SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS

[2024] FAI 14

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DETERMINATION

BY

SHERIFF PRINCIPAL DEREK C Y PYLE

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

into the death of

WARREN GEORGE FENTY

ABERDEEN, 10 May 2024

Introduction

[1] The investigation of Mr Fenty's death has taken far too long. It is now 10 years since the event. I discuss the reasons for that below, including the actings of the Crown and the failure of the presiding sheriff to make the determination, which resulted in my having to take the unprecedented step of taking over the inquiry.

[2] Due to the availability of modern technology introduced by the Scottish Courts and Tribunals Service during the course of the Covid pandemic, the fortunate position was reached whereby it was possible for me not only to listen to all of the evidence given during the inquiry but also to see the witnesses by way of the video recordings. Without that technology, I do not consider that there would have been any alternative to the rehearing of all of the evidence – with all the delay and possible prejudice to each or

all of the participants which that would have incurred. To that extent, the world has moved on from the traditional view courts have expressed where due to either death, incapacity or other reason a judicial office holder has been unable to produce a reasoned decision.

[3] In any fatal accident inquiry there are many interests involved, including public or private bodies and their employees and the general public interest. But in this case my view is that the primary interest is that of Mr Fenty's family, not least his mother. Everyone is affected by delay, but the family more than anyone. At a recent meeting I had with Mrs Fenty[1], it was obvious to me that the decade of delay had added a considerable burden to the grief caused by the loss of her son. It was also obvious to me that she had struggled – and continues to struggle – to understand the circumstances which had led her son to overdose on methadone, to be admitted to hospital and to end up dying in police custody. Whether having heard all of the evidence and having read this determination Mrs Fenty is able fully to understand what happened I cannot say. But I hope that what follows at least gives her some insight.

[4] My approach is to set out what are for the most part uncontroversial findings in fact.[2] I will then discuss the evidence under various headings and finally deal with various statutory matters required of a determination.

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[1] The holding of the meeting was the subject of criticism by some of the parties. I deal with that at the end of the determination.

[2] I have not included in the findings in fact all of the agreed matters in the Joint Minute. Not all of them are crucial and given that the determination is published I regarded some as confidential to Mr Fenty's family and need not be disclosed.

[5] The purpose of fatal accident inquiries is not to attach blame to any organisation or individual, but it can – and should – identify any failures which contributed to the death. At the outset, I can say that while Grampian Health Board and Police Scotland rightly accepted that changes in systems and processes were required as a result of Mr Fenty's death (and which they have introduced) I have concluded that no one individual can be held responsible. Indeed, all those involved, whether medical practitioners or police officers, were doing their best in what proved to be quite exceptional circumstances. Nevertheless, I do identify certain institutional failures by Police Scotland which, while not on the evidence being the cause of death or indeed materially contributing to it, resulted in missed opportunities to have Mr Fenty returned to hospital where it is likely, although by no means certain, that he would have survived. I also refer to failures by the forensic medical examiner at Kittybrewster custody centre (failures which he himself very fairly and readily admitted) which also resulted in the same missed opportunity.

[6] It is often the case that after hearing the evidence the sheriff will set out in considerable detail what changes to practices and procedures have occurred since the date of death – sometimes with recommendations for additional changes. I make no such recommendations in this case. Indeed, none of the parties invited me to do so. It is plain that the world has moved on considerably in the last 10 years and the current culture for the care of police custodies is fundamentally different. Given the length of time which has passed, I do not discuss these changes in great detail and describe the current position only in broad terms.

[7] I am grateful to all the parties' representatives for their very full written submissions at the end of the hearing of the evidence. They have made my task much easier.

Findings in fact

[8] In the early hours of 28 June 2014, Mr Fenty was found lying unconscious at a dwelling house in Aberdeen having taken an apparent overdose. He was taken by ambulance to Aberdeen Royal Infirmary.

[9] In the hospital high dependency unit, Mr Fenty received treatment for a methadone overdose by the infusion of the drug, Naloxone. The infusion was interrupted by the intravenous access being lost by the displacement of the cannula in Mr Fenty's arm and his refusal to allow it to be reinstalled. Nevertheless, the view of the clinicians was that while preferable it was not essential that the infusion continue. The infusion ceased at 12.44 hours. The manufacturer's recommended period for clinical observation after the cessation of the infusion is 6 hours, but that is subject to change depending upon the clinical appearance of the patient.

[10] Mr Fenty intimated his intention to discharge himself from the hospital. While the clinicians would have preferred that he remain within the hospital for the full 6 hours, after a psychiatric assessment was carried out the Accident and Emergency consultant, Dr Lee, released him from hospital at 15.20.

[11] During the whole period in hospital, Mr Fenty was observed by police constables who had been instructed immediately to detain him upon his discharge, all in terms of

the now repealed section 14 of the Criminal Procedure (Scotland) Act 1995 on suspicion of offences under the Misuse of Drugs Act 1971. He was immediately so detained and was transported to Kittybrewster custody centre.

[12] Prior to Mr Fenty's departure from hospital, Dr Lee asked one of the police officers whether or not he required him to complete a form. The police officer said that he did not. In accordance with the relevant Police Scotland standard operating procedure at the time, the police officer was correct.

[13] In Dr Lee's clinical judgement, the risk of opiate toxicity returning was low. Mr Fenty's level of consciousness remained at GCS 15, despite the rate of Naloxone infusion having been decreased twice and the infusion having ceased almost 3 hours previously. That judgement was a reasonable one. In any event, if Mr Fenty's discharge had been delayed until the hours had passed, namely 18.44, he would not have been in a clinical condition for him not to be so discharged.

[14] Mr Fenty and the police officers arrived at Kittybrewster at 15.46. Both officers were aware that Mr Fenty had been in hospital overnight, had taken a methadone overdose and that he had been treated in the hospital high dependency unit. One of the officers, Police Sergeant Moir, was aware that Mr Fenty had been treated with Naloxone.

[15] When a person is taken into police custody, he requires to go through a formal booking-in process, including a vulnerability assessment. The relevant Police Scotland standard operating procedure required that the arresting/ escorting officers inform the custody staff of any known issues which might affect the person's care and welfare whilst in police custody and all relevant information they had gained about the person

during their enquiry and interaction with him. The escorting officers handed over the responsibility for the booking-in to two other officers. This was not an unusual step. The custody officer was told that Mr Fenty had seemingly overdosed on methadone the previous night and had been treated in hospital. He was not told that Mr Fenty had been treated in the hospital high dependency unit and with Naloxone.

