite a long time and got pretty bored. A video of the holding area showed the deceased with his hands cuffed to the rear but managing to reach both hands to his left hand trouser pocket area. While this was happening, Constable FY had his head down and had not observed this. Later in the video, Constable FY could be seen taking out his mobile and scrolling through it and he accepted that at this point he was feeling exasperated with the wait. At other points he was looking to the ground and while Constable MM's attention was elsewhere than the deceased. He remembered the deceased fidgeted a lot and agreed

that at one point the deceased can be seen on the video with his hands at the area of his right sock.

[14] He agreed that in the holding area the deceased appeared drunk and drowsy but did not think he needed urgent medical attention and he seemed no different to the many people who were under the influence of alcohol or drugs when arrested and/or fell asleep in the holding area. Around 50% to 60% of the people he arrested were under the influence of alcohol, drugs, or both. Custody sergeants often sent persons to hospital when in his view it was overly cautious. It was a general belief that people were often taken to hospital when they did not need to be. Doctors would tell officers that they shouldn’t be there.

[15] Police Constables KS and CW spoke of attending at the holding area of Motherwell Police Office on 16 August 2019 and relieving Constables MM and FY from their duty at that time; monitoring the deceased in the holding area for a short time; accompanying him to the charge bar where it was noticed that he had an item in his mouth; assisting in removing the item from his mouth; transporting him, on the direction of the Police Custody Sergeant, to Wishaw General Hospital shortly after the item was discovered; and being present there with him when his condition markedly deteriorated and urgent medical intervention was required.

[16] The officers said that they were not given much detail on the handover from Constables MM and FY but had been told, on being instructed to go and relieve the officers, that the deceased was intoxicated. Constable CW said that the duration of the deceased’s wait in the holding area did seem long, but it was not uncommon.

[17] The Crown Office and Procurator Fiscal Service commissioned an independent expert review of the circumstances of the deceased's death. This was undertaken by serving Police Inspector Margaret Seagrove and was produced in the form of a Subject Matter Expert Report, dated 14 February 2022. Giving evidence, Police Inspector Seagrove spoke to the report and gave opinion evidence based on her expertise in the matter of the safe management and care of persons in police custody.

[18] She said that the Standard Operating Procedure is guidance to officers and staff. It can't be expected to cover all circumstances. Officers are trained to make dynamic risk assessments. The Standard Operating Procedure informs part of officers' training. New officers would learn from their tutors. Realistically, it was unlikely that they would read the Standard Operating Procedure. She referred in her evidence to the Version 13.00 of the Standard Operating Procedure for "Care and Welfare of Persons in Police Custody". This version was published on 30 October 2018 and was the version which was current at the time of the deceased's detention on 16 August 2019. It is Crown production number 20.

[19] Version 13.00 of the Standard Operating Procedure included the following (text emphasised in bold is as it appears in the SOP) :

> 5.3.1 Effective briefing and debriefing of Custody Supervisors and custody staff is essential when handing over responsibility for prisoners. This ensures that all relevant information in relation to the care and welfare of prisoners is passed on to and understood by the staff assuming responsibility. Custody staff

should refer to The Custody Officers' Guide as a guide to briefing the incoming staff.

5.3.2 Custody Supervisors are to ensure that full use is made of the hand-over period between shifts, which should incorporate a full and comprehensive briefing, including a physical check of all prisoners by the incoming Custody Supervisor, prior to the outgoing Custody Supervisor finishing duty. When this is completed, an entry must be made in the custody record for each prisoner. When a Risk Assessment Plan is agreed during a hand-over the Custody Supervisors are to ensure all relevant details are recorded on the National Custody System.

5.3.3 The oncoming Custody Supervisor is to ensure that all staff are fully briefed and conversant with the individual needs and requirements of those in custody. Where there are multiple members of custody staff on duty, it is essential that each is aware of their individual and collective responsibilities.

6.4 In the interests of officer safety and the safety of the prisoner as well as for the preservation of evidence, prisoners **must** be searched at the time of apprehension.

6.5 This initial search should be conducted thoroughly and discreetly, attempting to avoid public embarrassment or humiliation where possible whilst explaining to the prisoner the reasons for carrying out a search.

6.6 If it is not possible to conduct a search, due to the particular circumstances of the incident, care should be taken to ensure that the prisoner

has no opportunity to cause injury to themselves, any other person, or dispose of any evidence.

6.9 Arresting/escorting officers **must** inform custody staff of the impending arrival of a prisoner as soon as is reasonably practicable. This is particularly relevant where the prisoner is violent, as custody staff can prepare by ensuring the charge bar is clear to prevent injury.