[16] Mr Fenty was assessed as a high-risk custody due to recent self-harm marks on his wrists. He was taken to his cell, underwent a strip search and was provided with anti-suicidal clothing. He was placed on a 30-minute observation regime.

[17] In accordance with the accepted proper procedure, Mr Fenty ought to have been marked up to see the on-duty forensic medical examiner who would be expected to see him within 2 hours, ie by about 18.00.

[18] At the request of a police officer, the forensic medical examiner, Dr Weston, examined Mr Fenty at 20.55 to assess whether he was fit enough to be interviewed in relation to the suspected offences, because the police officer had witnessed Mr Fenty being sick. The police officer did not advise Dr Weston of the circumstances which had led to Mr Fenty's detention.

[19] Dr Weston during his examination was advised by Mr Fenty that he had taken someone else's methadone (200 mls), had been in hospital and that he was not a regular drug user. He also observed that Mr Fenty's pupils were pinpoint. Dr Weston checked with the custody desk whether a discharge letter had been issued by the hospital, but was advised that there was none. He deemed Mr Fenty to be fit for interview.

[20] Mr Fenty was interviewed, finishing at 21.43. During the interview, Mr Fenty was again sick. This was not recorded in the custody cell file; nor was it passed on to Dr Weston.

[21] During the course of the night, Mr Fenty was subject to cell visits. Neither of the officers who carried out the visits was aware that he had had a methadone overdose, been in hospital, been sick earlier and had been seen by Dr Weston.

[22] The relevant Police Scotland standard operating procedure required that at each visit the custody should be roused and spoken to and be required to give a distinct verbal response ("DVR"). PC Dawson carried out seven visits to Mr Fenty's cell between 22.43 and 04.52. Only his first two visits were DVR compliant. PCSO Murison carried out seven such visits between 00.40 and 06.40. Only the first visit was DVR compliant.

[23] The last visit to Mr Fenty's cell was by PCSO Campbell at 07.07 on 29 June 2014. She found Mr Fenty to be unresponsive. She immediately called for assistance. An ambulance was called. Paramedics arrived at 07.19 at which point police officers were trying to resuscitate Mr Fenty. He remained asystolic despite CPR which lasted for 20 minutes. He was pronounced dead at 07.25.

[24] The cause of Mr Fenty's death was methadone intoxication.

The evidence

[25] Evidence was heard from 19 witnesses (including four expert witnesses) over the course of 12 days. Much of the witnesses' evidence in chief was by way of their written

statements or reports, supplemented by additional oral examination in chief, and cross-examination. In addition, parties entered into two Joint Minutes of Agreement.

[26] The evidence fell into two chapters: the first related to the events which occurred while Mr Fenty was in Aberdeen Royal Infirmary having been taken there by ambulance; the second related to the period in which Mr Fenty was detained in Kittybrewster Police Station having been taken into custody at the hospital immediately following his medical discharge.

Aberdeen Royal Infirmary

[27] In the early hours of 28 June 2014, Mr Fenty was found lying unconscious at a dwelling house in Aberdeen having taken an apparent overdose. He was taken to Aberdeen Royal Infirmary where he underwent treatment, including treatment in the high dependency unit for a methadone overdose.

[28] Evidence was led of Dr John Lee who was the emergency consultant. He described that Mr Fenty was admitted to hospital in the early hours because of a methadone overdose and a suspected overdose of Quetiapine and Mirtazapine. The decision was made to give him a Naloxone infusion of 200mcg/ml, commencing at 05.20. Dr Lee took control of Mr Fenty's treatment from 08.00 and examined him an hour later. Mr Fenty told him that he had taken a few cups of methadone and no other medication. He was fully alert and his observations were normal/stable. The plan was gradually to reduce and then end the Naloxone infusion by midday. Shortly after midday, Dr Lee was told that Mr Fenty wanted to discharge himself from the hospital. He said that this

should not be allowed until a psychiatric assessment had been done. At 15.20 – after the assessment had been completed – Dr Lee reviewed Mr Fenty. He was fully alert and his conditions were stable, the Naloxone treatment having ended over 3 hours before. Dr Lee was satisfied that Mr Fenty could be discharged. During the course of the morning, Dr Lee was aware that Mr Fenty was "under police escort", a police officer being at or near his bed. At the point of the decision to discharge, a police officer was present. Dr Lee, being aware that Mr Fenty was to be taken into custody, asked the officer "if there was anything you need me to fill in". In asking that, he was meaning any additional information, he being under the mistaken impression, as he now recognised, that the police officers were recording the key events as they occurred during the course of the day. He was told that there was nothing to be filled in. He said that based on his previous experience there have been occasions when he has been asked to complete a form which would be for the benefit of the police surgeon. If he had been, he would have summarised the treatment received and the fact of the psychiatric assessment. He was aware of the general guidance that Naloxone treatment should be over a six-hour period, but that this was just a guide and in any event did not cover a situation where the patient wants to leave. A number of hours had elapsed since the end of the infusion. Mr Fenty was fully conscious and alert, his ventilation was normal and there were no concerning features. Moreover, he was being taken to a place of safety – a police office – and Dr Lee thought that he would be assessed there by the forensic medical examiner.

[29] In his evidence at the inquiry, I considered that Dr Lee was an impressive witness. He had carefully reflected on the treatment he had given to Mr Fenty and readily accepted that he should have recorded in the medical records that he would have liked to have kept Mr Fenty in hospital for longer but that he could not be kept against his wishes. He explained that this was in the context of the considerable time pressures he was under on the day, having responsibility for 100 patients. He also accepted that knowing now that the police officer was not taking any notes about the treatment it would have been beneficial to have provided information directly to the police surgeon. These candid comments, while not material to the issue of his overall professional competence, are to his credit.

[30] Evidence was also given by Staff Nurse Cheryl Cummings and Senior Staff Nurse Nicola Anderson. SN Cummings commenced her duties at 07.00 on 28 June 2014. During the handover of patients, she was told about Mr Fenty and that he was "under police escort". During the day she was aware of uniformed police officers being on the ward, but was not privy to any detailed discussion with them or between them and Mr Fenty. She confirmed that on his discharge the police officers did not seek any medical information from her; nor did she offer any. SNS Anderson was on duty during the latter part of Mr Fenty's attendance at hospital. She reported that at 10.30 Mr Fenty had gone to the toilet and removed the cannula which was being used for the administration of the Naloxone. He refused to have it reinstated but she was aware that Dr Lee was content that the dose he had already received had worked. She was aware of the presence of police officers and the eventual decision that Mr Fenty could be

discharged, but was not privy to any discussions between medical staff and police officers at that point.

[31] Police Constable Martin was the first police officer to be present while Mr Fenty was in hospital. He was a very junior officer, having been in post for only a matter of months. He was instructed that if Mr Fenty intimated an intention to discharge himself he should detain him under section 14 of the 1995 Act. At 14.00 he was relieved by Police Constable Melville (also a very junior officer) and duly passed on to him the instruction for the detention. Both officers were aware that Mr Fenty was in hospital because of a methadone overdose. PC Melville was in Mr Fenty's presence, apart from a period when he was being psychiatrically assessed, until he and Police Sergeant Moir detained Mr Fenty at 15.28, after which they took him to Kittybrewster Police Station.

[32] The solicitor for six of the police officers involved in the inquiry, including PS Moir, was critical of Dr Lee's decision to release Mr Fenty after only 3 hours, rather than the recommended 6 hours for Naloxone infusion and monitoring. The difficulty with that submission is that it ignores the fact that Mr Fenty had stated an intention to discharge himself, despite Dr Lee telling him that it was his preference that Mr Fenty stay in hospital – and in the context of his refusing the reinstatement of the cannula. In any event, this submission was not supported by any expert witness who gave evidence at the inquiry. Indeed, the contrary was true.

[33] Dr Michael Johnston is a very experienced consultant in emergency medicine. He was an impressive witness. He has considerable experience in his current role at Ninewells Hospital in Dundee and Perth Royal Infirmary of dealing with the same

situation as faced the staff at Aberdeen Royal Infirmary on Mr Fenty's admission. Dr Johnston considered that the clinical treatment conducted by the medical practitioners, including Dr Lee, to be appropriate in the circumstances. He noted that Mr Fenty had been discharged from hospital before the recommended period of 6 hours from the cessation of his treatment with Naloxone but that even if he had remained there for the full recommended period he still would have been discharged at that point. The basis for this conclusion was the evidence about Mr Fenty's physical presentation from the police officers and the forensic medical examiner, Dr Weston, during Mr Fenty's detention during the rest of the day and into the early hours of the following morning at Kittybrewster. In any event, Dr Johnston opined that many consultants in emergency medicine would have released Mr Fenty at the same time as Dr Lee. During his parole evidence, Dr Johnston said that what subsequently happened to Mr Fenty - the delayed return of opiate toxicity while at Kittybrewster - was highly unusual and unexpected.

[34] Indeed, as will become clear, Dr Johnston's expression of that point is highly significant for other aspects of the evidence in this inquiry and the conclusions to be reached.

[35] I note that in her final submissions counsel for Mrs Fenty did not seek to criticise the care her son received in hospital. I think that counsel was right to do so. On the evidence, the criticism levelled at Dr Lee by the solicitor for the six police officers was misplaced.

[36] A further important issue which arises is the system which was in place to communicate to relevant parties the clinical treatment provided in hospital. As Inspector Mark Fleming explained in his evidence, there was a procedure in place for the situation where a person was in custody but was then taken to hospital, including the preparation of an illness/injury form. But there was nothing in place for the situation which arose here, namely where the person to be detained and subsequently arrested visited the hospital before being transferred to the police custody unit. Dr Lee explained that at the time a discharge letter would be prepared by a junior doctor and subsequently approved by a consultant. The purpose of that letter was to inform the patient's general practitioner, doubtless to ensure, first, that the GP has a history of the treatment in case it is relevant for future health issues of the patient and, secondly, in case any follow up treatment is recommended by the hospital physicians. No such follow up was recommended. The letter was not envisaged as a means of communication to police officers about what care should be provided for a prisoner taken into custody following the hospital discharge. Dr Johnston did not criticise the system that was in place at the time in Grampian Royal Infirmary; nor indeed the steps which Dr Lee took.

[37] There was however a review by Grampian Health Board of its procedures. That was to be expected, not least because experience shows that defects in processes can become first known as a result of a tragic death, even where such defects are neither the cause of nor materially contributed to that death. Following discussion with Police Scotland, the latter has introduced a new standard operating procedure to deal with

situations like Mr Fenty's – Police Scotland Care and Welfare of Persons in Police Custody Standard Operating Procedure (SOP) Version 17, published on 4 May 2022. This provides as follows:

> "18 Persons Hospitalised from Locus
>
> There may be circumstances where a person is either taken directly to hospital from the locus prior to being arrested, or has been admitted to hospital prior to Police involvement.
>
> Where circumstances are such that an arrest is not affected [sic] until after person [sic] is discharged from hospital and thereafter taken directly to a Custody Centre, Officers must detail care instructions including brief details of treatment provided and the relevant Doctor/Nurse who examined them, within their Police issue notebook/ mobile device.
>
> This information must be accurately passed to the Custody Supervisor, who will assess if the person requires any further medical attention on arrival at the Custody Centre. The Custody Supervisor must ensure this information is recorded on NCS."

The Police Federation is concerned that the above imposes a duty on a police officer to obtain information which might properly not be provided by the medical staff. This issue has still to be resolved but for the purposes of this inquiry nothing turns on that.

[38] Evidence was given by Dr Donna Paterson, a consultant in emergency medicine in Aberdeen since 2016. She reviewed the procedures which were in place prior to her appointment. In 2015, in the year after Mr Fenty's death, a procedure was introduced whereby there would be direct telephone contact between the emergency department clinician and the on duty forensic medical examiner at discharge of every patient from the emergency department into police custody. She reported that the procedure was not well known by clinicians and that this has now been resolved by the introduction in

2020 of a standard operating procedure setting out the lines of communication to be followed in that situation, including the completing of any paper work provided by police officers. A discharge letter for the general practitioner is now produced electronically but it would not contain any more information than would have been provided to the forensic medical examiner or the police.