7.3.1 Where a cage van is being used for the carriage of prisoners, the escort will ideally occupy the seat nearest the cage so that they may keep the prisoner under observation at all times.

8.1.4 The Custody Supervisor is responsible for the care and welfare of the prisoner from the point that the prisoner arrives at the custody centre. Arresting/escorting officers **must** adhere to instructions given by the custody staff.

8.1.6 All prisoners should be subject to reasonable and proportionate control at all times for the protection of staff and the prisoner. If the prisoner cannot be processed immediately, arresting/escorting officers **must** remain with their prisoner and ensure that he/she is properly controlled and monitored.

8.1.7 Arresting officers **must** inform the custody staff of any issues they have knowledge of that may affect the care and welfare of the prisoner whilst in police custody.

9.1.4 A prisoner who is unable to walk unaided due to intoxication, recent injury, or current illness; or who cannot satisfactorily answer lifestyle questions should be referred to the custody-based HCP or conveyed to hospital.

9.5.1 On arrival at a custody suite, arresting officers should complete the top section of the Custody Checklist 051-001. This requires details of the prisoner and the circumstances of their arrest to the best of the offender's knowledge.

9.5.2 Details of the crimes alleged, the circumstances of arrest and the behaviour of the prisoner since the officers began their engagement should be disclosed to the custody staff in as much details as possible.

9.8.1 All police officers and staff should be aware that, in regards to a person who is eventually arrested, the relevant custody episode begins at the moment the person engages with the police, which of course may be some time before they are actually arrested.

9.8.2 For example, the behaviour of a person who is traced by police and their reactions to being arrested, any opportunities the person had to secrete or hide contraband, their demeanour or comments made during the journey to the custody suite, may provide valuable information to custody staff in determining levels of threat and vulnerability.

9.8.3 Arresting officers should be encouraged to inform custody staff of any local information which they may know about the prisoner, perhaps from previous dealings or arrests.

9.8.4 Ultimately, the arresting officers should be asked directly by custody staff at the charge bar if they have provided all pertinent and known information.

18.1.4 Particular care is to be taken in relation to prisoners who are:

- drunk, or
- under the influence of drugs
- a combination of a head injury and alcohol/drugs.

18.1.5 If a prisoner appears to be drunk and drowsy, they are to be placed in the recovery position and medical assistance summoned immediately.

[20] A letter from Superintendent Norrie Conway written to the Scottish Fatalities Investigation Unit on 12 February 2021, following on a Police Investigations and Review Commissioner (PIRC) report on the death of Mr MacGregor, set out a response by Police Scotland to the report. The response notes that there was no evidence to suggest police actions or omissions contributed to the death but acknowledges that the deceased could have been monitored more effectively while being transported to Motherwell Police Station and that his acceptance into custody could have been expedited. The response assures that, in respect of both aspects, areas for improvement had been identified and acted upon. A memorandum was published giving clear instruction that persons in custody being transported within a cell van must be under constant observations at all times. A further communication was issued stating that arresting and escorting officers must provide updates to custody staff of any issues that they have knowledge of which may affect the care and welfare of a person while in custody.

[21] The response noted that the presence of the deceased in the holding area had not been communicated by the early shift custody sergeant to the late shift custody sergeant which, along with the volume of other prisoners, caused a delay in the deceased being processed. Inspector Seagrove had identified from a summary of activity at the charge bar showed that there was a period of some 45 minutes between the time of completing processing of the prisoner ahead of the deceased (15:37 hours) and the deceased being brought to the charge bar (16:25 hours). A handover between shifts would have taken place at around 16:00 hours. The response advised that a short life working group had been tasked to identify areas for improvement and to streamline and standardize the approach to handover procedures. In the meantime, Quality Assurance Inspectors audit custody arrangements in real time, on a 24 hour basis.

[22] There had been a huge increase in the amount of CCTV coverage in custody suites around the time of COP26 and the introduction of electronic whiteboards into custody suites should allow for a better handover process.

[23] Police Inspector Seagrove was of the view that a search of the mouths and ears should be carried out as part of a systematic search. There was nothing written regarding such a search. A search of the mouth and ears would not interfere with the privacy of the individual nor have an impact on their dignity or wellbeing. An initial search must be thorough and discreet. In a search at the locus, the most which could be hoped to achieve by way of a thorough search would be a pat down and to search the pockets, waistband, and, if really concerned, the shoes.

[24] The Chief Constable led evidence by way of affidavit from Stewart Taylor, the Fleet Manager for Police Scotland, who spoke to the use of cell vans for transportation of prisoners. Cell vans are not used exclusively for transporting prisoners and are used for the transport of offices and kit. Most cells vans have rear facing seats in the back, facing the cage, about a foot away from it. The vans have ample room for storage of kit and equipment.