[39] I discuss Dr Weston's evidence below, but in the context of the cause of Mr Fenty's death or anything which materially contributed to the above processes – or rather the lack of them – it is essentially irrelevant. While I acknowledge that Dr Lee stated that the reasons he decided to allow the discharge of Mr Fenty from hospital included that he was going to, what Dr Lee described as, a safe place, namely police custody, and that he would have preferred that Mr Fenty remained in hospital for a few more hours, the fundamental reason was that Dr Lee considered that Mr Fenty's medical presentation was such that it was safe to discharge him. That view is fully supported by the evidence of Dr Johnston. Thus, the lack of the formal processes is peripheral to this inquiry.

[40] Much of the evidence was concerned with what information the police officers should have obtained from the hospital clinicians and what they knew or did not know about what had happened to Mr Fenty before his arrival at Kittybrewster. Officers were also criticised for not referring him to the forensic medical examiner immediately after his booking in. The problem with that is that there was no evidence before the inquiry that an examination by the forensic medical examiner within that timescale would have resulted in anything different than he being told by Dr Lee what had happened and that

he was satisfied that Mr Fenty was fit to be discharged. Indeed, such evidence as there is – namely from Dr Johnston – suggests that the advice from Dr Lee would have remained the same. Police Sergeant (now Inspector) Moir was also an impressive witness. He made the point that given that Mr Fenty had been discharged from hospital with no conditions attached and indeed with no follow up required, the police officers were entitled – indeed obliged given that they are not medically qualified – to treat Mr Fenty as fit and well like any other custody (subject to any additional problems such as suicide risk). As I discuss below, that position, which I accept, undermines the evidence of Inspector Fleming and, albeit to a much lesser extent, the evidence of Dr O'Keefe on the role of the forensic medical examiner and the police custody procedures. These observations are not the complete picture, as I explain, but they are relevant in relation to the procedures operating at the time over the passing of information from the hospital to the police.

Kittybrewster Police Station

[41] The primary evidence of the state of the facilities at Kittybrewster, the procedures followed by the various police officers and custody staff and the lessons learned was given by Inspector Mark Fleming who was instructed to carry out a comprehensive review of the procedures adopted at Kittybrewster following Mr Fenty's death. He prepared a report in which he is critical of the overall process for identification of the requirements of the care plan for Mr Fenty. But that criticism is based upon his understanding at the time that a person who had been administered

Naloxone should not be admitted into custody until 6 hours had passed. That understanding was based upon an email of September 2013 from an Inspector Chalmers. But he also acknowledged that further guidance had been introduced in 2017 in which it was noted that advice from NHS Scotland was that the period for observation after the administration of Naloxone could vary between two and 12 hours and that accordingly the "specific 6 hour rule had been removed". Nevertheless, he concluded that "the essential element was the requirement of arresting or escorting officers to obtain the time when Naloxone had last been administered, details of the discharging doctor and to notify the custody sergeant".

[42] Inspector Fleming accepted that he was not medically qualified to express an opinion on the effects of the volume of methadone consumed by Mr Fenty or how much Naloxone would be required to counteract it, but he regard himself as qualified, it seems, to have an opinion on the length of time for observation. The difficulty with that evidence is that it flies in the face of the medical evidence, particularly that of Dr Johnston. In order to evaluate the assessment of risk carried out by the police officers at Kittybrewster it is necessary to consider what clinical information would have been provided by Dr Lee if that had been given and then passed on to the custody officers. In my opinion, based on the evidence of Dr Lee and Dr Johnston all that would have been provided was that Naloxone of a specified amount had been given, observations had followed it and that Mr Fenty was clinically suitable for discharge from hospital. It would not have required him to be further observed for the effects of methadone. That is self-evident. If it were otherwise, Mr Fenty would not have been discharged. I

therefore do not take from Inspector Fleming's evidence that the police officers required to take any other steps in their assessment of risk and that their conclusion that Mr Fenty be regularly monitored while in custody was based not upon the fact of his having ingested methadone and had received Naloxone treatment but was upon the fact that he had a history of suspected self-harm and was therefore a suicide risk.

[43] But there is a further problem with Inspector Fleming's opinion: affidavits were produced late in the day and in light of his insistence that what he described as the "six hour rule" was in place for many years and was universally known – or ought to be – by custody officers. Those affidavits were by two senior doctors who would have been responsible at the relevant times suggested by Inspector Fleming. They both said that no such rule had ever been agreed with clinicians. I do not doubt that Inspector Fleming thought that was the position, but his misunderstanding of that necessarily means that he should not have imputed such knowledge onto the other officers. I accept that there was some support for his view in Dr Weston's evidence, but standing the terms of the affidavits – and indeed that Inspector Fleming admitted that the "rule" had not been committed to writing – I am bound to conclude that no such rule in fact existed. Indeed, that conclusion is further bolstered by the evidence of Dr Lee and Dr Johnston that the recommendation from the manufacturer is no more than that and cannot be used as a substitute for clinical judgement.

[44] I have other reservations about Inspector Fleming's evidence, which I discuss later, but what can be said at this stage is that, in my opinion, his misunderstanding of the role of custody officers in dealing with a custody who had been released by a

hospital emergency consultant as fit and well with no follow up after an overdose of methadone and administration of Naloxone inevitably means that his expert evidence must be treated with considerable caution.

[45] It also follows that the subsequent admitted failures in the observation process should be looked through the prism of possible suicide, rather than potential death due to opiate toxicity. That in turn means that for the purposes of this inquiry (but subject to my further observations below), namely to identify the cause of death or any failures which may have materially contributed to the death, these failures are essentially irrelevant.

[46] It also follows, on the evidence, that I cannot accept Inspector's Fleming's other conclusion that the custody sergeant should have contacted the forensic medical examiner for advice or at least directed custody staff to arrange for Mr Fenty to be assessed by the forensic medical examiner – or indeed have him returned to hospital. I acknowledge the evidence of Inspector Hannan that in accordance with the standard procedures at the time Mr Fenty ought to have been seen by the forensic medical examiner shortly after his arrival at Kittybrewster, and the evidence of Dr Weston that he would expect to have been asked to see any person who had previously been in hospital. But even if that had been done, there was no evidence to suggest that such an examination would have reached a conclusion different from the one reached by Dr Lee. In other words, at the time when such an examination might have taken place there was nothing to suggest a deterioration in Mr Fenty's condition. I say again that everything that happened during the evening and overnight to the time of Mr Fenty's death must

be considered in the light of Dr Johnston's uncontested expert opinion that the delayed opiate toxicity, which caused Mr Fenty's death, was highly unusual and unexpected.

Missed opportunities

[47] The conclusions I have reached are not the end of the matter however. Any system of safe working will include rules and procedures which can on occasion have unexpected benefits. Indeed, it is a necessary component of a sound health and safety regime. It is often evidenced by the term "the culture", but it can equally be processes which provide protection against known problems but also against unknown or unexpected ones. In my opinion, there were a number of institutional failures by Police Scotland, which while not material as a contributory cause of Mr Fenty's death were nevertheless precautions which if they had been taken would have presented *opportunities* for Mr Fenty to be returned to hospital, which on the evidence of Dr Johnston would have probably resulted in clinicians realising at some uncertain point in the hours before his death that Mr Fenty's life was at risk and would have been able to prevent it.

[48] The first of those failures was the lack of a standard operating procedure in the form which has now been introduced to deal with the situation, not of a person being in custody, going to hospital and returning, but of a person being taken to hospital first and then being taken into custody. That circumstance, which I accept on the evidence was highly unusual, should have been in the contemplation of the police when preparing the standard operating procedure. The section 14 detention power is no

longer part of the criminal law, but it was first introduced following the recommendations of the Thomson Committee by way of the Criminal Justice (Scotland) Act 1980. By 2014, it had been in force for over 30 years. I agree with counsel for Mrs Fenty that to all intents and purposes, throughout his hospital attendance, Mr Fenty was in police custody, a position accepted by Inspector Fleming in the sense that it was not logical to make a distinction for practical reasons. The standard operating procedure should accordingly have covered that situation.

[49] I should add however, in fairness to Police Scotland, that it had the task of unifying the operating procedures of the eight police forces in existence prior to its formation. It is clear from this inquiry that this required a formidable body of work and it was inevitable that it could not be done overnight. I also recognise, as explained below, that the procedures now in place are far superior to those which applied at that time, although at the same time I appreciate that this will be of little comfort to Mrs Fenty and her family.

[50] It should also be pointed out that the standard operating procedure at the time allowed for an early examination by the on-duty forensic medical examiner – a practice which we know from Dr O'Keefe's report was also required by Strathclyde Police. That in theory might result in a conversation - clinician to clinician - between the examiner and the hospital doctor.

[51] Dr O'Keefe was for 28 years the Principal Forensic Medical Examiner for Strathclyde Police and is currently an Honorary Senior Lecturer at Glasgow University. He has a wealth of experience in the management of drug dependent persons in police

custody and was plainly well versed in the treatment of opiate induced toxicity by way of Naloxone. In his evidence he focussed on two issues: the checks carried out by custody staff on Mr Fenty during the period of his custody, which I discuss below, and the examination by Dr Weston to establish Mr Fenty's fitness for a police interview.

[52] Dr Weston's examination began at 20.55. It lasted for only five minutes. He had been told that Mr Fenty had vomited shortly before. He was unable to identify a cause for that. He noted that Mr Fenty was lucid and orientated. Mr Fenty had told him that he taken someone else's methadone and had been to hospital that day. Dr Weston observed that Mr Fenty's pupils were pinpoint. Dr O'Keefe regarded this examination as inadequate, an opinion which Dr Weston now accepted. Dr O'Keefe considered that not only was Mr Fenty unfit for interview but also that he, Dr O'Keefe, would have had considerable concerns and reservations about Mr Fenty's continued detention in police custody and instead consideration should have been given to his being returned to hospital. Dr Weston did make inquiries about whether there was any written information from the hospital available for him to examine. He now accepted that he too easily assumed that as Mr Fenty had been in hospital earlier in the day and had been discharged the hospital had no concerns about his condition. With the benefit of hindsight, he accepted that he should have immediately referred Mr Fenty back to the hospital and was confident that they would have accepted him as a patient.

[53] Dr Weston did not attempt to put any gloss over his feelings of responsibility for what had happened. He was plainly an extremely experienced forensic medical examiner. Nevertheless, in fairness to him, two points should be made. First, the

purpose of the examination was only for the interview, not to test Mr Fenty's general condition after the ingestion of methadone. That leads to the second point: Dr Weston did go looking for information from the hospital. If Police Scotland had had appropriate procedures in place a written record would have been available for him to consider. There was no evidence of exactly what would have been in it, but it is reasonable to suppose that it would have been such that, at the very least, Dr Weston would have been able to come to a more informed view about what further steps, if any, to take. Accordingly, the nub of the issue remains the inadequacy of the process for obtaining information from clinicians at the hospital.

[54] Dr Johnston did not consider the vomiting or the pinpoint pupils as necessarily significant. Vomiting might be for a multitude of reasons unconnected to opiate toxicity. Pinpoint pupils might well be merely a side effect of the treatment which had been given in hospital. The half-life of methadone could be anything between 15 and 60 hours depending upon the individual patient. For signs of potentially life threatening opiate toxicity he would expect to observe a decreased level of consciousness, difficulty in being roused, inability to speak and breathing rate deteriorating significantly – below 10 or 12 breaths per minute. If the signs which Dr Weston observed had been noticed before Mr Fenty's discharge from hospital, the pinpoint pupils would not have delayed it and while the vomiting would have it was only because of a general position that patients are not discharged if they are unable to eat or drink. Nevertheless, Dr Johnston readily accepted, as Dr Lee had, that he would have re-admitted Mr Fenty to hospital if that had been requested by Dr Weston. He also noted that given when that decision

would have been made – shortly after Dr Weston's examination – in all likelihood Mr Fenty would have survived.

[55] For custody cell checks the relevant standard operating procedure at the time provided as follows:

> "At each visit, all custodies are to be roused and spoken to enough to give a distinct verbal response" (para 13.3.2)

Moreover, in an email from September 2013, a chief inspector had emphasised to the relevant managers that "a distinct verbal response was not "mmm", "hmmm" or a thumbs up".