[25] The Chief Constable also led evidence by way of affidavit from Stephan Dalchow, consultant anaesthetist and intensive care treatment at University Hospital Wishaw. Dr Dalchow spoke to the deceased's treatment at the hospital and gave opinion evidence, based on his expertise, that whether or not the deceased consumed drugs during the period from his detention at the locus until his presentation at the hospital this would have made no difference to the treatment and was not likely to have altered the outcome. Similarly, earlier attendance at the hospital would not have altered his treatment, the onset of cardiac arrest, or the sad outcome.

Submissions

[26] All parties were in agreement that there were no precautions which could reasonably have been taken which might realistically have resulted in Mr MacGregor's death being prevented. That was because of the consumption of drugs and alcohol before his arrest. All were also in agreement that the packet containing cocaine was likely placed in his mouth while he was in police custody on 16 August 2019.

[27] The Crown identified two matters for exploration. First, the presentation of the deceased over the course of the day until his collapse at the hospital and, second, that he was found with a package in his mouth over two hours after his arrest. The crown submitted that, after considering the evidence, it could be found that there was nothing in his behaviour or presentation which would have caused the officers to seek medical assistance before it was sought. That he had the package in his mouth could be dealt with in terms of section 26(2)(g). The court would be entitled to make any recommendation it considered should arise from that and one suggestion was that a more thorough search might be appropriate at an earlier stage where there was a delay in the process.

[28] For the family of the deceased, it was submitted that there were four issues to explore, under the headings of information gathering and sharing, search of the deceased, observation of the deceased, and Standard Operating Procedure. There were deficiencies in each area individually but there was also a cumulative effect. It was submitted that what should follow, for the purposes of section 26(2)(g), should be that police officers should be dissuaded from forming subjective assumptions about the need for medical assistance, the deceased ought to have been searched much sooner and more thoroughly than he was, the deceased should have been taken to hospital earlier than he was, and that the Standard Operating Procedure should be essential reading for all officers.

[29] For the Chief Constable of the Police Service of Scotland, it was submitted that no recommendations should arise given the initial and refresher training given to police officers and the procedure and infrastructure review since the death of Mr MacGregor.

[30] For the five police officers involved in interacting with the deceased on 16 August 2019, it was submitted that the police officers had complied with the Standard Operating Procedure. Mr MacGregor’s death was a tragic event brought about by the circumstances which occurred prior to his arrest and served as a sad reminder of the dangers of consuming controlled drugs and the particularly toxic mix of cocaine and alcohol.

Analysis

[31] It is evident from the evidence of Dr Dalchow as well as the agreed facts regarding the medical intervention, that everything which could be done by medical staff, to save the life of Mr MacGregor, was done.

[32] This inquiry arose from the fact that the deceased was in custody at the time of his death. It is clear, from the evidence, when and where Mr MacGregor's death occurred, that there was no accident which resulted in the death, and that the cause of the death is as set out in the findings of the post mortem.

[33] I considered whether there are any precautions which might have been taken while he was in custody which might realistically have resulted in the death being avoided, and any defects in the system of managing persons in custody which

contributed to the death. I concluded that during the period when the deceased was in custody on 16 August 2019, and before his presentation at the charge bar, he placed in his mouth a small bag which contained cocaine. It appeared that the bag was sealed at the time it was recovered from his mouth. Mr MacGregor had been consuming cocaine and alcohol over a period of some hours immediately before he was detained. The cause of his death arose from cocaine intoxication. Whether or not he consumed additional cocaine after his detention, the outcome is not likely to have been different. Therefore the court is unable to say that his death might realistically have been avoided or that any defects in a system of working contributed to his death. This leads to that part of the determination in terms of section 26(2)(e) and (f) of the 2016 Act.

[34] I went on to consider whether there are any other facts which are relevant to the circumstances of the death. I concluded that there were facts, including deficiencies in the application of the Standard Operating Procedure, in the circumstances surrounding Mr MacGregor's death, which either have already been addressed or might still be addressed, so that other deaths in similar circumstances might be prevented. That might be where, for example, a person was prevented from consuming what transpired to be a fatal quantity of drugs while in police custody. The Standard Operating Procedure has guidance which, if applied, should reduce the risk of a person being able to conceal an item such as a package of drugs and place it in their mouth, as the deceased did and which could lead to the person's death.