[56] In his evidence before the inquiry, Dr O'Keefe said that the minimum procedure should be that, if sleeping, the custody should be wakened, whether by touching his foot, knee or even his ear, his eyes should be open and he should provide answers to questions on where he thought he was and his name, address and date of birth. Inspector Hannan, the custody sergeant at the point Mr Fenty was booked in, described it as "some sort of cognitive response", not a grunt, nod or thumbs up.

[57] I should emphasise that it is for Police Scotland to decide their procedures for ensuring the care and welfare of custodies. It is best placed to determine what is and what is not an appropriate means for carrying out cell checks. Accordingly, any comments I make should not be interpreted as putting a gloss on the police definition of distinct verbal response or suggesting that current procedures should be changed. But one of my responsibilities is to analyse the procedures which were in place at the time of Mr Fenty's death and how they were implemented. That is not in order to apportion

blame – not a matter for this inquiry – but it is appropriate for me to identify failures which might have prevented the death.

[58] PC Dawson and PCSO Murison accepted in their evidence that they had failed to carry out DVR compliant checks of Mr Fenty. PC Dawson carried out seven checks between 22.43 and 04.52. Only the first two visits were DVR compliant. PCSO Murison carried out seven checks between 00.40 and 06.40. It was only on the first of those checks did she obtain a compliant DVR.

[59] PC Dawson, in his evidence, explained the background circumstances which he and PCSO Murison faced that night. He was a relief officer, just helping out as backfill for the permanent custody staff. He had been performing that role for 3 years but primarily when the previous custody facility at Queen Street was full and, say, four or five custodies were transferred elsewhere and he would supervise them. 90% of the time he would be doing the booking-in role, not the cell checks. On the night of Mr Fenty's detention, the situation in Kittybrewster was chaotic. He and PCSO Murison were running around like headless chickens. The facility had first been opened only a few days before. The fire alarm was faulty and going off. The CCTV cameras were malfunctioning. The fingerprint machine was not working, with the result that one officer who would normally perform cell checks spent his whole shift dealing with that problem. There were 42 custodies, a number which he had never experienced before. He was feeling "very distressed". He knew of the standard operating procedure although he had never read it. He was aware of the email emphasising the need for DVR compliant checks. He accepted that he and PCSO Murison probably failed to

notice a deterioration in Mr Fenty's condition and if they had done so they should have called for medical assistance. He had not had any hand-over discussion when he started his shift because immediately upon his arrival, 15 minutes before the start of it, he had to assist Dr Weston with another custody, which took him to 22.20, twenty minutes after the start of his shift. He could not check the Cell files for each custody. Some are up to 16 pages. To read all those for 42 custodies was unrealistic. He did not know that Mr Fenty was on 30-minute checks because of a suicide risk, although he had thought that was probably the reason. He certainly knew nothing about the methadone overdose. Checks of female custodies were not supposed to be done by male officers – and vice versa. But because of the high number of custodies and the short staffing, he and PCSO Murison had to breach that rule. During the night, there was a dirty protest by another custody. That alone took him away from his other duties for an hour.

[60] PCSO Murison also said that she had been running around like a headless chicken. At the start of her shift she had a brief handover from another PCSO, but no mention was made of Mr Fenty. It was impractical to read the Cell files. She had only been doing the job for a short time. She could not remember any training on the terms of the standard operating procedure. She accepted now that she should never accept a grunt as DVR compliant but she did not know that at the time. This was only her second shift at Kittybrewster, and for the previous one she had been at the booking-in desk. When she did the checks she just assumed that Mr Fenty was in a deep sleep – a natural thing for what she regarded as a run of the mill custody albeit subject to a risk of suicide and therefore had to be watched for that.

[61] PCSO Valerie Campbell gave evidence about her discovery of Mr Fenty's condition immediately before emergency medical assistance was called at 07.00. She gave some evidence on the practicalities of performing DVR compliant checks. She accepted that she had been trained to get the custody actually to say something and she would never leave a cell without getting something by way of communication, but "you can't get what you can't get". The rule has to be put in perspective. Not all custodies are in the mood to speak to police officers – often the contrary. "We [custody staff] all want a chat, but sometimes all you get is a grunt, a moan, an "OK", maybe a wave." The key thing is to get a response which is acceptable, bearing in mind that you get to know the custody on a personal level. If in doubt, she would shake or prod the custody but only if some other officer is present.

[62] Inspector Fleming was unimpressed by this body of evidence. Yes, Kittybrewster had some teething problems, but they were not such as to override the fundamental duty to ensure that custodies in the care of the police are looked after properly. Their care and welfare is the priority. There were two fingerprint machines. The custody sergeant should not have instructed an officer to be diverted to that problem. The current staff numbers at Kittybrewster have nearly doubled (on Mondays to Fridays there are a police sergeant and four staff; Saturdays police sergeant and five staff; Sundays police sergeant and six staff) and there is now a nurse on site at all times. The ratio of custodies to officers is now 10:1. But the reason for the increase was a change in the modelling of the staff duties. In the previous facility at Queen Street, there were days when there were up to 36 custodies. The problem on the night was a failure

to prioritise custody welfare. It was indeed a breach of the standard operating procedure to have officers entering a cell of a custody of the opposite sex, but it was "OK to depart from that". Every DVR check should be performed to the same standard, no matter the condition of the custody, the test being whether the custody is "fit and well". The training programme of new staff in 2014 would have included training on DVR. A PCSO would not be in an operational environment without that training. The contemporaneous CCTV footage did not imply that there was chaos. The checks which were performed by PC Dawson and PCSO Murison were, more or less, done timeously. Accordingly, time pressures were not there to warrant them being non-compliant.