[35] I will first deal with a number of areas raised in submissions, some of which include relevant facts, but which did not result in a recommendation in the inquiry. I

was satisfied that when the deceased was searched following arrest at the locus, he was searched at an early stage and as thoroughly as was feasible while permitting him his dignity. The search included areas where drugs might be concealed without going further than the waistband area. It resulted in recovery of cannabis. A more thorough search at that point would not permit a person in custody to maintain their dignity. I accepted evidence that it would not have been feasible to search him further within the van due to the lack of space. A more thorough search, that is a strip search, would take place after the deceased was presented at the charge bar because of the finding of cannabis on him. Having considered the prospect of the introduction of a further search once a person was in the holding area, I concluded that the opportunity for any more extensive search than the initial search would be limited by lack of privacy in the holding area, where other persons were being held in the same area. Although it is a possibility that such a search might be carried out as part of a dynamic risk assessment on a case by case basis, I concluded that I should not make any recommendation in the inquiry in that regard. Rather, proper observation between the initial search and the strip search should be an adequate measure to reduce the risk of a person consuming drugs in that time.

[36] From the evidence, it was clear that the deceased was able to access the package of drugs after he was searched and while handcuffed to the rear or to the front. It is more likely that he then placed the item in his mouth after he was handcuffed to the front but it is not possible to say exactly when during the time he was in police custody that this occurred, other than that it was after the initial search. He was able to access

his trouser pocket area while handcuffed to the rear. I cannot exclude that he took the item from his person or the cage while he was in the cell van and then place it on the bench where he was sitting to lean over and pick it up with his mouth. What I do infer, from the evidence, is that the item was placed in his mouth at some time between him being searched initially (at which time he was talkative and there was no sign of him having any item in his mouth) and the item being discovered at the charge bar (when he was not answering verbally).

[37] The deceased and the officers escorting him had a long wait in the holding area. While staff at the custody suite must have been aware of their presence when they allowed them entry to the custody suite via secure entry buzzer on their arrival, it seems that their presence in the holding area was overlooked or forgotten. The screen showing the holding area, which would have reminded custody officers of their presence, was broken. I am satisfied that measures which have since been taken by the Police Service of Scotland have satisfactorily addressed the issue of undue delay in this part of the process being caused by deficiencies in monitoring the holding area or in the handover between custody staff shifts.

[38] In respect of the issue of seeking medical attention, the officers thought the deceased to be both drunk and tired. A significant proportion, if not a majority, of detained persons are under the influence of alcohol or drink or both. I could not go as far as reaching the Chief Constable's suggested finding that cocaine toxicity did not manifest itself until the deceased's collapse in the hospital. However, at the same time, there was no evidence that the deceased was unwell from the ingestion of drugs at the

time of his waiting in the holding area as opposed to his behaviour being due to, for example, being drunk and tired. Inspector Seagrove did not consider that the time which elapsed before which police sought medical attention was an issue of concern and it is not a matter from which any recommendation arises. There is however an issue arising as to the officers' knowledge and acceptance of the guidance within the Standard Operating Procedure in this regard, which I come on to address.

[39] The issue of gathering and sharing of information by escorting officers to relieving officers and custody suite staff has been considered. There were instances where it could have been better. In particular, the arresting officers were in possession of knowledge relevant for the purposes of custody staff, that being the details of his consumption of drugs and alcohol over a particular period of time. The arresting officers should have expected to provide this information to custody staff at the charge bar if they were not relieved from their duty. Where it transpired that they were relieved of their duty before attending the charge bar, this information should have been passed to the relieving officers for onward transmission to the custody staff. There seemed to be some emphasis in evidence that, in any event, the deceased would be asked questions which might elicit relevant information regarding his consumption of drugs. That is an important part of the process of ingathering information and will be effective if the person is willing and able to provide the relevant information. However, it should not be seen as absolving escorting officers at the end of the day from their own responsibility to ensure information is gathered and shared. I am satisfied that the Standard Operating Procedure (at 8.1.7, 9.5.2, 9.8.2, 9.8.3, 9.8.4) provides for adequate

information sharing and that the steps taken by the Police Service of Scotland since Mr MacGregor's death, reminding officers of the importance of information sharing, serves to address the deficiencies arising in this case.

Recommendations

[40] I now turn to the issues in respect of which I have made recommendations.

[41] The Standard Operating Procedure does not include that an initial search of the person include a search of the mouth and ears. I am satisfied that the deceased did not, in fact, have drugs in his mouth on arrest. However, a search of the mouth and ears, as suggested by Inspector Seagrove, might well reduce the likelihood a person being able to carry concealed drugs in police custody. I accepted her evidence that such a search could still allow for a person's dignity to be preserved and the inclusion of it in an initial search seems worthy of consideration. The issues of safety and feasibility are ones which would presumably have to be taken account of in any such consideration.