[63] I have already explained the problem with Inspector's Fleming's belief about the six-hour rule for Naloxone. In my opinion, that mistaken belief coloured much of his overall approach to his investigation, report and his conclusions within it. But there are further problems:

a. When first instructed (by a chief inspector), he was told that it was unnecessary for him to interview anyone. He should simply rely upon their statements. He said that if he had thought it necessary to do such interviews, he would have done so, but it is difficult to understand how he could decide that. It seems to me that a truly independent investigator would have done so, not least so that any differing views could be put to the various witnesses.

b. I do not doubt that he performed his task with an objective frame of mind, but it cannot be ignored that he was at the time a sergeant within the

custody facility, albeit not on duty, and indeed as an inspector now he has a supervisory role over it and other custody facilities in the area.

c. While I accept that PC Dawson should have, as he himself accepted, carried out his checks in a manner which was DVR compliant and that strictly speaking he had time to do so, his description of the environment on the night and the pressures he and others were under would not have been so quickly dismissed by an independent investigator. By doing so, Inspector Fleming, in my opinion, did not address the important question of whether there were underlying institutional weaknesses at Kittybrewster.

d. I do not understand why Inspector Fleming appeared to accept without criticism that the standard operating procedure was not followed on the night for same sex visits to cells when he, rightly, set such great store on the standard operating procedure for other events.

e. PCSO Murison and PCSO Campbell both said that they would not seek to prod or otherwise physically touch a custody to rouse them without another officer being present. That makes sense. Yet, Inspector Fleming did not address the necessary question that if there were only two officers carrying out the checks how such physical checks could possibly have been done, particularly, as we now know, PC Dawson was away for an hour dealing with the dirty protest. That alone indicates that the facility was short-staffed on the night.

f. The same conclusion should have been reached on the deployment of the officer to the fingerprinting process. To blame the custody sergeant misses the

point: if it is accepted, as I am bound to do, that fingerprinting is an important part of the process a malfunctioning machine should not be dismissed merely as a teething problem in a new facility. The correct answer should have been that contingencies ought to have been in place to deal with such potential issues, primarily by the provision of sufficient staff to deal with the unexpected.

g. In justification of the overall system, Inspector Fleming relied upon a general rule that the manner in which cell checks are carried out should be to the same standard no matter the condition of the custody. That may well be true, but taken to its logical conclusion it means that all the criticisms he otherwise makes of what occurred during the relevant period, including what passed at the hospital and at the booking-in desk, are irrelevant. That cannot be true of course. The point is surely that a custody officer has to deal with each custody as an individual. ("You get to know them personally", as PCSO Campbell testified.) A certain minimum standard is required, but each case should be treated on its merits. Inspector Fleming might well agree with that. But the overall point is that in answering questions in cross-examination by the solicitor for PCSO Murison about the effectiveness of the then standard operating procedure he produced a response which, at least to me, suggested an overreaching desire to defend at all costs the procedure for cell visits.

h. I would have expected that an independent report would have covered not just the general provision of training of custody staff but the reasons for the individual officers apparently not knowing about the standard operating

procedure. That might be their fault, but there might also be institutional shortcomings in their training, which ought to have been investigated to ensure that any lessons would be learned.

[64] In my opinion, the failure to perform DVR compliant cell checks can be put down to more than the admitted failures of the officers. Kittybrewster had been open for only a few days. There were problems which ought to have been anticipated, not of themselves but to cover the possibility of them arising. That should have been by the provision of additional staff. Moreover, in deciding on the staff provision, no-one seems to have considered the quality of the staff, rather than just their quantity. Two officers were left to deal with 42 custodies. One of them was only a relief officer; the other had been in post for only a month or so. It was always likely that such officers, particularly PCSO Murison, would struggle to cope. Accordingly, this is, in my opinion, an institutional failure by Police Scotland.

[65] It is impossible to know with any certainty that compliant DVR checks would have resulted in either custody officer seeking the advice of the forensic medical examiner. Various witnesses, including Dr O'Keefe, thought that it would. But neither officer, even if aware of the methadone overdose and the Naloxone treatment, would have been aware of what clinical signs to watch out for, such that they should have sought medical assistance. As they and others said, other than the suicide risk factor neither officer – nor indeed other officers who gave evidence – regarded Mr Fenty as any different from all the other custodies. He had been discharged from hospital as fit and well. As Dr Johnston said, Mr Fenty's delayed opiate toxicity was unexpected.

Vomiting or pinpoint pupils were not necessarily signs of it. Instead, other factors should have presented themselves. It is impossible on the evidence to know if and when those factors were present in Mr Fenty. Nevertheless, in my opinion, it can be concluded that if Kittybrewster had been run properly and DVR compliant checks had been performed, it is *possible* that medical assistance would have been sought for Mr Fenty, that he would have been returned to hospital and that he would have survived.

[66] For completeness, I should mention that the inquiry also heard expert evidence from Dr Katherine Morrison. Counsel for Grampian Health Board was very critical of her evidence. There was some force in that, but as none of the parties relied extensively upon her evidence in their submissions and I did not think it added more to the evidence of the other experts, I say no more about it.

[67] I emphasise again that the failures by Police Scotland must be looked at through the prism of it having only recently been formed and it having a huge task in bringing all of the various legacy practices into a national form which would not only be comprehensive but which would also require a major training campaign to ensure that it was learned and properly understood by all staff. On top of that, it had a brand new custody facility. These are all mitigating factors which I recognise. Moreover, the officers on the day were dealing with a medical event which the clinicians themselves had not expected and therefore had not considered as a risk which needed to be mentioned to either Mr Fenty, the police or Mr Fenty's general practitioner.

[68] Inspector Fleming's evidence on the present arrangements for custody units in general and Kittybrewster in particular was much more impressive. While I see no point in discussing these in detail given that 10 years has elapsed, I do observe that the culture has completely changed, that staff numbers have nearly doubled, that the operational model has been revamped, that DVR compliance is now universal (a point illustrated by the evidence of PCSO Murison in which she clearly now understood what she was supposed to do), that Kittybrewster has a permanent nurse presence on site, and there is a robust audit system in place to ensure that the rules are always followed.

[69] I should finally add under this chapter that on one view Inspector Fleming was put in an invidious position. It would have been better for him and for the investigation as a whole that someone independent had been appointed to give expert evidence from the police point of view. Preferably, that would have been from a different police force, but if not certainly from someone who was not part of the Aberdeen custody division. That is not to say that Inspector Fleming would not have had an important role, but it would have assisted the inquiry to know that the opinions expressed were from someone without any previous engagement within the custody facility under scrutiny.

Delay

[70] The Crown produced a timeline setting out what steps were taken. I do not rehearse those steps in detail and make only the following observations:

1. From the date of death until May the following year, the Crown had to await the investigation by PIRC, which was completed in October 2014, and the

production of the post mortem report. During that time, the Crown had active discussions with PIRC on what further work was required. I have no criticism of that period.

2. It was, however, not until June 2018 – over 3 years later – that the next step took place, which was a letter to Mr Fenty's mother advising that a joint inquiry into other custody deaths required completion before further steps be taken with this one. At the procedural hearing I invited the procurator fiscal depute to take the opportunity to explain the gap. He declined to do so. I can therefore only conclude that the gap cannot be excused.

3. The hospital and GP records and the CCTV recordings were not requested until July 2018. It is unknown when they were received, but it was not until February 2019 that experts were contacted to provide reports. While there were changes in staff during that time, why it took 7 months for this process is unexplained. Dr Johnston was first instructed at the end of May 2019. Over the coming months work was done on further information sought by him, doubtless causing a delay in production of his report, which was in late 2019. I have no criticism of that period.

4. Contact was then made with the sheriff clerk to make the arrangements for the inquiry, the first day of which took place on 14 September 2021. I have no criticism of that delay, given that it occurred during the Covid pandemic.

5. The inquiry took place for two weeks in September and there was then a gap until February 2022. I have no criticism of that. Under my instruction,

sheriff clerks are aware that fatal accident inquiries should be given appropriate priority within the system, but there can be delays, sometimes because of the unavailability of the particular sheriff due to other programming commitments but more usually because of the unavailability of all the various parties' representatives who have other commitments, including in counsel's case the High Court and one or more of the other inquiries, including major national ones, which are proceeding at the same time. It is difficult to co-ordinate so many diaries.

6. The Crown advised that major changes have been made in the investigation of sudden deaths, including a very substantial increase in the available staffing resource. That should be recognised and, indeed, there is now a very helpful system in place for the Crown to give quarterly progress reports to each of the sheriffs principal on the investigation of deaths within each sheriffdom. That secures an element of accountability and scrutiny, which my colleagues and I regard as a significant change. But the history of this inquiry is still a further illustration of unnecessary delay and how and why it should be avoided. Looking at it as a whole, over a period of 5 years and 2 months only some 22 months were usefully spent.

[71] This delay was compounded by the delay in the issue of the determination. As I have said before, I cannot explain the failure of the sheriff to do so other than to say it was for personal medical reasons. I do however myself accept that the problem should have been identified by me 6 months or so before it was. I have always had a system in

place for the monitoring of written work by the sheriffs in the sheriffdom, but that did not include fatal accident inquiries, the reason being that until now it has never been a problem. But I accept that I should have. It would have meant that by 3 months after the final date of the hearing I would have been asking questions. In the event, I was unaware of the problem until March last year, some 7 months later. I cannot go into what happened after that, except to say that I was ever conscious that other than the eventual issue of the determination by the sheriff the only, most unattractive, alternative was a rehearing of the inquiry, a step I was only very reluctantly willing to take – albeit that was indeed what happened. I promised parties that I would issue the determination four weeks after the last procedural hearing. It was only during the course of considering the evidence that I discovered that I had not been provided with all of the productions. Eventually the Crown sent me a pen drive only to find that it did not open. I required the assistance of the technology experts within the Scottish Courts and Tribunals Service to resolve it, by which time three weeks of preparation time had been lost. I was then on previously arranged leave abroad for three weeks. I have however on my return been in a position to produce the determination within just over three weeks overall.

Meeting with Mrs Fenty

[72] Some parties' representatives were critical of my decision to meet Mrs Fenty without the other parties being present, such that a motion to recuse myself from the inquiry was made. I refused it. I of course readily accept that a judicial office holder

should not meet parties in private without the attendance of all. That is a basic rule of natural justice. I also of course readily accept that justice must be seen to be done. In other words, the perception of a reasonable bystander must be taken into account. However, the situation here was unprecedented. All parties were affected by the unconscionable delay, but as I have already said I considered that Mrs Fenty had been hit the hardest. For that reason, I considered that not only in the interests of justice but also out of common humanity she was entitled to an explanation for it directly from me. The sheriff clerk was present throughout and I was careful to advise Mrs Fenty, which I had to repeat on several occasions during the meeting (understandably so given Mrs Fenty's rightful concerns), that I could not discuss the merits. A full minute of the meeting was provided to all parties. I consider that for these reasons the meeting was appropriate and that justice was served – and was seen to be served.

Formal findings

[73] I make the following formal findings:

(a) W**hen and where the death occurred:**

Mr Fenty died on 29 June 2014 at 07.25 hours at Kittybrewster Police Station, Aberdeen.

(b) W**hen and where any accident resulting in the death occurred; and (d) the cause or causes of any accident resulting in the death:**

The death was not as a result of an accident.

(c) T**he cause or causes of the death:**

The cause of death was methadone intoxication.

(e) A**ny precautions which (i) would 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:**

(1) The Police Scotland standard operating procedure for care of custodies should have had a procedure for the obtaining by police officers from hospital clinicians information on the nature of the medical condition, the treatment and any further precautions which should be taken post discharge where a person has been admitted into hospital prior to arrest into police custody;

(2) The forensic medical examiner should have carried out a more thorough medical examination of Mr Fenty, which created a missed opportunity which if taken might have resulted in his re-admission into hospital and which would be likely to have avoided his death;

(3) The custody officers should have conducted cell checks of Mr Fenty in accordance with the then standard operating procedure, which created a missed opportunity which might have resulted in them seeking the advice of the forensic medical examiner, which might in turn have resulted in Mr Fenty's re-admission into hospital, which might have avoided his death.

(f) A**ny defects in any system of working which contributed to the death or any accident resulting in the death:**

(1) The Police Scotland standard operating procedure for care of custodies should have had a procedure in terms set out at para (e)(1) *supra*;

(2) Police Scotland should have had a system in place to ensure that the Kittybrewster custody centre opened with sufficient staff to cover all eventualities, including unexpected problems with new equipment, thereby allowing custody staff to perform their duties properly, including the passing on of information at shift changes and the recording of relevant information on the cell file computerised system.

(g) A**ny other facts which are relevant to the circumstances of the death:**

None.