[42] Constable FY seemed to know only of the existence of the Standard Operating Procedure. This was not because of a lack of recall on his part. Rather, his recollection was that the Standard Operating Procedure was not specifically referenced in training. He had not looked at them subsequently before the deceased's death. Inspector Seagrove explained that officers would learn from their tutor's training and that realistically it was not expected that they would read the Standard Operating Procedure. Constable FY gave his view of how the Standard Operating Procedure worked. He

spoke with what seemed, on the face of it, some authority on them when in fact he had not read them. It seemed that a false sense of familiarity with the Standard Operating Procedure can arise in officers, which in turn reduces the effectiveness of the Standard Operating Procedure. There seemed to be a lack of standardized basic knowledge of the Standard Operating Procedure among officers. Both Constable MM and FY seemed to disagree with what in fact is the guidance on how to react if a person was drowsy and drunk and yet Constable FY, at least, had not read it. While a dynamic risk assessment could certainly justify deviation from the Standard Operating Procedure, there should be a familiarity in the first place with the procedure and its principles should form a foundation when making a dynamic risk assessment. It would seem preferable if a dynamic risk assessment was at least partially informed by the content of the Standard Operating Procedure.

[43] The cage of the cell van not being searched before the deceased was placed in it, was a deviation from the Standard Operating Procedure which was not justified by a dynamic risk assessment. It was said that the van "would" have been searched at the start of the shift, however that does not address the issue of a person leaving an item in the van during the course of the shift and before the deceased entered. The decision to sit in the front facing front passenger seat on the journey to the police office was made in the absence of knowledge of that aspect of the Standard Operating Procedure and without a discernible risk assessment. There did not appear to be a good basis for failing to pass on information to the custody officer or the relieving officers about the deceased's use of drugs and the finding of cannabis on his person. With a view to

addressing the issue I have made a recommendation that a review takes place to ensure that training incorporates specific reference to the Standard Operating Procedure in order to test and ensure that officers are familiar with it and how to reference it.

[44] The version of the Standard Operating Procedure at Crown Production 20 provides at 7.3.1 that where a cage van is being used for the carriage of prisoners, the escort will *ideally* (my emphasis) occupy the seat nearest the cage so that they may keep the prisoner under observation at all times. I gathered from the evidence from Inspector Seagrove that the rear facing seat was often inaccessible because of kit and equipment which was not moved. The evidence of Stewart Taylor was that the vans have kit storage areas between seats and that there is ample storage for kit and equipment. Having considered the varying accounts given by Constable FY and also the account of Constable MM about the way in which Constable FY sat in the front seat of the van, I could not rely on the account that he was sitting diagonally, and I was not persuaded of any significant level of observation being made of the deceased while he was in the van. From the evidence, it is clear that a person wearing handcuffs to the rear is still able to move their hands to parts of their person where items may be hidden. Unobserved, within a cell van cage, a person could place any such item onto the bench and thereafter lean over to the bench to pick the item up with their mouth. Consistent observation from a rear facing seat would significantly negate the opportunity to do so undetected. The word "ideally", used in the Standard Operating Procedure, introduces an element of ambiguity where it seems that rear facing seats are often not used when they might feasibly be. I have therefore recommended that, unless it is not feasible to move any

obstruction from the rear facing seat, then the rear facing seat should be used for the purpose it was designed for.

[45] The officers and the deceased had a long wait in the holding area. It is obvious and understandable that the officers' concentration was slipping to the point that, despite them both being present in room, neither officer noted the deceased's hands move round at his trouser pocket area apparently manipulating around that area. One was looking through the glass door while the other had their head down to the floor. On another occasion they did not notice his hands at his sock area. On another occasion, one officer was scrolling through his phone where there was apparently no need at that time and he was not looking at the deceased. Both officers should have been aware that their concentration was slipping and it would be better if they were to take steps to counter this. I have made a recommendation in that regard.

[46] Although it is not a matter which the court is to make a determination upon in an inquiry such as this, I wish to acknowledge and highlight a matter which Mr Gilbride raised on behalf of the mother of the deceased. The family of Mr MacGregor experienced a delay in being informed of the hospitalization and sudden collapse of Mr MacGregor. This was compounded by police referencing incorrect personal details when they did so. Understandably this added to the family's considerable distress at a very difficult time for them. The matter was noted by all those present at the inquiry and I am confident that appropriate steps will be taken to ensure that lessons are learned from it.

[47] I conclude by extending my sincere condolences, and that of parties in the inquiry, to the family of Mr MacGregor.